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Experiences and Perspectives of Women Veterans Use of the Veterans' Health Administration Services

Leanne Anthon
University of Wisconsin-Milwaukee

EXPERIENCES AND PERSPECTIVES OF WOMEN VETERANS USE OF THE VETERANS' HEALTH ADMINISTRATION SERVICES

by

Leanne Nicole Anthon

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ABSTRACT

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Leanne Nicole Anthon

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Under the Supervision of Professor Julie Ellis, PhD

Women make up 10% of the veteran population. With a projected increase of up to 16% by 2043, this is the fastest-growing demographic in the US military (National Center for Veterans Analysis and Statistics, 2017). This population may have experiences unique from their non-military counterparts such as military sexual trauma (MST), environmental exposures, post-traumatic stress disorder (PTSD), and stress related to their military occupation that may predispose this group to decreased quality of life (QOL). In recent years, the Veterans Health Administration (VA) healthcare system has attempted to increase the healthcare accessibility and services provided to the growing number of women veterans (WVs) who get care from the VA. Because only 37% of WVs are established VA patients, it can be assumed that WVs are receiving their care outside of the VA or not obtaining healthcare services at all. Additionally, 30% of WVs who seek healthcare at the VA left within the first three years of use. A qualitative study using thematic analysis was conducted to identify the experiences and perspectives of WVs who use the Veterans Affairs Healthcare System and to understand the barriers and frustrations WVs face when using the VA. Four major themes were identified: quality of care received at the VA, barriers to receiving care at the VA, frustrations with the system, and private insurance supplementation. The study found many WVs experience barriers and

frustrations when using the system, and some prefer civilian care over the VA to avoid these challenges. However, if the care were more gender-focused, participants expressed that they would prefer the VA as it is important to be connected to others who understand military service.

DEDICATION

This dissertation is dedicated to all those that have helped and supported me achieve this goal. It truly takes a village; I have a great one surrounding me!

To my kids, Elijah, Noelle, Vienna, and Jordana, thank you for your support, encouragement, and faith in me. I hope I inspire you to never stop learning in life and know that all things (even the hard times we've gone through the last five years) can work for our good and God's glory.

To my parents, Jerry and Carmen, thank you for your faith and for always believing in your daughters. We can change the world with just the support you show us! To my sisters, Jackie and Lynley, and their families, thank you for supporting me and pushing me to continue. I'm glad you two are creative and entrepreneurial to keep dreaming of how we can grow. We all need and support each other and that's how we all can be successful in life.

To my participants, thank you for taking time out of your lives to meet with me. After the first few interviews, it became clear that telling your stories was a great responsibility. I hope I have told them well, and effectively captured your experiences.

Finally, to God be the glory! Thank you for allowing me to be able to complete this degree, despite some pretty heavy stuff. I pray this degree will allow me to make a difference.

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LIST OF ABBREVIATIONS

CCSP	Child Care Subsidy Program
CDC	Center for Disease Control
CWV	Center for Women Veterans
LGBTQ	Lesbian, gay, bisexual, transgender
MCC	Maternity Care Coordinator
MCC-TCP	Maternity Care Coordinator Telephone Care Program
MST	Military Sexual Trauma
PTSD	Post-Traumatic Stress Disorder
QOL	Quality of Life
SDOH	Social Determinants of Health
US	United States
USMC	United States Marine Corps
USN	United States Navy
VA	Veterans Affairs Health Administration
VCP	Veterans Choice Program
VISN	Veteran Integrated Services Network
WHC	Women's Health Clinic
WH-PCP	Women's Heath Primary Care Providers
WVS	Women Veterans

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Chapter One: Introduction

Problem and Significance

The Veterans Health Administration (VA) is the largest healthcare organization in the United States, with over 9 million veterans enrolled (Department of Veteran Affairs, 2021). In recent years, the VA has attempted to increase the accessibility and services provided to the growing number of women veterans (WVs) who get care from the VA. WVs comprise 10% of this population, the fastest-growing demographic of veterans, with projections to increase to at least 16% by 2043 (National Center for Veterans Analysis and Statistics, 2017). Of this population, 40% are from racial or ethnic minority groups, compared to 23% of male veterans (Frayne et al., 2014). WVs face the same challenges as male veterans but have also experienced higher mental, physical, and social health disparities that lead to lower quality of life (QOL; Oster et al., 2017). Injuries from intense physical activity, potential trauma, toxic substance exposure, and military sexual trauma (MST) are commonly found in WVs. These experiences could lead to physical and mental health diagnoses that may require care after the service member has left the military. Given the increase in the number of WVs, the large percentage of WVs from a racial or ethnic minority group, the historically male-dominated environment of the VA, and the unique makeup of the women veteran (WV) population, the VA may need to adjust current practices to serve the needs of WVs better.

Background

Medical care provided by the VA was first implemented in 1865 when the need for caring for the country's Civil War veterans was apparent (Peterson, 2015). The Department of Veteran Affairs has increased benefits throughout the years, including disability compensation, vocational rehabilitation, and growing healthcare services (Peterson, 2015). The federal

government provides funding through VA healthcare for veterans annually each fiscal year. There are 171 VA medical centers and 1,112 VA outpatient sites throughout the country to serve the healthcare needs of US military veterans (Department of Veteran Affairs, 2021).

Unfortunately, in recent years, the VA has faced setbacks in caring for our nation's veterans. For example, the VA is now associated with excessive spending, inadequate healthcare (Kizer & Jha, 2014), and long wait times (Jones et al., 2021). Additionally, to add to the confusion and frustrations surrounding VA healthcare, the VA classifies each veteran who applies for care based on eight priority groups. Differences in groups are based on military service history, disability rating percentage, income level, Medicaid eligibility and other VA benefits a veteran receives to determine how quickly a veteran could be seen (Department of Veteran Affairs, 2021). For example, a veteran in priority group 1 does not pay for care received at the VA because they have at least a 50% service-connected disability, are unemployable, and have received the Medal of Honor. Whereas the veteran in priority group 8 pays copays for care received at the VA because they have no service-connected disability, and a high-income level (Department of Veteran Affairs, 2021). While the VA provides most healthcare-related services such as surgeries, trauma care, mental health services, orthopedics, pharmacy, radiology, and physical therapy (Department of Veteran Affairs, 2021), they lack support for women-specific care. Due to the historically large numbers of male veterans, the VA has had to adjust to caring for the increasing number of WVs. For example, a 2015 study found providers explicitly trained in women's health and female-specific services lacking (Cordasco et al.). Most VA facilities care for general gynecological services, such as pap smears and contraceptive prescriptions, but

refer to community providers for more complex services such as maternity care and fertility treatments (Department of Veteran Affairs, 2022; Department of Veteran Affairs, 2021).

WV's sacrifice more than just their time, energy, and comfort during military service. For example, in addition to military experiences common in many veterans such as exposure to dangerous toxic substances and the trauma of combat, WVs have higher rates of sexual violence, chronic pain, and combat trauma compared to male veterans (Der-Martirosian et al., 2013; Lehavot, Washington, Davis, Der-Martirosian, & Yano, 2013). Chronic pain is one of the leading conditions in US military veterans. It affects veterans at a 40% higher rate than nonveterans, with female veterans experiencing a higher incidence of severe chronic pain than male veterans (Nahin, 2017). The presence of chronic pain has been associated with increased psychiatric conditions, poor sleep quality, and decreased QOL (Nahin, 2017; Seidl et al., 2015). Due to the physicality of military service, WVs experience a higher rate of pain conditions, such as musculoskeletal diagnoses and joint disorders (Frayne et al., 2015; Haskell et al., 2012). Up to 78% of female veterans experience chronic pain (Hasket et al., 2006), making this diagnosis a priority for WVs healthcare.

Military Sexual Trauma (MST) is defined as sexual assault and repeated threatening sexual harassment during military service (Kelly et al., 2011; Muirhead et al., 2017). More than 30% of WVs experienced some form of MST while serving in the military (Department of Defense Sexual Assault Prevention and Response Office, 2020; Kelly et al., 2011). WVs who experience MST are at a five to nine-fold increase in the likelihood of experiencing mental health-related diagnoses such as post-traumatic stress disorder (PTSD) compared to those veterans who have not experienced MST (Suris et al., 2007). A sentinel study conducted in 2000

by Sadler et al. found that ten years after experiencing MST, WVs continued to have decreased QOL, decreased emotional and physical health, and more financial, relationship, and educational problems than those in a similar cohort who did not experience MST. The physical and emotional fallout of MST was like or worse than those suffering from a significant chronic illness (Sadler et al., 2000). Additionally, WVs who experience MST have higher rates of gender-based discrimination at VA facilities after military service (MacDonald et al., 2020), making MST an essential consideration when organizing care for the WV.

WVs are also at risk of exposure to radiation, chemicals, and emotional and physical trauma that can increase the incidence of infertility (Teichman, 2012; White, Steele, & O'Callaghan, 2016; Blake & Komp, 2014). Mancuso et al. (2020) completed a study of 996 WVs and found that 18% reported a history of infertility. According to the Centers for Disease Control (CDC), the rate of infertility for civilian women is 6% (2021). The association with infertility was related to poor perceived physical health, higher rates of depression, chronic pain, cancer, (Cedars et al., 2017; Hanson et al., 2017; Mancuso, 2020; Ryan et al., 2014), and cardiovascular disease (Parikh et al., 2012). Additionally, medications used to treat many mental health conditions, such as PTSD, may reduce the ability to conceive or may be teratogenic in pregnancy (Goyal et al., 2012; Perlstein, 2015). While infertility in WVs is under-researched, these statistics show it is a critical need for many and is an essential component of WV care.

Depression is the most reported condition by WVs (Frayne et al., 2018). Brown et al. (2019) conducted a study looking at Gulf War WVs and found that 45.3% of female veterans experienced depression compared to 26.1% of male veterans. These results are consistent with

the study completed by Adams et al. (2021), which found rates of depression being 46% in females compared to 21% in males and higher incidences of psychotropic medication prescriptions in the use of mental health services. Depression also occurs in WVs with other diagnoses such as anxiety, PTSD, reproductive issues, and osteoporosis (Bastian et al., 2016; Brown et al., 2019) and is a risk factor for suicide (Kumpula et al., 2019). Depression affects WVs QOL and can cause functional decline, and behavioral problems, and it affects WVs at a greater incidence than male veterans (Bastian et al., 2016; Katon et al., 2016). In several studies, WVs with a PTSD diagnosis had more severe depressive symptoms and lowered QOL than male veterans (Galovski et al., 2013; Maguen et al., 2012; Tiet et al., 2015). Because suicide is a prominent risk factor for depression, finding effective ways to meet the needs of WVs depression could decrease the incidences of suicide and increase QOL in the WV population. The rate of suicide among WVs who use the VA has increased from 14.4 per 100,000 to 17.3 per 100,000 between 2001 and 2014, twice that of nonveteran women (Department of Veteran Affairs, 2018).

From the literature on common healthcare issues in WVs, there may be complex healthcare needs that likely need healthcare support long after leaving military service. Additionally, the presence of multiple diagnoses in WVs is common. For example, chronic pain is associated with increased mental health symptoms, including depression, anxiety, and suicidal ideation (Naylor et al., 2019). The diagnosis of MST is strongly correlated to also having a PTSD diagnosis (Murdoch et al., 2004; Suris et al., 2007). In one study looking at WVs seeking a PTSD disability rating, 71% of those experienced some form of MST (Zinow et al., 2007). The presence of fibromyalgia was commonly co-diagnosed with sleep disturbance issues (Choy,

2015; D'Aoust, 2017; Rizzi et al., 2016), chronic pain (Walitt et al., 2015), and depression (D'Aoust, 2017; Frayne et al., 2004; Sherman et al., 2000). WVs who experience infertility had higher depression, chronic pain, and cancer rates (Cedars et al., 2017; Hanson et al., 2017; Mancuso, 2020; Ryan et al., 2014). These studies indicate that WVs have multiple diagnoses that may need complex healthcare to meet their needs.

VA Programs

A common barrier for veterans receiving care at the VA is transportation, distance, and long wait times (Washington et al, 2011; Washington et al., 2015; Elnitsky et al., 2013). The VA has created several programs to assist WVs with healthcare utilization to decrease these barriers. The Veterans Choice Program (VCP) allows veterans to see non-VA providers in their communities with VA funding to allow easier access for veterans in facilities closer to their homes (Mattocks & Yehia, 2017). With the historically significant male population of the US military, the VA has been working to implement policies and changes to meet the needs of WVs better. Some existing programs to help meet the needs of WVs include the Center for Women Veterans (CWV) which helps serve as an advocate for the transformation and responsible treatment of WVs (Department of Veterans Affairs, 2022) and the Women's Health Primary Care Providers (WH-PCP) where WVs can receive care from female providers for primary care and specialty services. In addition, the Women Veterans Call Center was created for WVs to speak with staff specializing in female-specific services, so the WV can better understand their healthcare options and benefits (Department of Veterans Affairs, 2021). The House Committee on Veteran's Affairs has a Women Veterans Task Force to develop policies that explicitly support WVs through outreach, oversight, and legislation (Women Veterans Task Force, 2021).

Finally, the VA came out with VHA Directive 1330.02 (2017), which assists healthcare providers in the duties and responsibilities of caring for WVs.

Even with these programs, WVs underuse VA healthcare (Copeland et al., 2020). Because only 37% of WVs are enrolled patients with the VA, it can be assumed they are receiving their care outside of the VA healthcare system (Bastian et al., 2016; Mattocks et al., 2018) or not obtaining healthcare services at all. Additionally, Friedman et al. (2011) found that 30% of WVs who seek healthcare at the VA left within the first three years of use indicating WVs are underutilizing the VA healthcare system. Looking at the experiences and perspectives of WVs with the VA could improve healthcare outcomes and better meet their needs.

Research Problem

Of the 2.03 million WVs, only 755,807 were enrolled in the VA healthcare system for 2019 (Congressional Research Service, 2021). WVs may experience many barriers to receiving care at the VA. For example, one in five female veterans delayed or went without healthcare in the past year due to difficulties getting off work, caregiver responsibilities, or transportation issues (Cordasco et al., 2016). The diagnosis of MST and lack of gender-sensitive care may also contribute to the delay or refusal of WVs to seek care (Washington et al., 2011b). In a recent study, one in four WVs experienced gender-based discrimination by male veterans at a VA facility (Klap et al., 2019), providing a reason for WVs to delay or refuse care at the VA based on negative gender-based experiences (MacDonald et al., 2020). Due to the high instance of MST (Gilmore et al., 2016) and because the VA is still male-dominated, WVs may be uncomfortable seeking care at VA facilities (Klap et al., 2019). They may associate their previous negative military experiences with the current VA system. This could result in WVs dropping out of VA

care or delaying in seeking needed care if they feel uncomfortable with that environment (Washington et al., 2011).

Compared to male veterans, WVs who use the VA report lower QOL, lower access to care, lower satisfaction with services, and greater care non-compliance (Bean-Mayberry et al., 2003; Kimerling et al., 2011; Runnals, et al., 2014). This put WVs at risk for adverse health outcomes and decreased QOL (Klap et al., 2019). Therefore, improving VA services is not just making things better in an abstract way, it will prevent deaths and help WVs live meaningful lives. WVs have unique, under-researched healthcare needs that should focus on more intense investigations. Research is inadequate in the WV population, and ongoing studies are critical to improving their health outcomes, the QOL, and identifying areas of improvement in the VA system.

Research Questions

Based on the stated research problem and the objectives, the goal of the proposed research study was to answer the following questions:

1. How does being a female veteran impact their health status?
2. What are the experiences of WVs who use, or have used the VA?
3. How does the use of the VA impact WVs current health status?

Research Aims and Objectives

Given the lack of research regarding WVs use of the VA, this study explored the experiences of WVs who have sought or are seeking care from the VA through open-ended questions and a qualitative, inductive approach. The first objective was to identify what effect being a WV has on health status. Questions were asked to guide the conversation to inquire

more about each participant's military service, why they joined the military, what their health was like before joining, and what their health was like during their military service.

The second objective was to explore the experiences of WVs use of the VA. The researcher asked questions about the services WVs receive from the VA and their overall satisfaction of the healthcare system.

The third objective was to identify how the use of the VA might be associated with the WVs current health status. In this section of the interview, questions were asked to guide the conversation to identify the participant's current healthcare status and to see if the VA currently meets the WVs healthcare needs.

Research Significance and Justification

As previously stated, compared to female non-veterans, WVs report poorer overall health (Lehavot et al., 2012), poorer functional status, poorer mental health, lower QOL (Devine et al., 2019; Shen & Sambamoorthi, 2021), and less social support (LaCroix, 2016). WVs also experience different QOL outcomes compared to male veterans which may impact their healthcare needs. For example, compared to male veterans, WVs have significantly lower QOL scores (DeVine, et al., 2019; Katon et al., 2016; Teh et al., 2008), have a higher risk of homelessness (Byrne, 2013), more unemployment (Kleykamp, 2013) and higher divorce rates (Southwell, 2016). Approximately 80% of post 9-11 female veterans are 43 years old and younger (Vance, Alhussain, & Sambamoorthi, 2020), increasing the need for contraceptive, and infertility services. When WVs have access to comprehensive care, depression decreases, QOL improves, and health outcomes improve (Bastian et al., 2015; deKleijn et al., 2015; Di Leone et al., 2016) indicating the importance of quality care from the VA.

This study contributes to nursing science by creating new knowledge surrounding both needed research areas of WV experiences and perceptions of the VA and guiding practice, health policy, and future research in healthcare. Themes drawn from the data obtained during this study could inform future VA policies regarding WVs needs and attitudes toward the current strategies. For example, it may reduce barriers WVs face when they enter a VA facility or receive care from a VA provider. Additionally, the results could allow further research to advance nursing science and to provide better quality care for the WV population.

Potential Limitations

There are several potential limitations to the proposed study. First, in a qualitative study, the researcher gathers information from specific individuals based on their unique experiences and situations. This exclusive context will affect the possibility of generalizing to other populations and studies. As the goal of qualitative research is to gain a deep understanding of an unknown topic, not for generalizing to other populations, this could be seen as a strength instead of a weakness. Second, confounding variables could affect the results of the perceived satisfaction or dissatisfaction of WVs with the VA. For example, WVs who experience MST have higher rates of gender-based discrimination at VHA facilities after military service (MacDonald et al., 2020). Because of this, the WV may hold a negative opinion of military-related facilities, and this could affect how they answered study questions. The lack of generalizability and the presence of confounding factors are the two main limitations of this study.

Conclusion

In summary, this first chapter discusses the context of the study, including the unique needs of WVs when seeking healthcare from the VA. The research objectives used to identify

the extent and perceived satisfaction with VA use and the social domains surrounding the WVs VA use. The value of research is argued. In Chapter Two, outcome studies on WV experiences and perceptions of their care at the VA are identified, along with other information relevant to the chosen phenomenon. This literature review serves as the primary manuscript. Chapter Three presents the methodology and the results of the dissertation and is the secondary manuscript looking at the experiences and perspectives of WV's use of the VA. Chapter Four, the third manuscript, is the policy piece looking at a historical perspective of WV's use of the VA and recommendations for the future. Chapter Five concludes the dissertation with a summary of the literature review, a synthesis of the findings, and policy recommendations. The content and organization of the dissertation and the targeted journals that each manuscript will be submitted are listed in Table 1.1.

References

Adams, R. E., Hu, Y., Figley, C. R., Urosevich, T. G., Hoffman, S. N., Kirchner, H. L., Dugan, R. J., Boscarino, J. J., Withey, C. A., & Boscarino, J. A. (2021). Risk and protective factors associated with mental health among female military veterans: results from the veterans' health study. BMC *Women's Health, 21*(1), 1–10.

Bastian, L. A., Hayes, P. M., Haskell, S. G., Atkins, D., Reiber, G. E., LaCroix, A. Z., & Yano, E. M. (2016). Improving our understanding of health issues in older women veterans. *The Gerontologist*, *56*(1), 10-13.

Bean-Mayberry, B. A., Chang, C. C. H., McNeil, M. A., Whittle, J., Hayes, P. M., & Scholle, S. H. (2003). Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. *Journal of General Internal Medicine*, *18*(3), 175-181.

Blake, P. K., & Komp, G. R. (2014). Radiation exposure of US military individuals. *Health physics*, *106*(2), 272-278.

Brown, M. C., Sims, K. J., Gifford, E. J., Goldstein, K. M., Johnson, M. R., Williams, C. D., & Provenzale, D. (2019). Gender-based differences among 1990-1991 gulf war era veterans: Demographics, lifestyle behaviors, and health conditions. *Women's health issues*, *29,* S47–S55.

Byrne, T., Montgomery, A. E., & Dichter, M. E. (2013). Homelessness among female veterans: A systematic review of the literature. *Women & Health*, *53*(6), 572-596.

Cedars, M. I., Taymans, S. E., DePaolo, L. V., Warner, L., Moss, S. B., & Eisenberg, M. L. (2017). The sixth vital sign: what reproduction tells us about overall health. Proceedings from a NICHD/CDC workshop. *Human Reproduction Open*, *2017*(2).

Choy, E. H. (2015). The role of sleep in pain and fibromyalgia. *Nature Reviews Rheumatology*, *11*(9), 513-520.

Congressional Research Service. (2021). *Veterans health administration: Gender-specific health care services for women veterans.* https://crsreports.congress.gov/product/pdf/IF/IF11082#:~:text=It%20includes%20not%20only%20reproductive,health%20care%20system%20in%20FY2019.

Copeland, L. A., Finley, E. P., Vogt, D., Perkins, D. F., & Nillni, Y. I. (2020). Gender differences in newly separated veterans' use of healthcare. *American Journal of Managed Care*, *26*(3), 97-104.

Cordasco, K. M., Mengeling, M. A., Yano, E. M., & Washington, D. L. (2016). Health and Health Care Access of Rural Women Veterans: Findings from the National Survey of Women Veterans. *Journal of Rural Health, 32*(4), 397–406.

D'Aoust, R. F., Rossiter, A. G., Elliott, A., Ji, M., Lengacher, C., & Groer, M. (2017). Women veterans, a population at risk for fibromyalgia: the associations between fibromyalgia, symptoms, and quality of life. *Military medicine*, *182*(7),1828-1835.

deKleijn, M., Lagro-Janssen, A. L., Canelo, I., & Yano, E. M. (2015). Creating a roadmap for delivering gender-sensitive comprehensive care for women Veterans: Results of a national expert panel. *Medical Care*, *53*(4).

Department of Defense Sexual Assault Prevention and Response Office. (2020). *Department of Defense Annual Report on Sexual Assault in the Military, Fiscal Year 2020.* https://www.sapr.mil/sites/default/files/DOD_Annual_Report_on_Sexual_Assault_in_the_Military_FY2020.pdf

Department of Veteran Affairs. (2022). *Center for women veterans.* https://www.va.gov/womenvet/

Department of Veterans Affairs. (2018). *VA national suicide data report 2005-2015.* www.mentalhealth.va.gov/suicide_prevention /Suicide-Prevention-Data.asp.

Department of Veterans Affairs. (2021). *Women's veterans health care.* https://www.womenshealth.va.gov/outreachmaterials/GeneralHealthandWellness/maternity.asp

Department of Veterans Affairs. (2022). *Women veterans health care.* https://www.womenshealth.va.gov/

Der-Martirosian, C., Cordasco, K. M., & Washington, D. L. (2013). Health-related quality of life and comorbidity among older women veterans in the United States. *Quality of Life Research, 22*, 2749–2756. doi:10.1007/s11136-013-0424-7.

Devine, D. T., McMillan, S. C., Kip, K., & Powell-Cope, G. (2020). Quality of life among women veterans. *Journal of the American Association of Nurse Practitioners*, *32*(11), 745-755.

Di Leone, B. A., Wang, J. M., Kressin, N., & Vogt, D. (2016). Women's veteran identity and utilization of VA health services. *Psychological Services*, *13*(1), 60.

Elnitsky, C. A., Andresen, E. M., Clark, M. E., McGarity, S., Hall, C. G., & Kerns, R. D. (2013). Access to the US department of veterans affairs health system: Self-reported barriers to

care among returnees of operations enduring freedom and Iraqi freedom. *BMC health services research*, *13*(1), 1-10.

Friedman, S. A., Phibbs, C. S., Schmitt, S. K., Hayes, P. M., Herrera, L., & Frayne, S. M. (2011). New women veterans in the VHA: A longitudinal profile. *Women's Health Issues*, *21*(4), 103-111.

Frayne, S. M., Phibbs, C. S., & Friedman, S. A. (2014). Sociodemographic Characteristics and Use of VHA Care and Non-VA Care. *Washington, DC, Department of Veterans Affairs, Women Veterans Health Strategic Health Care Group*.

Galovski, T. E., Blain, L. M., Chappuis, C., & Fletcher, T. (2013). Sex differences in recovery from PTSD in male and female interpersonal assault survivors. *Behavior research and therapy*, *51*(6), 247-255.

Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., Simpson, T., Carter, M. E., Blais, R. K., & Gundlapalli, A. V. (2016). Military sexual trauma and co-occurring posttraumatic stress disorder, depressive disorders, and substance use disorders among returning Afghanistan and Iraq veterans. *Women's Health Issues, 26*(5), 546–554.

Goyal, V., Borrero, S., & Schwarz, E. B. (2012). Unintended pregnancy and contraception among active-duty servicewomen and veterans. *American journal of obstetrics and gynecology*, *206*(6), 463-469.

Hanson, B., Johnstone, E., Dorais, J., Silver, B., Peterson, C. M., & Hotaling, J. (2017). Female infertility, infertility-associated diagnoses, and comorbidities: a review. *Journal of Assisted Reproduction and Genetics*, *34*(2), 167-177.

Haskell, S. G., Heapy, A., Reid, M. C., Papas, R. K., & Kerns, R. D. (2006). The prevalence and age-related characteristics of pain in a sample of women veterans receiving primary care. *Journal of Women's Health*, *15*(7), 862-869.

Haskell, S. G., Ning, Y., Krebs, E., Goulet, J., Mattocks, K., Kerns, R., & Brandt, C. (2012). Prevalence of painful musculoskeletal conditions in female and male veterans in 7 years after return from deployment in Operation Enduring Freedom/Operation Iraqi Freedom. *The Clinical Journal of Pain*, *28*(2), 163-167.

Jones, A. L., Fine, M. J., Taber, P. A., Hausmann, L. R., Burkitt, K. H., Stone, R. A., & Zickmund, S. L. (2021). National media coverage of the veterans affairs waitlist scandal: Effects on veterans' distrust of the VA health care system. *Medical care*, (*5*), 322.

Katon, J. G., Lewis, L., Hercinovic, S., McNab, A., Fortney, J., & Rose, S. M. (2017). Improving perinatal mental health care for women veterans: description of a quality improvement program. *Maternal and child health journal*, *21*(8), 1598-1605.

Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: Interpersonal violence, PTSD, and mental health in women veterans. *Research in nursing & health*, *34*(6), 457-467.

Kimerling, R., Bastian, L. A., Bean-Mayberry, B. A., Bucossi, M. M., Carney, D. V., Goldstein, K. M., ... & Frayne, S. M. (2015). Patient-centered mental health care for female veterans. *Psychiatric Services*, *66*(2), 155-162.

Kizer, & Jha, A. K. (2014). Restoring trust in VA health care. *The New England Journal of Medicine, 371*(4), 295–297. https://doi.org/10.1056/NEJMp1406852

Klap, R., Darling, J. E., Hamilton, A. B., Rose, D. E., Dyer, K., Canelo, I., ... & Yano, E. M. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs medical centers and impacts on delayed and missed care. *Women's Health Issues*, *29*(2), 107-115.

Kleykamp, M. (2013). Unemployment, earnings and enrollment among post 9/11 veterans. *Social science research*, *42*(3), 836-851.

Kumpula, M. J., Wagner, H. R., Dedert, E. A., Crowe, C. M., Day, K. T., Powell, K., Batdorf, W. H., Shabana, H., Kim, E., & Kimbrel, N. A. (2019). An evaluation of the effectiveness of evidence-based psychotherapies for depression to reduce suicidal ideation among male and female veterans. *Women's Health Issues, (29),*103–111.

Lehavot, K., Der-Martirosian, C., Simpson, T. L., Shipherd, J. C., & Washington, D. L. (2013). The role of military social support in understanding the relationship between PTSD, physical health, and healthcare utilization in women Veterans. *Journal of Traumatic Stress, 26*, 772–775.

MacDonald, S., Hausmann, L. R., Sileanu, F. E., Zhao, X., Mor, M. K., & Borrero, S. (2017). Associations between perceived race-based discrimination and contraceptive use among women veterans in the ECUUN study. *Medical Care*, *55*, 43.

MacDonald, S., Judge-Golden, C., Borrero, S., Zhao, X., Mor, M. K., & Hausmann, L. R. (2020). Experiences of perceived gender-based discrimination among women veterans: data from the ECUUN study. *Medical care*, *58*(5), 483.

Maguen, S., Cohen, B., Ren, L., Bosch, J., Kimerling, R., & Seal, K. (2012). Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with posttraumatic stress disorder. *Women's Health Issues*, *22*(1), 61-66.

Mancuso, A. C., Summers, K. M., Mengeling, M. A., Torner, J. C., Ryan, G. L., & Sadler, A. G. (2020). Infertility and health-related quality of life in united states women veterans. *Journal of Women's Health 29*(3), 412–419.

Mattocks, K. M., Yano, E. M., Brown, A., Casares, J., & Bastian, L. (2018). Examining women Veteran's experiences, perceptions, and challenges with the veterans choice program. *Medical Care*, *56*(7), 557-560.

Mattocks, K. M., & Yehia, B. (2017). Evaluating the veterans choice program: Lessons for developing a high-performing integrated network. *Medical Care*, *55*, 1-3.

Muirhead, L., Hall, P., Jones-Taylor, C., Clifford, G. D., Felton-Williams, T., & Williams, K. (2017). Critical questions: Advancing the health of female veterans. *Journal of the American Association of Nurse Practitioners*, *29*(10), 571-580.

Murdoch, M., Polusny, M. A., Hodges, J., & O'Brien, N. (2004). Prevalence of in-service and post-service sexual assault among combat and noncombat veterans applying for department of veterans affairs posttraumatic stress disorder disability benefits. *Military Medicine*, *169*(5), 392-395.

Nahin R.L. (2017). Severe pain in veterans: the impact of age and sex, and comparisons to the general population. *Journal of Pain. 18*(3):247-254.

National Academies of Sciences, Engineering, and Medicine. (2018). Evaluation of the Department of Veterans Affairs mental health services.

National Center for Veterans Analysis and Statistics, Department of Veteran Affairs. (2017). *Women veterans report: The past, present, and future of women veterans.* https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf

Naylor, J. C., Kilts, J. D., Shampine, L. J., Parke, G. J., Wagner, H. R., Szabo, S. T., ... & Marx, C. E. (2020). Effect of pregnenolone vs placebo on self-reported chronic low back pain among US military veterans: A randomized clinical trial. *JAMA network open*, *3*(3), e200287-e200287.

Oster, C., Morello, A., Venning, A., Redpath, P., & Lawn, S. (2017). The health and wellbeing needs of veterans: a rapid review. *BMC psychiatry*, *17*(1), 1-14.

Parikh, N. I., Cnattingius, S., Mittleman, M. A., Ludvigsson, J. F., & Ingelsson, E. (2012). Subfertility and risk of later life maternal cardiovascular disease. *Human Reproduction*, *27*(2), 568-575.

Pearlstein, T. (2015). Depression during pregnancy. *Best Practice & Research Clinical Obstetrics & Gynecology*, *29*(5), 754-764.

Peterson, H. (2015). *Roots of VA healthcare started 150 years ago.* https://www.va.gov/health/newsfeatures/2015/march/roots-of-va-health-care-started-150-years-ago.asp

Rizzi, M., Cristiano, A., Frassanito, F., Macaluso, C., Airoldi, A., & Sarzi-Puttini, P. (2016). Sleep disorders in fibromyalgia syndrome. *Journal of Pain & Relief*, *5*(2), 232-236.

Runnals, J. J., Garovoy, N., McCutcheon, S. J., Robbins, A. T., Mann-Wrobel, M. C., Elliott, A., ... & Strauss, J. L. (2014). Systematic review of women veterans' mental health. *Women's Health Issues*, *24*(5), 485-502.

Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2014). Voluntary and involuntary childlessness in female veterans: Associations with sexual assault. *Fertility and Sterility*, *102*(2), 539-547.

Sadler, A. G., Mengeling, M. A., Syrop, C. H., Torner, J. C., & Booth, B. M. (2011). Lifetime sexual assault and cervical cytologic abnormalities among military women. *Journal of Women's Health*, *20*(11), 1693-1701.

Seidl, J. N. T., Pastorek, N. J., Lillie, R., Rosenblatt, A., Troyanskaya, M., Miller, B. I., ... & Linck, J. (2015). Factors related to satisfaction with life in veterans with mild traumatic brain injury. *Rehabilitation Psychology*, *60*(4), 335.

Southwell, K. H., & MacDermid Wadsworth, S. M. (2016). The many faces of military families: Unique features of the lives of female service members. *Military Medicine*, *181*(suppl_1), 70-79.

Suris, A., & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, & Abuse*, *9*(4), 250-269.

Teh, C. F., Kilbourne, A. M., McCarthy, J. F., Welsh, D., & Blow, F. C. (2008). Gender differences in health-related quality of life for veterans with serious mental illness. *Psychiatric Services*, *59*(6), 663-669.

Teichman, R. (2012). Health Hazards of Exposures During Deployment to War. *Journal of Occupational & Environmental Medicine, 54*(6), 655–658.

Vance, B., Alhussain, K., & Sambamoorthi, U. (2020). Five-year trend in healthcare access and patient-reported health outcomes among women veterans. *Nursing Forum, 55*(2), 165–173.

Walitt, B., Nahin, R. L., Katz, R. S., Bergman, M. J., & Wolfe, F. (2015). The prevalence and characteristics of fibromyalgia in the 2012 National Health Interview Survey. *PloS one*, *10*(9), e0138024.

Washington, D. L., Bean-Mayberry, B., Mitchell, M. N., Riopelle, D., & Yano, E. M. (2011). Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. *Women's Health Issues*, *21*(4), 112-119.

Washington, D. L., Bean-Mayberry, B., Riopelle, D., & Yano, E. M. (2011b). Access to care for women veterans: Delayed healthcare and unmet need. *Journal of General Internal Medicine*, *26*(2), 655.

Washington, D. L., Farmer, M. M., Mor, S. S., Canning, M., & Yano, E. M. (2015). Assessment of the healthcare needs and barriers to VA use experienced by women veterans: findings from the national survey of women Veterans. *Medical Care*, *53*(4), 23-31.

White, R. F., Steele, L., O'Callaghan, J. P., Sullivan, K., Binns, J. H., Golomb, B. A., ... & Grashow, R. (2016). Recent research on gulf war illness and other health problems in veterans of the 1991 Gulf War: Effects of toxicant exposures during deployment. *Cortex*, *74*, 449-4

Zinzow, H. M., Grubaugh, A. L., Monnier, J., Suffoletta-Maierle, S., & Frueh, B. C. (2007). Trauma among female veterans: A critical review. *Trauma, Violence, & Abuse*, *8*(4), 384-400.

Table 1.1

Chapters and Manuscript Placement with Target Journals

	Title	Aim	Target Journal (s)
Chapter 1	Introduction	To introduce the dissertation	N/A
Chapter 2/ Manuscript 1	Barriers for the Woman Veteran When Using the VA: A Literature Review	To report the findings of current literature surrounding WV's use of the VA	• Military Behavioral Health* • Military Psychology
Chapter 3/ Manuscript 2	Experiences and Perspectives of Women Veterans Use of the Veterans Health Administration	Study methods and results paper	• Military Medicine* • Journal of Veteran Studies • Military Psychology • Military Behavioral Health
Chapter 4/ Manuscript 3	Policy Recommendations for the Improvement of the VA for the Woman Veteran	Policy paper	• Armed Forces & Society * • Military Psychology • Military Medicine
Chapter 5	Conclusion	To conclude the dissertation	N/A
*Current manuscript format			

Chapter 2: Literature Review

Leanne Anthon[a]*

[a] College of Nursing, University of Wisconsin-Milwaukee, Milwaukee, WI, USA

*Correspondence: lnanthon@uwm.edu

Manuscript 1: Barriers for the Woman Veteran When Using the VA: A Literature Review

The purpose of this chapter is to present the current state of the science on the experiences of women veterans (WVs) use of the Veterans Health Administration (VA). Empirical literature about WVs was reviewed. Literature regarding WV healthcare and the use of the VA guided the literature review in the current study. The most significant ideas that emerged from a review of the literature included the prevalence of sexual trauma, gender bias, racial bias, and lack of coordinated care. The manuscript has been formatted to the Military Behavioral Health Journal specifications and will be submitted for publication in Spring 2023.

Manuscript 1: Barriers for the Woman Veteran When Using the VA: A Literature Review

Abstract

This literature review began with a search of relevant databases deemed most likely to provide valuable results. The researcher reviewed general information related to the nature of the VA and then looked at the specific aspects of WVs health issues. Finally, outcome studies on WV experiences and perceptions of their care at the VA were identified, along with other information relevant to the chosen phenomenon. Empirical literature about WVs was reviewed. Literature regarding WV healthcare and the use of the VA guided the literature review in the current study. The search strategy focused on databases related to health and psychological issues, and databases that were more general in scope. After a thorough review of all the materials gathered, it appears that gaps in the literature are related to specific healthcare needs such as maternity care, health promotion recommendations, and WV barriers when attending VA facilities.

Keywords: *women veterans, women veteran health, female veteran, servicewomen, healthcare, VA healthcare system*

Background

The Department of Veterans Affairs (VA) is the United States (US) largest healthcare organization operating 171 VA medical centers and 1,112 VA outpatient sites throughout the country (Department of Veteran Affairs, 2021). Unfortunately, in recent years, the VA has faced setbacks in caring for our nation's veterans. For example, the VA is now associated with excessive spending, inadequate healthcare (Kizer & Jha, 2014), and long wait times (Jones et al., 2021). While the VA provides most healthcare-related services such as surgeries, trauma care, mental health services, orthopedics, pharmacy, radiology, and physical therapy (Department of Veteran Affairs, 2021), they lack support for women-specific care. Due to the historically large numbers of male veterans, the VA has had to adjust to caring for the increasing number of WVs. For example, a 2015 study found providers explicitly trained in women's health and female-specific services lacking (Cordasco et al.). Most VA facilities care for general gynecological services, such as pap smears and contraceptive prescriptions, but refer to community providers for more complex services such as maternity care and fertility treatments.

Compared to male veterans, WVs who use the VA report lower QOL, lower access to care, lower satisfaction with services, and greater care non-compliance (Bean-Mayberry et al., 2003; Kimerling et al., 2011; Runnals, et al., 2014). This puts WVs at risk for adverse health outcomes and decreased QOL (Klap et al., 2019). Therefore, improving VA services is not just making things better in an abstract way, it will prevent deaths and help WVs live meaningful lives. Clearly, WVs have unique, under-researched healthcare needs that should be the focus of more intense investigations. Research is inadequate in the WV population, and ongoing studies are critical to improving their health outcomes, the QOL, and identifying areas of improvement in the VA system.

VA Programs

A common barrier for veterans receiving care at the VA is transportation, distance, and long wait times (Washington et al., 2011; Washington et al., 2015; Elnitsky et al., 2013). For example, one in five WVs delayed or went without healthcare in the past year due to difficulties getting off work, caregiver responsibilities, or transportation issues (Cordasco et al., 2016). The diagnosis of MST and lack of gender-sensitive care may also contribute to the delay or refusal of WVs to seek care (Washington et al., 2011b). In a recent study, one in four WVs experienced gender-based discrimination by male veterans at a VA facility (Klap et al., 2019), providing a reason for WVs to delay or refuse care at the VA based on negative gender-based experiences (MacDonald et al., 2020). Due to the high instance of MST (Gilmore et al., 2016) and because the VA is still male-dominated, WVs may be uncomfortable seeking care at VA facilities (Klap et al., 2019). They may associate their previous negative military experiences with the current VA system. This could result in WVs dropping out of VA care or delaying seeking needed care if they feel uncomfortable with that environment (Washington et al., 2011).

The VA has created several programs to assist WVs with healthcare utilization to decrease these barriers. The Veterans Choice Program (VCP) allows veterans to see non-VA providers in their communities with VA funding to allow easier access for veterans in facilities closer to their homes (Mattocks & Yehia, 2017). With the historically significant male population of the US military, the VA has been working to implement policies and changes to meet the needs of WVs better. Some of these programs in place to help meet the needs of WVs include the Center for Women Veterans (CWV) which helps serve as an advocate for the transformation and responsible treatment of WVs (Department of Veterans Affairs, 2022) and the creation of the Women's Health Primary Care Providers (WH-PCP) where WVs can receive

care from female providers for primary care and specialty services. In addition, the Women Veterans Call Center was created for WVs to speak with staff who specialize in female-specific services, so the WV can better understand their healthcare options and benefits (Department of Veterans Affairs, 2021). The House Committee on Veteran's Affairs has a Women Veterans Task Force to develop policies that explicitly support WVs through outreach, oversight, and legislation (Women Veterans Task Force, 2021). Finally, the VA came out with VHA Directive 1330.01 (2010), which assists healthcare providers in the duties and responsibilities of caring for WVs.

Even with these programs, WVs underuse VA healthcare (Copeland et al., 2020). Because only 37% of WVs are enrolled patients with the VA, it can be assumed they are receiving their care outside of the VA healthcare system (Bastian et al., 2016; Mattocks et al., 2018) or not obtaining healthcare services at all. Additionally, Friedman et al. (2011) found that 30% of WVs who seek healthcare at the VA left within the first three years of use indicating WVs are underutilizing the VA healthcare system. Looking at the experiences and perspectives of WVs with the VA could improve healthcare outcomes and meet their needs.

Search Strategy

The researcher searched Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medical Literature and Retrieval System Online (MEDLINE), PsychInfo, and Google Scholar. Google Scholar was searched to gather initial information to help point towards specific search terms that would be helpful in searches conducted in academic databases. The operators 'and' and 'or' were used to combine keywords in multiple databases to find the relevant articles to the search. Abstracts of identified articles were reviewed using keywords and were included or excluded based on their perceived relevancy. Search term examples that

were used while conducting this literature review were “women veterans,” “women veteran health,” “female veterans or women veterans or servicewomen or servicewomen,” “healthcare,” and “VA healthcare system.” Studies were eligible for inclusion because they pertained to WVs health issues, were peer-reviewed, and were written in English. Articles were excluded if they were considered off-topic or were deemed otherwise inappropriate for this particular study. After duplicates were removed, the initial search strategy resulted in 49 citations from electronic databases.

Thematic Review

As previously described, the VA strives to provide comprehensive care for US military veterans. Because historically the military has been primarily males, the VA has focused on the care and treatment of this population. As a result, the specific health needs of women may not be adequately addressed by the VA (National Academies of Science, 2018). With the increasing number of women joining the military, the VA is working on providing comprehensive care for WVs (Klap et al., 2019). The most significant ideas that emerged from a review of the literature included the prevalence of sexual trauma, gender bias, racial bias, and lack of coordinated care.

Military Sexual Trauma

WVs are more likely to experience military sexual trauma (MST) during military service than male veterans (Skinner et al., 2000; Murdoch et al., 1995, Turner & Frayne, 2004). Experiencing MST can affect QOL and has been associated with chronic physical and mental health-related disorders (Booth et al., 2012; Ryan et al., 2016; Sadler et al., 2011; Suris & Lind, 2008) and an increase in infertility (Mancuso, 2020). Researchers found that over 30% of WVs experienced some form of MST while serving in the US military in 2020 (Department of Defense Sexual Assault Prevention and Response Office, 2020; Kelly et al., 2011).

Women's experiences of sexual violence may also contribute to feelings of discomfort when entering male-dominated environments at the VA (Kelhle-Forbes et al., 2017; National Academies of Sciences, 2018). With the high prevalence of MST among WVs, the VA implemented the Women's Health Clinics (WHC) to help meet the sensitive needs of WVs. Having clinics designed explicitly for WVs can increase the comfort level of the veteran, potentially increase healthcare compliance, and reduce the chance of gender-based discrimination (MacDonald, 2020). Due to the high incidence of MST in the WV population and the large male environment of the military, WV may be more comfortable seeking care at a female-specific clinic (Washington et al., 2011b). The WVs seen in a WHC report an increase in comfort level, better privacy, better care, and more willingness to receive follow-up care than in a primary care clinic (Bean-Mayberry et al., 2003).

Gender-based discrimination

Even with these improvements in making VA facilities welcoming for WVs, in a recent study conducted in 2020, one-third of the 2294 participants experienced gender-based discrimination when receiving care at a VA facility (MacDonald et al.). Examples of the discrimination in the study ranged from micro-aggressions of feeling the healthcare team was not listening to the participant due to being a WV to being treated with less courtesy and respect due to gender. The WVs who rated higher incidences of gender-based discrimination were those that had chronic physical and mental health-related diagnoses. In contrast, those WVs who received most of their care from a consistent provider or who received care at a WHC noted lower incidences of discrimination. These findings are consistent with the study completed by Klap et al. (2018) indicating 25% of WVs having experienced some harassment,

including inappropriate and unwanted comments by male veterans at VA facilities. Participants in this study were WVs who had at least three primary care appointments at a VA facility in the previous 12 months. The WVs who experienced the harassment were more likely to report not feeling welcome at the VA, were those with MST exposure, those with poor health, and those with anxiety, and had delayed or missed care recommendations.

WVs also experienced unmet gender-sensitive needs when receiving mental health treatment. Kimmerling et al. (2015b) found nonwhite Hispanic WVs, younger WVs, those without a consistent primary care provider, those who were parenting, and those who had dual VA and non-VA mental health care providers reported VA services were not meeting their mental health needs. Participants in this study who rated VA mental health care utilization poorly included ease of use, lack of women-only support groups, availability of female providers, and lack of gender-related comfort in a health care setting as reasons why the VA was not meeting their mental health needs. In recent years, the VA has recognized that provider preference based on gender when receiving healthcare can play a factor in WVs utilization of VA healthcare benefits (Veterans Health Administration, 2008; Washington et al., 2007). Especially in the male-dominated environment of the VA, recognizing this is an important step to offer better care for WVs. Compared to male veterans, WVs are more likely to have a chronic medical or mental health condition (Frayne et al., 2013; Oster et al., 2017). Because there are 2.03 million WV in the US, with numbers expected to increase (Congressional Research Service, 2021), the VA will likely be faced with an increase in gender-sensitive such as PTSD and MST.

Experiences of bias were not only reported as occurring on a gender-based level but discrimination was also reported based on racial bias we well. MacDonald et al. (2020) found that non-Hispanic white WVs experienced higher gender-based discrimination rates compared to Hispanic and African American WVs. Regardless of the ethnicity in the study, it is cthat lear WVs experience gender-related discrimination at VA healthcare facilities. However, there are indications that WVs experience racial-based discrimination as well.

Racial-based discrimination

Statistics from the latest Women Veterans Report conducted by the VA (2015) showed that 19.0% of the WV population is Black, 2.0% is Asian, 9.1% Hispanic, and 65.9% non-Hispanic White. The experiences of nonwhite patients who perceived the presence of racial bias have been shown to lead to a lack of preventative care, delays, underutilization in seeking care, poor compliance, and lack of provider trust (Burgess et al., 2008; Casagrande et al., 2007; Jacobs et al., 2014; Trivedi & Ayanian, 2006). Specifically for women, the perception of racial discrimination or unwelcomeness between provider and patient has decreased compliance with recommendations, such as breast and cervical cancer screenings (Jacobs et al., 2014).

Hausmann et al. (2011) found perceptions about racial discrimination within the VA correlated to negative patient experiences, lower patient rating scores, and lower provider communication ratings. For example, regarding contraceptive options, WVs in a racial minority group and at high risk of unintended pregnancy have been prescribed less effective birth control options than white WVs (Judge-Golden et al., 2019; MacDonald et al., 2017). Borrerro et al. (2012) completed a study of 103,950 WVs. They found that Black and Hispanic WVs were more likely than White WVs to have gaps between hormonal contraceptive refills, and Black WVs were more likely to have less overall contraceptive coverage. This puts the Black WVs at an

increased risk of unintended pregnancy and could indicate this population of WVs are not being informed of different contraception options that may work better for their lifestyles, or they are hesitant to speak up and ask about other options due to a lack of trust with their provider (Borrerro et al., 2012).

Racial-based inconsistencies were also found in other areas of WV healthcare. The prevalence of minimally invasive and laparoscopic hysterectomies is higher in White and Latina WVs than in Black WVs (Callegari et al., 2018; Gray et al., 2020). Minimally invasive and laparoscopic hysterectomies are the preferred surgical methods to remove a uterus because these methods have reduced complication rates, shorter hospital stays, and lower hospital costs than an open hysterectomy (Aarts et al., 2015). One possible reason for the disparity could be the lack of training in minimally invasive procedures, lack of available resources for the providers in VA hospitals, or lack of community options for those providers in VA hospitals with a large Black WV population (Callegari et al., 2018). If this is the case, healthcare inequality is being continued by the VA through inadequate care for this population. With these results, it is no surprise that Black and Hispanic veterans have higher rates of distrust of the VA compared with other White veterans (Jones et al., 2021).

When looking at ethnicity and race in the care WVs receive at the VA, there are clear areas for improvement, especially with health promotion and the use of contraceptives, and surgical procedures like hysterectomies. From the literature, it appears Black WVs do not receive their preferred method of birth control and are having higher risk surgical procedures than their peers from other racial or ethnic groups. Racial-based discrimination can have a confounding challenge to WVs and cause them to delay or miss needed healthcare based on

both the WVs gender and also based on her race. WV's also experience challenges with factors of care coordination, especially with maternity care.

Maternity Care Coordination

Almost 41% of WVs who use the VA are of childbearing age (Department of Veteran Affairs, 2017b), making maternity care a critical need in this population. Because the VA does not provide maternity services, WVs receive care through community providers paid for by the VA (Department of Veterans Affairs, 2012). The organization of this care is implemented by Maternity Care Coordinators (MCC; Department of Veteran Affairs, 2021). The MCC role, created in 2012, serves as a liaison between the VA and maternity community providers to ensure WVs receive timely and appropriate services and organized care during and after pregnancy (Veterans Health Administration, 2012). Partridge et al. (2012) recommend that early maternity care is vital for the health of the baby and mother. Finding a non-VA provider early in pregnancy can add to the stress of arranging care and increases the importance of the MCC for pregnant WVs.

Katon et al. (2019) found that WVs felt when the MCC was present and involved, the coordination of services was an essential factor in getting the prompt care needed early in pregnancy. However, when the MCC was not involved in the individual WVs pregnancy journey, the WV felt alone. The MCC is in a vital position to help decrease the stress and anxiety of assisting the WV to find new providers promptly and helping to arrange for authorizations or to establish care (Katon et al., 2019). Especially for those WVs who live in rural areas where there may be a lack of local maternity care providers (Kozhimanni et al., 2020), and health utilization and outcomes are worse compared to urban WVs (Cordasco et al., 2016) the MCC is critical to help increase maternity and infant health outcomes through care coordination.

Unfortunately, the care and involvement of the MCCs are inconsistent across VAs nationwide, leaving many WVs without the help and support of timely maternity care and an increase in post-partum health incidences. Mattocks et al. (2019) found that poor ratings with integrated care throughout pregnancy led to higher rates of mental healthcare needs during the post-partum period. Those WVs in rural areas and those where an MCC was not actively involved in their care coordination were discouraged from finding a non-VA maternity provider and establishing care independently (Katon et al., 2018). The difficulty with care coordination during pregnancy could lead to the WVs not returning to the VA for care after pregnancy (Mattocks et al., 2019). The coordination of care becomes even more confusing when the veteran receives both VA and non-VA services simultaneously.

The organization poses a challenge to pregnant WVs, who continue to receive VA-provided care for other physical and mental health diagnoses (Cordasco et al., 2018; Mattocks et al., 2019). In an earlier study by Katon et al. (2017), over half of the participants had a mental health diagnosis before becoming pregnant. One challenge for the WV is the follow-up of mental health care during and after pregnancy because the MCC only coordinates maternity care. In WVs, where a mental health diagnosis is higher than in civilian women (Mattocks et al., 2010), getting adequate mental health care and treatment, especially while pregnant, is necessary. Recent studies have that shown pregnant WVs with mental health-related diagnoses have experienced frustrations integrating VA and non-VA care (Mattocks et al, 2019; Mattocks et al., 2018; Mattocks et al., 2017). Katon et al. (2019) also found that many pregnant WVs had interruptions in their mental health care treatment while pregnant due to lack of coordination of care, especially during the postpartum period. The frustrations WVs experience when

receiving VA and non-VA care while pregnant could result in delayed, missed, or inadequate care (Katon et al., 2019; Mattocks et al., 2018; Mattocks et al., 2017).

Maternity care coordination is essential for the WV population, especially those with multiple diagnoses and those who live in rural areas that lack local healthcare providers. When the MCC is involved with care coordination throughout the WVs pregnancy, the WV receives comprehensive care for maternity needs and other diagnoses such as mental health conditions. When there is a lack of care coordination, the WV experiences frustration, and poor healthcare utilization and is at risk for higher mental health-related diagnoses during the post-partum period (Katon et al., 2019; Mattocks et al., 2019). In addition to gender and racial-based discrimination and maternity care coordination challenges WVs found at the VA, sexual identity is another aspect of treatment inequality within the VA healthcare system.

Sexual Identity

It is estimated that over 1 million veterans identify as lesbian, gay, bisexual, or transgender (LGBTQ; Department of Veteran Affairs, 2022b). The LGBTQ identity is more common with WVs than among male veterans (Blosnich et al., 2013). Compared to LGBTQ civilian women and heterosexual women, WVs in a sexual minority group experience a higher rate of mental health diagnoses, sleep problems, smoking, and poor physical health (Blosnich et al., 2013). Being in a sexual minority is also associated with increased health disparities (Graham et al., 2011) and may increase the incidence of delayed or missed care.

For instance, Sherman et al. (2014) conducted a study of 58 LGBTQ veterans where only 28% of the participants found the VA to have a welcoming environment to those in a sexual minority, and only 25% disclosed their sexual identity to their VA providers. Kauth, Barrera, & Latini (2019) also found that 18% of LGBTQ veterans felt unwelcome, and 64% felt somewhat or

very unwelcome at the VA. Shipherd et al. (2018) found three times as many LGBTQ WVs delayed or missed care in the previous 12 months compared to heterosexual WVs. The main concerns were feeling unwelcome, unsafe, or fearful of harassment when going to the VA facility for healthcare. Shipherd et al. (2018) also found that the biggest concern for LGBTQ WV in their study was the comments and actions of male veterans causing emotional harm and feelings of unwelcomeness for the WV.

These findings are consistent with the study by Lehavot et al. (2017) that out of 298 transgender veterans surveyed, 46% delayed seeking care for physical health-related problems, and 38% delayed seeking care for mental health-related issues the year before the survey. However, despite the large number of participants who delayed seeking care, 79% were satisfied with the physical health care they received at the VA, and 69% were satisfied with their mental health care. These studies show WVs who identify as being in a sexual minority could perceive the VA as having an unwelcome environment that could lead to delayed or missed care based on their sexual identity.

From the literature review, WVs are in a unique position where they may be experiencing difficulties or discrimination at VA facilities within several of these themes. The concept of intersectionality can be described as how the connection between social categories such as race, class, and gender (Crenshaw, 1989, Crenshaw, 1991) can put WVs at higher risk of delayed, missed, or unmet care. For example, a black WV who is a lesbian may be experiencing both racial and gender-based discrimination when receiving care at the VA. Or a white WV who is pregnant and has an MST disability may experience difficulties receiving reproductive care and experiencing gender discrimination while receiving VA care. Because WVs are not

exclusively members of only a race, gender, or sexual identity, associating with two or more vulnerable groups could lead to an increase in health disparities. It could affect the care they receive (Albright et al. 2021).

Meade (2020) stated that understanding intersectionality within the WV population is needed to provide comprehensive and welcoming care. WVs are diverse, with almost 40% belonging to a racial, ethnic, or sexual minority, compared to 23% of male veterans (Aponte et al., 2011; Frayne & Mattocks, 2012). Minority status, and gender discrimination, put WVs at an increased risk of sexual violence victimization and can impact a female veteran's use of VA services (MacDonald et al., 2020). These increased risk variables indicate the need for specific approaches to the healthcare of female veterans. Timely, comprehensive, gender-specific health care can significantly improve the healthcare compliance of WVs. Informing WVs of available options, having adequately trained staff, and providing more gender-specific services are essential to WVs (Devine et al., 2020). These implementations can increase the welcomeness the WV feels when receiving care at a VA facility and can decrease the incidences of delayed, missed, or unmet care needs.

Conclusion

This literature review covers significant topics related to the treatment needs of WVs at VA facilities. Barriers to receiving care at VA facilities included MST, gender and racial-based discrimination, maternity care coordination difficulties, and sexual minority discrimination. This literature review also shows that WVs could experience treatment inequality or discrimination based on these factors. Being a WV can increase the risk of healthcare disparities; the combination of these concepts could also pose a bigger problem for WVs. WVs are in a unique position where they may be experiencing difficulties or discrimination at VA facilities based on

an intersection of identities within several of these themes. The actual needs of WVs include the opportunity to be seen in healthcare communities where they are comfortable and free from discrimination.

In summary, WVs have unique healthcare needs and need for increased research in this population. The literature review revealed that WVs have many diagnoses for which the VA can provide care. Potential barriers that prevent WVs from receiving their care at the VA are feeling uncomfortable, unwelcome, or unclear where they should be seen leading to delayed or missed healthcare potentially resulting in delayed or missed care. Additional research could be conducted to fill in the gaps in our understanding to provide better care for the WV population at VA facilities.

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References

Aarts, J. W., Nieboer, T. E., Johnson, N., Tavender, E., Garry, R., Mol, B. W. J., & Kluivers, K. B. (2015). Surgical approach to hysterectomy for benign gynecological disease. *Cochrane Database of Systematic Reviews*, (8).

Albright, D. L., McDaniel, J., Suntai, Z., Horan, H., & York, M. (2021). Pregnancy and binge drinking: An intersectionality theory perspective using veteran status and racial/ethnic identity. *Maternal and Child Health Journal, 25*(8), 1345-1351.

Aponte, M., Cherry, S., Fitzelle, G., Holder, K. A., Kagniniwa, B., Montgomery, S., ... & Thomas, E. (2011). America's women veterans: Military service history and VA benefit utilization statistics. *Department of Veteran Affairs.*

Bastian, L. A., Hayes, P. M., Haskell, S. G., Atkins, D., Reiber, G. E., LaCroix, A. Z., & Yano, E. M. (2016). Improving our understanding of health issues in older women veterans. *The Gerontologist*, *56*(1), 10-13.

Bean-Mayberry, B. A., Chang, C. C. H., McNeil, M. A., Whittle, J., Hayes, P. M., & Scholle, S. H. (2003). Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. *Journal of General Internal Medicine*, *18*(3), 175-181.

Blosnich, J., Foynes, M. M., & Shipherd, J. C. (2013). Health disparities among sexual minority women veterans. *Journal of Women's Health*, *22*(7), 631-636.

Booth, B. M., Davis, T. D., Cheney, A. M., Mengeling, M. A., Torner, J. C., & Sadler, A. G. (2012). Physical health status of female veterans: contributions of sex partnership and in-military rape. *Psychosomatic Medicine*, *74*(9), 916-924.

Borrero, S., Mor, M. K., Zhao, X., McNeil, M., Ibrahim, S., & Hayes, P. (2012). Contraceptive care in the VA health care system. *Contraception*, *85*(6), 580-588.

Burgess, D. J., Ding, Y., Hargreaves, M., Van Ryn, M., & Phelan, S. (2008). The association between perceived discrimination and underutilization of needed medical and mental

health care in a multi-ethnic community sample. *Journal of Health Care for the Poor and Underserved*, *19*(3), 894-911.

Callegari, L. S., Katon, J. G., Gray, K. E., Doll, K., Pauk, S., Lynch, K. E., ... & Gardella, C. (2019). Associations between race/ethnicity, uterine fibroids, and minimally invasive hysterectomy in the VA healthcare system. *Women's Health Issues*, *29*(1), 48-55.

Casagrande, S. S., Gary, T. L., LaVeist, T. A., Gaskin, D. J., & Cooper, L. A. (2007). Perceived discrimination and adherence to medical care in a racially integrated community. *Journal of General Internal Medicine*, *22*(3), 389-395.

Congressional Research Service. (2021). *Veterans health administration: Gender-specific health care services for women veterans.* https://crsreports.congress.gov/product/pdf/IF/IF11082#:~:text=It%20includes%20not%20only%20reproductive,health%20care%20system%20in%20FY2019.

Cordasco, K. M., Mengeling, M. A., Yano, E. M., & Washington, D. L. (2016). Health and Health Care Access of Rural Women Veterans: Findings from the National Survey of Women Veterans. *Journal of Rural Health, 32*(4), 397–406.

Crenshaw, K. (1989). Demarginalizing the Intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U. Chi Legal f.,* 139.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev., 43,* 1241-1299.

Department of Defense Sexual Assault Prevention and Response Office. (2020). *Department of Defense Annual Report on Sexual Assault in the Military, Fiscal Year 2020.*

https://www.sapr.mil/sites/default/files/DOD_Annual_Report_on_Sexual_Assault_in_the_Military_FY2020.pdf

Department of Veteran Affairs. (2022). *Center for women veterans.* https://www.va.gov/womenvet/

Department of Veteran Affairs. (2017b). *Health care services for women veterans.* file:///C:/Users/lanth/Downloads/1330_01(4)_D_2021-01-08.pdf

Department of Veteran Affairs. (2022). *LGBT Veteran healthcare.* https://www.patientcare.va.gov/LGBT/docs/va-pcs-lgbt-factsheet-lesbian-bisexual.pdf

https://www.womenshealth.va.gov/outreachmaterials/GeneralHealthandWellness/maternity.asp

Department of Veterans Affairs. (2013). *Women veteran profile.* https://www.va.gov/vetdata/docs/SpecialReports/Women_Veteran_Profile5.pdf

Department of Veterans Affairs. (2017b). Women veterans report: The past, present, and future of women veterans. *Washington, DC: National Center for Veterans Analysis and Statistics*, 1-72.

Devine, D. T., McMillan, S. C., Kip, K., & Powell-Cope, G. (2020). Quality of life among women veterans. *Journal of the American Association of Nurse Practitioners*, *32*(11), 745-755.

Elnitsky, C. A., Andresen, E. M., Clark, M. E., McGarity, S., Hall, C. G., & Kerns, R. D. (2013). Access to the US department of veterans affairs health system: Self-reported barriers to care among returnees of operations enduring freedom and Iraqi freedom. *BMC health services research*, *13*(1), 1-10.

Frayne, S. M., & Mattocks, K. M. (2012). Sourcebook: women veterans in the Veterans Health Administration. Volume 2: sociodemographics and use of VHA and non-VA care.

Friedman, S. A., Phibbs, C. S., Schmitt, S. K., Hayes, P. M., Herrera, L., & Frayne, S. M. (2011). New women veterans in the VHA: A longitudinal profile. *Women's Health Issues*, *21*(4), 103-111.

Frayne, S. M., Phibbs, C. S., & Friedman, S. A. (2013). Sociodemographic Characteristics and Use of VHA Care and Non-VA Care. *Washington, DC, Department of Veterans Affairs, Women Veterans Health Strategic Health Care Group*.

Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., Simpson, T., Carter, M. E., Blais, R. K., & Gundlapalli, A. V. (2016). Military sexual trauma and co-occurring posttraumatic stress disorder, depressive disorders, and substance use disorders among returning Afghanistan and Iraq veterans. *Women's Health Issues, 26*(5), 546–554

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. *Washington, DC: Institute of Medicine*, *10*, 13128.

Gray, K. E., Ma, E. W., Callegari, L. S., Magnusson, S. L., Tartaglione, E. V., Christy, A. Y., & Katon, J. G. (2020). Understanding variation in availability and provision of minimally invasive hysterectomy: A qualitative study of department of veterans affairs gynecologists. *Women's Health Issues, 30*(3), 200–206.

Hausmann, L. R., Hannon, M. J., Kresevic, D. M., Hanusa, B. H., Kwoh, C. K., & Ibrahim, S. A. (2011). Impact of perceived discrimination in health care on patient-provider communication. *Medical care*, *49*(7), 626.

Jacobs, E. A., Rathouz, P. J., Karavolos, K., Everson-Rose, S. A., Janssen, I., Kravitz, H. M., ... & Powell, L. H. (2014). Perceived discrimination is associated with reduced breast and cervical cancer screening: the Study of Women's Health Across the Nation (SWAN). *Journal of Women's Health*, *23*(2), 138-145.

Jones, A. L., Fine, M. J., Taber, P. A., Hausmann, L. R., Burkitt, K. H., Stone, R. A., & Zickmund, S. L. (2021). National media coverage of the veterans affairs waitlist scandal: Effects on veterans' distrust of the VA health care system. *Medical care*, (*5*), 322.

Judge-Golden, C. P., Wolgemuth, T. E., Zhao, X., Mor, M. K., & Borrero, S. (2020). Agreement between self-reported "Ideal" and currently used contraceptive methods among women veterans using the Veterans Affairs Healthcare System. *Women's Health Issues*, *30*(4), 283-291.

Katon, J. G., Lewis, L., Hercinovic, S., McNab, A., Fortney, J., & Rose, S. M. (2017). Improving perinatal mental health care for women veterans: description of a quality improvement program. *Maternal and child health journal*, *21*(8), 1598-1605.

Katon, J. G., Ma, E. W., Sayre, G., Zephyrin, L. C., Cordasco, K. M., Yano, E. M., & Fortney, J. C. (2019). Women veterans' experiences with Department of Veterans Affairs Maternity Care: current successes and targets for improvement. *Women's Health Issues*, *28*(6), 546-552.

Kauth, M. R., Barrera, T. L., & Latini, D. M. (2019). Lesbian, gay, and transgender veterans' experiences in the Veterans Health Administration: Positive signs and room for improvement. *Psychological Services*, *16*(2), 346.

Kehle-Forbes, S. M., Harwood, E. M., Spoont, M. R., Sayer, N. A., Gerould, H., & Murdoch, M. (2017). Experiences with VHA care: a qualitative study of US women veterans with self-reported trauma histories. *BMC women's health*, *17*(1), 1-8.

Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: Interpersonal violence, PTSD, and mental health in women veterans. *Research in nursing & health*, *34*(6), 457-467.

Kimerling, R., Bastian, L. A., Bean-Mayberry, B. A., Bucossi, M. M., Carney, D. V., Goldstein, K. M., ... & Frayne, S. M. (2011). Patient-centered mental health care for female veterans. *Psychiatric Services*, *66*(2), 155-162.

Kimerling, R., Pavao, J., Greene, L., Karpenko, J., Rodriguez, A., Saweikis, M., & Washington, D. L. (2015b). Access to mental health care among women Veterans: is VA meeting women's needs? *Medical Care*, *53*(4 Suppl 1), S97.

Kizer, & Jha, A. K. (2014). Restoring trust in VA health care. *The New England Journal of Medicine, 371*(4), 295–297. https://doi.org/10.1056/NEJMp1406852

Klap, R., Darling, J. E., Hamilton, A. B., Rose, D. E., Dyer, K., Canelo, I., ... & Yano, E. M. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs medical centers and impacts on delayed and missed care. *Women's Health Issues*, *29*(2), 107-115.

Kozhimannil, K. B., Interrante, J. D., Tuttle, M. S., Henning-Smith, C., & Admon, L. (2020). Characteristics of US rural hospitals by obstetric service availability, 2017. *American Journal of Public Health, 110*(9), 1315–1317.

Lehavot, K., Der-Martirosian, C., Simpson, T. L., Shipherd, J. C., & Washington, D. L. (2013). The role of military social support in understanding the relationship between PTSD, physical health, and healthcare utilization in women Veterans. *Journal of Traumatic Stress, 26*, 772–775.

MacDonald, S., Hausmann, L. R., Sileanu, F. E., Zhao, X., Mor, M. K., & Borrero, S. (2017). Associations between perceived race-based discrimination and contraceptive use among women veterans in the ECUUN study. *Medical Care*, *55*, 43.

MacDonald, S., Judge-Golden, C., Borrero, S., Zhao, X., Mor, M. K., & Hausmann, L. R. (2020). Experiences of perceived gender-based discrimination among women veterans: data from the ECUUN study. *Medical care*, *58*(5), 483.

Mancuso, A. C., Summers, K. M., Mengeling, M. A., Torner, J. C., Ryan, G. L., & Sadler, A. G. (2020). Infertility and health-related quality of life in united states women veterans. *Journal of Women's Health 29*(3), 412–419.

Mattocks, K. M., Kroll-Desrosiers, A., Kinney, R., & Singer, S. (2019). Understanding maternity care coordination for women veterans using an integrated care model approach. *Journal of General Internal Medicine*, *34*(1), 50-57.

Mattocks, K. M., Mengeling, M., Sadler, A., Baldor, R., & Bastian, L. (2017). The Veterans choice act: A qualitative examination of rapid policy implementation in the department of veterans affairs. *Medical care*, *55*, 71-75.

Mattocks, K. M., Skanderson, M., Goulet, J. L., Brandt, C., Womack, J., Krebs, E., ... & Haskell, S. (2010). Pregnancy and mental health among women veterans returning from Iraq and Afghanistan. *Journal of Women's Health*, *19*(12), 2159-2166.

Mattocks, K. M., Yano, E. M., Brown, A., Casares, J., & Bastian, L. (2018). Examining women Veteran's experiences, perceptions, and challenges with the veterans choice program. *Medical Care*, *56*(7), 557-560.

Mattocks, K. M., & Yehia, B. (2017). Evaluating the veterans choice program: Lessons for developing a high-performing integrated network. *Medical Care*, *55*, 1-3.

Meade, V. (2020). Embracing diverse women veteran narratives: Intersectionality and women veteran's identity. *Journal of Veterans Studies, 6*(3), 47–53.

Murdoch, M., Polusny, M. A., Hodges, J., & O'Brien, N. (2004). Prevalence of in-service and post-service sexual assault among combat and noncombat veterans applying for department of veterans affairs posttraumatic stress disorder disability benefits. *Military Medicine*, *169*(5), 392-395.

National Academies of Sciences, Engineering, and Medicine. (2018). Evaluation of the Department of Veterans Affairs mental health services.

Oster, C., Morello, A., Venning, A., Redpath, P., & Lawn, S. (2017). The health and wellbeing needs of veterans: a rapid review. *BMC psychiatry*, *17*(1), 1-14.

Partridge, S., Balayla, J., Holcroft, C. A., & Abenhaim, H. A. (2012). Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: a retrospective analysis of 28,729,765 US deliveries over 8 years. *American Journal of Perinatology*, *29*(10), 787-794.

Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2014). Voluntary and involuntary childlessness in female veterans: Associations with sexual assault. *Fertility and Sterility*, *102*(2), 539-547.

Sadler, A. G., Mengeling, M. A., Syrop, C. H., Torner, J. C., & Booth, B. M. (2011). Lifetime sexual assault and cervical cytologic abnormalities among military women. *Journal of Women's Health*, *20*(11), 1693-1701.

Sherman, M. D., Kauth, M. R., Shipherd, J. C., & Street Jr, R. L. (2014). Provider beliefs and practices about assessing sexual orientation in two veterans health affairs hospitals. *LGBT Health*, *1*(3), 185-191.

Shipherd, J. C., Darling, J. E., Klap, R. S., Rose, D., & Yano, E. M. (2018). Experiences in the veterans health administration and impact on healthcare utilization: comparisons between lgbt and non-lgbt women veterans. *LGBT Health*, *5*(5), 303-311.

Skinner, K. M., Kressin, N., Frayne, S., Tripp, T. J., Hankin, C. S., Miller, D. R., & Sullivan, L. M. (2000). The prevalence of military sexual assault among female Veterans' Administration outpatients. *Journal of Interpersonal Violence*, *15*(3), 291-310.

Suris, A., & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, & Abuse*, *9*(4), 250-269.

Trivedi, A. N., & Ayanian, J. Z. (2006). Perceived discrimination and use of preventive health services. *Journal of general Internal Medicine*, *21*(6), 553-558.

Turner, C., & Frayne, S. (2004). Veterans' health initiative: Military sexual trauma. *TRACE Code*, *3*.

Veterans Health Administration. (2008). *Uniform mental health services in VA medical centers and clinics*. Washington, DC: VHA Handbook.

Veterans Health Administration. (2012). *VHA Handbook 1330.03: Maternity health care and coordination.* Washington, DC: VHA Handbook.

Washington, D. L., Bean-Mayberry, B., Mitchell, M. N., Riopelle, D., & Yano, E. M. (2011). Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. *Women's Health Issues*, *21*(4), 112-119.

Washington, D. L., Bean-Mayberry, B., Riopelle, D., & Yano, E. M. (2011b). Access to care for women veterans: Delayed healthcare and unmet need. *Journal of General Internal Medicine*, *26*(2), 655.

Washington, D. L., Farmer, M. M., Mor, S. S., Canning, M., & Yano, E. M. (2015). Assessment of the healthcare needs and barriers to VA use experienced by women veterans: findings from the national survey of women Veterans. *Medical Care*, *53*(4), 23-31.

Washington, D. L., Kleimann, S., Michelini, A. N., Kleimann, K. M., & Canning, M. (2007). Women veterans' perceptions and decision-making about Veterans Affairs health care. *Military Medicine*, *172*(8), 812-817.

Chapter 3: **Methods & Results**

Manuscript 2: Experiences and Perspectives of Women Veterans Use of the Veterans Health Administration

The purpose of this chapter is to present the study's methods and results about the perceptions of Women Veterans (WVs) experiences with the Veterans Affairs Healthcare

System (VA) using a qualitative, phenomenological approach. Potential limitations are explained to enhance the current knowledge on the phenomena of WVs, advance the science of nursing, and lead to future research. The manuscript has been formatted to the specifications for Military Medicine and will be submitted for publication in 2023.

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Contact: Leanne N Anthon

Email: lnanthon@uwm.edu

Manuscript 2: Experiences and Perspectives of Women Veterans Use of the Veterans Health Administration

Leanne Anthon[a]

Affiliations:

[a] College of Nursing, University of Wisconsin-Milwaukee, Milwaukee, WI, USA

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Abstract

Women veterans (WVs) have higher mental, physical, and social health disparities compared to male veterans and civilian women. These health disparities often require WVs to be frequently monitored by a healthcare provider. In recent years, the Veterans Health Administration (VA)

healthcare system has attempted to increase the accessibility and services provided to the growing number of WVs who use the VA. This study aims to explore the experiences and perspectives of WVs who use or have used the VA. The study used a qualitative, phenomenological approach using thematic analysis to look at the experiences of WV's use of the VA healthcare system. As a result of qualitative analysis, four main themes emerged from the participant interviews. Themes included quality of care received at the VA, barriers to receiving care at the VA, frustrations with the system, and private insurance supplementation. The study found many WVs experience barriers and frustrations when using the system, and some prefer civilian care over the VA to avoid these challenges. However, if the care were more on par, they expressed that they would prefer the VA as it is important to them to be connected to others that understand military service.

Keywords: *women veterans, veteran affairs, VA, female veteran, military*

Background

The Veterans Health Administration (VA) is the largest healthcare organization in the United States, with over 9 million veterans enrolled (Department of Veteran Affairs, 2021). In recent years, the VA has attempted to increase the accessibility and services provided to the

growing number of women veterans (WVs). WVs comprise 10% of this population, the fastest growing demographic of veterans, with projections to increase to at least 16% by 2043 (National Center for Veterans Analysis and Statistics, 2017). Of this population, 40% are from racial or ethnic minority groups, compared to 23% of male veterans (Frayne et al., 2014). WVs face the same challenges as male veterans but also experience mental, physical, and social health disparities that lead to lower quality of life (QOL; Oster et al., 2017). WVs have higher sexual violence, chronic pain, and combat trauma rates than male veterans (Der-Martirosian et al., 2013; Lehavot et al., 2013). Injuries from intense physical activity, potential trauma, toxic substance exposure, and military sexual trauma (MST) are commonly found in WVs. These experiences could lead to physical and mental health diagnoses that may require care after the service member has left the military.

Study Aim

Given the increase in the number of WVs, the large percentage of WVs from a racial or ethnic minority group, the historically male-dominated environment and culture of the VA, and the unique makeup of the WV population, the VA may need to adjust current practices to serve the needs of WVs better. This study explored the experiences and perceptions of WVs who use the VA healthcare system. This study aims to identify information that could lead to healthcare policy improvement for WVs at the VA.

Methods

Design

The method used for this study was a phenomenological qualitative approach and thematic analysis. A goal of qualitative research is to get a better understanding of a chosen phenomenon in the natural setting through interviews and observations in an intimate and

personalized manner (Denzin & Lincoln, 2018). This research method looks at the why, what, and how the phenomenon occurs (Yin, 2003). Qualitative studies are conducted in a natural setting where the participants should be comfortable and can speak freely to better understand the meanings of the phenomenon (Polit & Beck, 2010; Denzin & Lincoln, 2011). A phenomenological approach looks at the lived experiences of the participants and allows their stories to be told in a natural setting (Creswell & Poth, 2018; Lindseth & Norberg, 2021). A qualitative method was chosen because participant experiences provide a highly subjective view of a phenomenon. This method is the best approach because it allows the WVs to freely share their stories and allows for a deeper understanding of their experiences with the VA healthcare system. The healthcare needs of WVs are complex including not only the usual health issues that women face, but health concerns related to military experiences including MST, the physical demands of military service, higher rates of PTSD and depression, and intersectionality. Thematic analysis was used to analyze the data because it can provide a description of the patterns that arise from the interviews (Saldana, 2021).

Before conducting the interviews, a semi-structured interview guide was created to help facilitate the interview and obtain the data. The goal of the interview guide was to ask open-ended questions to allow for participant-led discussion. There were three main aims in the interview guide. The first aim focused on understanding the military experiences of the participants and to understand their health status prior to, and while in the military. The second aim was to seek to identify the participants' post military health experiences, including their use of the VA. The final aim asked about any suggested improvements that could be made at the VA

from the lens of a WV. This question aimed to identify areas of improvement from the WV perspective.

Prior to conducting the interview, the researcher obtained verbal and electronic written consent and provided a copy to each participant. The consent form also includes a list of resources for the participants if the need arose following the interview. After the interviews were conducted, the recorded transcripts were printed from the researcher's Zoom account to allow the researcher to easily analyze, store, and code the interview data.

Sample

Recruitment was conducted by posting an IRB-approved flyer to social media groups directed toward WVs. Snowball sampling was also used to identify additional participants. The study included a sample of 20 Department of Defense (DOD) WVs who have served in the US military. Inclusion criteria were WVs over 18 years of age that currently use, or have used the VA for their healthcare, and identify as a WV. Exclusion criteria are WVs who are enrolled at a VA but have never been seen at a VA healthcare facility and those who have been a patient for less than six months.

Setting

Each participant was asked to participate in two, one-hour individual interviews via Zoom virtual meeting platform. Conducting interviews through a virtual format allowed for the recruitment of participants from various areas of the country, increasing the opportunity for diversity in the sample. Individual interviews also allow for in-depth descriptions on a more personalized level (Bloomberg & Volpe, 2019). All interviews were guided by semi-structured open-ended questions to gain information on the participant's lived experiences of the complex health concerns of WVs and their experiences with VA care.

Ethical Considerations

Given the high incidence of MST and PTSD among female veterans, there was a risk of potential triggers throughout the interview. The study used safeguards to ensure the participants were safe, protected and their rights were respected. For example, the researcher obtained informed consent before starting the study. Each participant was also emailed a copy of the consent form with a list of resources available for later use if the participant became distressed following the interview. After the interview, all transcripts were assigned a number, and participants were given a pseudonym to be used for the remainder of the study. Any identifying characteristics were de-identified throughout the transcription process. All responses were kept confidentially in a password-protected file on the researcher's laptop. Finally, participants were informed they may leave the study at any time throughout the interview if they choose to for any reason without any risk to confidentiality.

Data Analysis

Upon interview completion, transcripts were coded to identify the top attributes related to the phenomenon and thematic analysis was used to interpret the codes. Coding aims to simplify participant information into terms that are easier to understand, group, and study (Saldana, 2013). The coding process took several steps (Saldana, 2013):

Step 1. Initial reading: transcripts were read through, making a note of initial impressions or topics.

Step 2. Open coding: transcripts were read noting major themes common throughout the interviews. Codes, words, or short phrases were created to symbolize and capture the data to open new possibilities when looking at the data. Descriptive labels were attached to discrete instances of the phenomena using words and phrases from the participants.

Step 3. Axial coding: conclusions were drawn between the developed codes that are grouped together to tie them together and develop relationships between the data.

Step 4. Selective coding: codes were connected based on the core categories or themes based on the core aspects of the participant experiences.

Step 5. Analyze the data: using thematic analysis, codes were identified overarching themes to capture the main points or topics throughout the participant interviews.

Additional rounds of coding were completed as necessary until the information was accurately categorized into workable data. A deductive approach was used to code the data based on the domains used to develop the interview guide (a priori codes). An inductive analytic approach was used to further identify categories of the participant experiences within those a priori codes.

Results

As shown in Table 1, twenty WVs completed an interview and provided demographic information that is reported below. Demographics included six officers, 14 enlisted, 16 white, three black, and 1 Native American. Seventeen of the participants worked full-time outside of the home. Five of the participants had children 18 years old or younger. They were all single parents and had between 3-5 children. Three participants served in the Air Force, 11 in the Army, two in the United States Marine Corps (USMC), and four in the United States Navy (USN). Time spent in the military ranged from 3 years to 23 years. Three participants retired after serving 20 years, and twelve participants wanted to retire after serving 20 years but had to leave the military early due to health-related reasons. The remaining five participants did not intend on retiring when they started service. The use of the VA with the participants varied between four and 20 years. All the participants are currently enrolled in the VA. However, 9

participants solely use the VA, seven also have civilian insurance, and 4 use the VA but pay out of pocket for some civilian services like counseling, chiropractic, massage, and acupuncture services. See Table 3.1 for the demographics of the participants.

Table 3.1 Demographics of Participants

	Enlisted	Officer	Black	Native American	White	Full time employment	Parent	Branch
Participant A	X				X	X	X	Army
Participant B	X				X	X	X	Army
Participant C	X				X	X		USMC
Participant D		X			X	X		Air Force
Participant E	X		X			X	X	USN
Participant F		X			X			Army
Participant G	X				X	X	X	USN
Participant H		X			X	X		Army
Participant I	X		X			X	X	Army
Participant J	X				X			USN
Participant K	X				X	X		Army
Participant L	X				X	X		Army
Participant M	X			X		X		Air Force
Participant N	X				X	X		Army
Participant O		X	X			X		Army
Participant P		X			X			Air Force
Participant Q	X				X	X		Army
Participant R	X				X	X		Army
Participant S		X			X	X		USMC
Participant T	X				X	X		USN

Total:	14	6	3	1	16	17	5	Air Force: 3 Army: 11 USMC: 2 USN: 4

Themes and Sub-themes

When coding was performed, four main themes emerged from the participant interviews. Themes of quality of care received at the VA, barriers to receiving care at the VA, frustrations with the system, and private insurance supplementation emerged. Themes and subthemes are listed in Table 3.2.

Quality of care received

Quality, in this theme, is described as the standard of care that is provided when receiving care at the VA. Participant C, an enlisted veteran who has been using both the VA outpatient clinic and a VA hospital for the past 27 years summarized:

"My irritation started with the VA is when I had bad care, I had really, really bad care. When I had good care, the people were amazing."

Participants described the positive quality of care as "amazing", "top notch", and "fantastic." The negative quality of care was described as "incompetent", "rude", and "inexperienced."

Positive Quality of Care Received

Participants had positive things to say about the VA. When looking at close monitoring of care, the use of secure messaging, collaboration with medical colleges, VA providers being more informed of veteran issues than civilian providers, or virtual care options, the participants felt there were several positive qualities of care provided at the VA.

Four participants felt civilian healthcare could learn from the VA in how they follow up with veterans and provide care. For example, Participant S, a three-time cancer survivor felt the VA "watches me like a hawk" and follows up with her more often than her civilian providers. She was also very impressed with the collaboration with her civilian provider and VA providers during her cancer treatments. Participant L, an enlisted veteran who recently started using the VA when she lost her private insurance when her husband lost his job stated:

"They are just outstanding. I can't say enough good things about them, and I don't understand why they got such a bad rap. Truthfully, they're so polite, they call back, they follow up. They really gone beyond the call of duty, I think they've been phenomenal."

Another praise for the VA was the secure messaging system My HealtheVet. This program allows veterans to contact their providers directly. Participant Q, an enlisted veteran who has been using the VA for the past 7 years and has a demanding full-time job stated:
"*I have really appreciated the secure messaging system. I've used that a lot and I find that with providers that use it consistently, it's much easier for me to communicate with them."*
However, not all providers use the system. Participant Q further stated:
"It's easier than it is for me to be playing phone tag with somebody, right? And leaving messages with nurses and hoping that everything's recorded the way it should be. The providers that use it consistently, it's been great. The ones that don't, it's really difficult because I send this information and I don't hear back from them for months."

Four WVs live in areas where VA hospitals had collaborated with excellent teaching medical colleges. These participants stated they felt they received great care from these partnerships.

Participant L, who receives care at one of these facilities with collaborations, and has had care from specialists at the teaching hospital stated:

"They are top-shelf doctors. They're not just playing someone out of the back alley. I feel like I have gotten superior care, truthfully."

These WVs felt the VA at these facilities went above and beyond to ensure that you're being treated privately and with great respect and they felt they received a high level of care.

Finally, participants felt the VA providers were more aware of veteran experiences and what challenges they face. Participant O, a 63-year-old officer who has used the VA for the past 20 years stated she appreciates the environment of the VA because of this awareness of veteran issues. She states:

"Here are people who have a similar experience to me. um, whereas you go to civilian doctor, they're looking at your history and they're like you had what and where like, why were you there? And you're like, I was in the military whereas, at the VA, you don't have to explain that. They know that everyone has lived, like multiple places. And you know that whole kind of scenario and you have people with broken bones and things like that."

Many participants also appreciate the option to have virtual appointments due to the barriers many have when attending face-to-face VA appointments. Participant G, an enlisted WV who is a single mother of 4 young kids, stated she prefers face-to-face appointments but has too many personal responsibilities to attend in person. She stated:

"I do virtual appointments because it's virtually impossible to get there without jumping through hoops."

Participant M, an enlisted WV who served for 17 years, describes why she prefers virtual appointments:

"I'm able to pull myself away and feel safe. If I'm sitting in front of someone or in a group setting, I have to leave the appointment and hide in the VA. It's (virtual) not the best quality, but I feel safer."

Participant J, an enlisted WV who has severe physical disabilities due to her military service stated she attends virtual appointments because she cannot sit in a car or drive due to her military-related injuries. Other participants who are not able to drive state they rely on friends or family members to take them. Many participants indicated when they did not have a ride or childcare, they had to forgo their care, highlighting the importance of offering virtual visit options.

Negative Quality of care received

The negative quality of care experiences was related to the lack of care surrounding women-specific care provided at the VA. As Participant O commented regarding her frustrations with the lack of gender-related care at the VA:

"I don't know why it never occurred to them that if you bring women into the military at some point they're going to leave" and need healthcare like the male veterans. Participants felt they should be able to receive more care at the VA instead of being referred out to the community. For example, Participant N was frustrated when she had to go to a local provider for her mammogram. She stated:

"Like we all earned the right to go there like why isn't the care there? It's something that we earned. It's kind of like, well, this is what you get."

While participants would like to be able to receive all their healthcare at VA hospitals, others expressed shame and embarrassment when having to ask where gender-specific clinics are located at the VA. For example, Participant Q had trouble finding a gynecologic clinic in a VA hospital. She had to ask several staff members where the clinic was before finding someone knew where it was. Participant Q expressed embarrassment with having to ask several people, mostly male staff members, the same question repeatedly and stated:

"You can direct me to the vending machine that's got the good Snickers on the 7th floor, but you can't get me to the gynecology clinic, and you can't put a sign up anywhere?"

Discouragement and lowered expectations with gender-specific care at the VA was common among the participants. Participant K explained her feelings on this topic:

"I don't think the VA's ever gonna be there when it comes to women and their health issues. You know, when it comes to mammograms, they have to refer me out to do a mammogram. The VA doesn't do them. How long have women been serving? Ohh, I don't know since the beginning. You know, and now they can't even do a mammogram."

Three WVs also stated they were not provided proper hygiene products when they were inpatients at VA hospitals. Participant K later shared her recent experience:

"And of course, at that point, I happen to start my period. I asked the nurse, who was a guy if I can get either some napkins or tampons because I just started my period. I don't think we have that stuff. What do you mean? You know you can treat patients right. You should have this stuff, but it didn't dawn on me. They are used to treating male patients, not female patients. So, something as simple as a tampon or pad I couldn't get. So, I had to do a makeshift pad out of toilet paper. For three days, I was in the hospital and the same nurse couldn't figure out why

there was blood in my urine samples. I'm like, you've got to be fucking kidding me. I just told you that the day before I started my period and you can't provide me with any, you know, sanitary napkins or tampons. But you can't tell me you couldn't ask one of the other nurses on the floor that happened to be female. You know, so yeah, I mean, it was utterly disgusting. It was just like, God, this is nasty. And then again, your esteem comes down because you don't matter."

While many participants would like to receive all their care at VA facilities, there seemed to be some shame when having to ask for departments that specifically treated WV issues due to a lack of awareness by the staff of what some of these issues were and where departments were to better direct the WV. Participants alluded to concerns about women's issues such as menstruating while being an inpatient at VA facilities and not being provided proper resources, or fertility and childbearing issues. Additionally, due to the historically large male presence at the VA, there seemed to be a collective understanding among participants that they would get lowered standards of care regarding gender-specific issues.

Barriers to receiving VA Care

Barriers WVs experience when receiving VA care are related to lack of appointment offerings, and difficulty attending face-to-face appointments due to competing responsibilities.

Participant G summed up the overall frustration that WVs experience just getting to a location where they can receive needed care:

"We're battling many things just walking in the front door."

Appointment availability

The WVs interviewed expressed frustration with the time availability of appointments offered by the VA. Given the personal responsibilities of the participants, such as motherhood, and in many cases, single motherhood, working full time, and driving long distances to get to

the nearest VA hospital or outpatient facility, the WVs had difficulty fitting in VA appointments during the traditional work week and due to competing responsibilities.

For example, getting off work to make traditional appointment times is a barrier. Participant Q stated:

"The times are not convenient, and sometimes it's just the point where I have to go. I have to miss work. I have to just get in when it's. Kind of convenient to them, but not me."

Others expressed challenges with workplaces understanding the need to take an entire day off work to attend a VA appointment. For the participants in this study, the VA outpatient clinics ranged from 15 minutes to one hour away, and the closest VA hospitals were one-3.5 hours away. Participant N, a white enlisted WV who works full time, stated her employer didn't understand why she needed an entire day off of work for her routine appointment. She stated: *'It's difficult when you have a full-time job to come in and see them. You can get in early for blood work at like seven, 7:30 in the morning, but pretty much the place shuts down at 4:30. And that's not convenient. I wish they had, like, a day of the week. Or maybe they were open later to catch people that still have full-time jobs. They must miss work. When I have the VA appointment it is literally an all-day event."*

Participant H, a retired officer who can attend the traditional office visits during the week explained why she does not use the VA for urgent or emergent issues:

"Sometimes it takes a long time to get an appointment. So, for something like urgent, that I feel it's urgent, I can't go to get an appointment. I'll go to a private clinic."

Transportation

Participant C commented on how a barrier for her to attend appointments at the VA was transportation. She stated:

"*It's very hard for me to drive. I can't turn my neck, I can't move my back. It's very difficult. Driving is my biggest obstacle."*

She further stated she forgoes care because she of her issues with getting to the VA for appointments. Other participants commented that transportation also being an issue. Although there are services that offer rides for veterans to attend appointments at the VA, the participants in this study who had transportation as a barrier where not comfortable riding in a van with other veterans when they were likely to be male.

Childcare

Many of the participants in the study who are mothers preferred face-to-face visits with their providers but scheduled virtual appointments when possible due to the extra stress of finding childcare or bringing their children to the VA. For example, Participant G, a single mother of four, described her experience with her face-to-face VA appointments. She stated:

"Because by the time I'm done, daycare will be closed and I have to pay the $30 fee or whatever it is like. So, what I have to do is, I have to go get them, take them to someone who can watch them so I can go to my appointment. And that's why it's even more frustrating when I have a canceled or late appointment because I'm just like, you know, how much work do I have to go through to even get to this appointment?"

Participant I, a single mother of five children, expressed similar stress with her VA appointments when trying to take her children with her:

"For me wanting to go in is, you know, oh my gosh, I got the kids, you know, can I fit this double stroller in this office? You know? Then I take them out this stroller, they're gonna be everywhere."

These experiences show that WVs have many factors that must be considered when making VA appointments. Participants indicated when they did not have childcare or were unable to get off of work, they had to forgo their care.

Building design

Other participants commented on the stress related to going to the VA and having to experience the military environment again. Participant O described her increased anxiety when she stated:

"You have to go through the gauntlet just to get into it) women's health center)."

Other participants were enrolled in VA facilities where the WHC had separate waiting rooms or even separate entrance, however, this is not common among most VA facilities. Due to the high incidence of MST among WVs, many prefer to be seen in WHC's or those with a higher female presence. Due to the building design of many VA's, it appears to be a challenge to provide consistent women-only environments.

Frustrations with the system

Frustrations with the VA were another theme for WVs who use the system. These frustrations ranged from a high turnover of providers, difficulty making appointments, and feeling like they must fight to receive quality care. For example, Participant K described her attitude towards the frustrations she experiences with her VA healthcare:

"And you have to look at it with a sense of humor. Otherwise, you're just gonna sit there and cry and blow your head out."

Provider Turnover

Eighteen participants commented that they were assigned new providers because their previous doctor or nurse practitioner left the VA or changed roles in the agency. Often, these were reassigned without the WV being notified or being asked which new provider the WV would like to have. Participants also commented on the dismissal they felt when being assigned providers rather than being offered the opportunity to look up available providers and choose which one they felt would be the best fit for them. Participant M, an enlisted WV who served for 17 years, stated:

"They assign me to a provider I'd never met before. I don't know anything about them. You know, when you're in the civilian world, your health insurance allows you to choose your provider. So, you do the research, you look up there, you know, I look up, first of all reviews. Second of all, I look up how they had any lawsuits does it, has there been malpractice? Like, I look that stuff up. And the VA, they don't let you see that they don't. They don't allow you to."

Another issue with provider turnover is assigning a male provider when the participant prefers a female. One WV described how unsettling it was to have a male provider walk into her exam room for her gynecological appointment when she had previously requested all female providers. Participant N stated:

"It was always a surprise who I would see. I was missing the courtesy of letting me know ahead of time. In a civilian clinic, they wouldn't just switch the provider or put a male provider in with a patient who prefers a female provider."

The turnover of providers was a frustration for many participants as they had to "start over" every time they got a new provider. Many participants who liked their current providers

but had to be reassigned, had a lapse in care or lost motivation to keep taking care of their health. Participant G:

"Yeah, pretty much. You know, you never see the same one. So how can you build a rapport with your doc and trust your doc if you never see the same doc twice?"

This participant went on to describe how frustrating it was for her to continuously get new providers:

"A*nd if I do go like I said, I end up seeing a new person every three months and it's just like, ohh, you know, I have to re-explain everything just to get my medicine refilled and like. I'm not going to keep making huge efforts to go."*

Participant Q had a similar experience:

"Every time I meet a new VA provider, there's a 50/50 chance, right? You're like they could be like a lot of new, newer, younger doctors are, you know, finishing residency, joining the VA. They're really passionate, and they care a lot. And then there's the doctors that probably couldn't be employed anywhere else, and you never know what you're gonna get when you walk in, and you just hope for the best."

Finally, Participant J added:

"Unfortunately, people fall through the cracks, and they just have too many providers leave."

These results show the dissatisfaction the participants had in the study with the frequent turnover of providers. This could result in another hurdle for the WVs to get adequate healthcare and lack of motivation to continue with care.

Difficulty making an appointment

Another frustration participants experienced was the difficulty in contacting the VA to schedule an appointment. Participants stated they waited weeks to get a call back from the VA, and when calling to make an appointment, they must set aside hours to complete the task. Participant Q, who works in an environment where she cannot have her phone on her, stated:

"And so it's very difficult for me to carve out 45 minutes to make a VA phone call in the middle of my workday, and it's very difficult for me to wait on a callback from the VA because that means that I cannot do my job. I can't be working. I'll plan to call the VA on my day off or my afternoon off when I go to the chiropractor or whatever. Like, I have to schedule when I'll be able to call them."

Another stated:

"But any time I have to call the main VA for anything, it's a good., it's over 20 minutes on hold. And then whether you get hung up on or transferred where you're supposed to go with, you know, crap shoot."

Finally, Participant P confirmed:

"Because I feel like the VA system is so hard to contact. Like if you have a question, you know, I know I can umm e-mail and they're very good about getting back. But I feel like you can't call with the question. It goes through this main system and I mean. It's just cumbersome to try to make appointments to get appointments."

While Participant P has been able to email her provider through MyHealthy Vet, the VA's secure messaging platform, she also stated:

"I'm just not that into technology liked I'd rather pick up the phone and talk than I would email. So, I guess I'm just so old and I think if that's me (A 60 year old) gosh, how is it for the older veterans? Is this just for young kids?"

Difficulty making an appointment and contacting your VA provider was a big frustration for many WVs. While My HealtheVet is one option for WVs to contact their team, it is not an option, or easy, for all WVs.

Finally, the combination of frustrations was difficult for participants who needed close monitoring. For example, Participant B, an enlisted WV who has been using the VA since she was discharged 12 years ago, had difficulty in making appointments and with provider turnover. She stated:

"The 1st 10 years of returning home I almost became one of 22 a day. It was hard. It was hard because first of all, getting an appointment. There was really difficult, I didn't have the care that I needed. I didn't have any kind of prescriptions. I didn't have anything to help my mind racing at night. So, I was looking for repair. I was looking for, you know, my sanity back. I wasn't insane. But, you know, I just. I was looking for any relief and talking to someone was OK, but it didn't solve anything. Every three months I would go to an appointment for counseling, mental health or social work or whatever, and I was going. I was going like once a week, but every three months I would get a new person because the VA can't keep anybody. And so, I was just like, I'm not going to keep freaking coming here. Like, if I have to start over from the beginning and like, I'm trying. Like, I'm trying to work towards a certain goal."

This participant experienced multiple frustrations with the VA system that was negatively affecting her mental and physical health. This highlights the importance of consistent care, and ease of access, especially for this vulnerable population.

Fighting for Care

Eighteen participants felt they had to fight for the care they received at the VA. This was either through requesting new providers to find one to fit their needs, asking for more treatments or tests, or paying for a civilian provider to get the proper diagnosis and then taking that back to the VA to get the appropriate treatment. For example, Participant C stated: *"You always have to fight him on everything, and you shouldn't have to. Your job is to take care of my health. I'm telling you what my symptoms are."*

Participant J felt like she had great practitioners, but they had to fight to find a provider who wasn't burned out and frustrated with the system.

She stated, *"There's no compassion, no giving a crap. I literally have to fight every time I go to a doctor."*

Participant E described her process with getting adequate care at the VA:
"The VA will put a Band-Aid on it when you can get into them, but if you actually want to get treated, do you have to go to an outside provider? So, this is what I've learned, and I learned this from some of the old vets and some of my family members. You go to an outside provider. You always keep health insurance, you know, but you got to an outside provider. Go ahead and get diagnosed and then you come. You bring your medical records from them to the VA to continue your treatment. So that way I'm not having to pay a deductible or for my prescriptions and things of that nature."

She further stated she had a great team of practitioners right now but she had to fight for those providers and needed the combination of civilian and VA care to be properly treated.

Participant N stated, she felt like a hamster on a wheel, going round and round and never getting anywhere with her VA provider. Participant J stated: *"I'm not looking for pills. I'm looking for actual treatments."*

The WVs quoted in this section provide a synopsis of the attitudes of many participants regarding the need to be proactive and advocate for themselves. Those participants who were currently happy with their healthcare team felt they had to offer suggestions, tests, and treatments to their provider to get the care they needed based on their military service.

Supplementation with Private Insurance

As previously stated, seven participants also held civilian insurance. This was through their employer, a spouse's employer, or paid out of pocket. Various reasons were given for having dual healthcare plans. Participant O stated she carries civilian insurance through her employer because she felt the VA was unprofessional and outdated. She stated:

"It's very disheartening and I really feel, I consider myself very blessed. I have a really good job and I have really good benefits, but I feel really, really bad for someone who leaves the military today, who may be in a situation where they may have to depend on VA benefits or the hospital care. It's not. It's not up to par with what it's for, what it should be, which is really sad."

Some participants keep private insurance in addition to having the VA for reasons including having the option to see a civilian provider, and for financial security. Participant Q recently paid $550 out of pocket to see a civilian specialist. Participant Q commented:

"She (VA provider) wasn't capable of assessing my functional ability and that I should see someone else, even though she had 500 pages of my medical records since 2015 at her disposal. So, I paid to see a civilian and the civilian was like, would you like to know what's wrong? And I was like, I sort of forgot that that was an option. Like anybody cared to find out what was wrong."

This participant also stated:

"They (civilians) give me actual medical care instead of a conversation."

Financial Security

Participant P, where both herself and her husband are veterans, commented paying on for private insurance in addition to the VA:

"Just because we are scared, you know, to use the VA (solely) because it's so inaccessible. We just don't feel comfortable with just the VA. It's a financial security."

Those who keep private insurance, or had it available for them through spouses or an employer felt compassion for those WVs who have no choice but to rely solely on the VA. Participant K stated:

"I use my private insurance and through my husband, I've got secondary insurance, so in that respect, I am very lucky."

Peace of Mind

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Others felt civilian care was more proactive in finding the root causes of problems with their health conditions. The participants who carried health insurance did not want to rely only on the VA for healthcare, and in some cases, were willing to pay out of pocket for civilian care. These participants also expressed compassion for the WVs who had no choice and only had VA care.

Table 3.2 Major Themes and Subthemes Identified Through Data Analysis

Theme	Subtheme	Significant Quote
1. Quality of care received	A. Close monitoring of health B. Virtual options C. Lack of gender-specific care	*A. The VA watches me like a hawk* *B. "I do virtual appointments because it's virtually impossible to get there without jumping through hoops and which sucks."* *C. "I don't know why it never occurred to them that if you bring women into the military at some point they're going to leave" and need healthcare*
2. Barriers to receiving care	A. Appointment availability	*A. "The times are not convenient, and sometimes it's just the point where I have to go. I have to miss work. I have to just get in when it's. Kind of convenient to them, but not me."*

3. Frustrations with care received	A. Provider Turnover B. Difficulty making appointments C. Fighting for Care	A. *"Yeah, pretty much. You know, you never see the same. So how can you build a report with your doc and trust your doc if you never see the same doc twice*?" *B. "But any time I have to call the main VA for anything, it's a good., it's over 20 minutes on hold. And then whether you get hung up on or transferred where you're supposed to go with, you know, crap shoot."* *C. "There's no compassion, no giving a crap. I literally have to fight every time I go to a doctor."*
4. Supplementation with private insurance	A. Financial Security	*A. "Just because we are scared, you know, to use the VA (solely) because it's so inaccessible. We just don't feel comfortable with just the VA. It's a financial security."*

Discussion

This study sought to identify the experiences and perspectives of WVs who use the VA healthcare system. The WVs interviewed have used the VA for at least six months, and all are currently enrolled patients of the VA. Discussing this issue with the researcher seemed to be

stressful for many participants. Throughout the interviews, several veterans had their support dogs, three had their husbands sitting with them, and one confessed to smoking marijuana right before the interview to calm her nerves. The themes identified were quality of care received, barriers to receiving care, frustrations with the system, and supplementation of private insurance.

Quality of care included positive and negative aspects of care received at the VA. Positive aspects were close monitoring by providers, experienced care provided, and the opportunity for virtual appointments. Negative aspects included a lack of gender-specific care.

While specific diagnoses were not evaluated in this study, co-morbidities among WVs is common. Sheahan et al., (2020) found that WVs who use VA primary care have higher comorbidities than male veterans including MST, PTSD, diabetes, cancers, hyperlipidemia, and alcohol and nicotine use. The presence of these comorbidities could correlate with closer monitoring from VA providers. Additionally, WVs seen in women's Health Clinics (WHC) rate higher satisfaction scores (Bastian et al., 2014; Bean-Mayberry et al., 2015), than WVs who are seen in a traditional clinic. The WVs in this study who experienced positive quality of care from the VA were seen in both the traditional clinics and WHCs, indicating they could have gotten quality care from either setting.

For some patients with varying diagnoses, virtual appointments have been shown to decrease barriers, are more convenient, and are as effective as face-to-face appointments (El Ashmawy et al., 2021; Harris et al., 2022; Zhang et al., 2022). This is consistent with the findings of this study where WVs were able to use virtual appointments when competing responsibilities make it hard to attend face-to-face appointments, for the ability to leave an appointment if

triggered or stressed, or when physical disabilities make it difficult to sit in a vehicle for a long distance to the VA facility. In this study, those who used virtual appointments might have preferred face-to-face appointments but appreciated the possibility of attending virtually to better fit into their lives.

WVs in this study had the most negative experiences with the VA regarding gender-specific care. Due to the lower numbers of women in the military, the VA has historically focused on male veterans' health (Sheahan et al., 2022). This was shown in a 2015 study that found providers explicitly trained in women's health and female-specific services to be lacking (Cordasco et al.). However, in recent years, the VA has implemented many new programs to serve WVs needs better. Some of these programs in place to help meet the needs of WVs include the Center for Women Veterans (CWV) which helps serve as an advocate for the transformation and responsible treatment of WVs (Department of Veterans Affairs, 2022) and the creation of the Women's Health Primary Care Providers (WH-PCP) where WVs can receive care from female providers for primary care and specialty services. In addition, the Women Veterans Call Center was created for WVs to speak with staff who specialize in female-specific services, so the WV can better understand their healthcare options and benefits (Department of Veterans Affairs, 2021). The House Committee on Veteran's Affairs has a Women Veterans Task Force to develop policies that explicitly support WVs through outreach, oversight, and legislation (Women Veterans Task Force, 2021). Finally, the VA came out with VHA Directive 1330.01 (2010), which assists healthcare providers in the duties and responsibilities of caring for WVs. These programs could decrease the negative experiences of WVs in the VA. While the

VA has improved the care for WVs, the current study shows disparities between policy and practice continue to exist.

Barriers WVs face when seeking care at the VA are related to lack of appointment offerings, difficulty attending face-to-face appointments due to transportation issues or competing responsibilities such as childcare, and the building design of VA facilities that prevent the WHCs from functioning as there were intended to. Unlike civilian women, childcare, travel, and transportation issues, and needing time off work are common themes to WVs. For civilian women competing priorities like the responsibility of raising children or working full time is a major barrier for women to miss or delay healthcare (Boitano et al., 2022, Chen et al., 2012; Katz et al., 2014). This is consistent with a study by Cordasco et al., (2016) where one in five veterans recently delayed or went without care due to difficulties getting off work, caregiver responsibilities, or transportation issues. Because WVs are more likely to be single parents (Muirhead, 2017), many participants did not have a spouse or partner to rely on to assist in childcare responsibilities. Several participants commented that they put off going to the provider since the appointments available were not convenient for them or they had too many barriers to making appointments within a reasonable time. Many of these WVs admitted going to the Emergency Department (ED) because they could not fit the appointments in with their other responsibilities and the problem got too advanced to take care of at home. They felt they would not end up in the ED if they had better access to primary care appointments. This is consistent with findings by O'Malley (2013), Dolton & Pathania, (2016), and Chang et al., (2018) found better accessibility to primary care reduced the number of emergency room visits and reduced adverse health outcomes. The final barrier WVs faced was building design. The VA

implemented the Women's Health department in 1988 to focus on providing women-specific needs in a safe environment at VA facilities (Department of Veteran Affairs, 2022. This department offers opportunities for WVs to be seen at the VA by women providers and staff. Some VA facilities have separate waiting rooms and entrances for Women Health Clinics (WHC) patients. Due to the high incidence of MST in WVs, walking into a VA facility may produce a trigger for past experiences. For example, Participant H expressed increased anxiety when going to the VA for her appointments. She remembers her time in the military when her chief stated women are "walking, talking, mattresses," and associates her time in the military with her care at the VA. Participant O also commented that after she was raped in the military, her chief told her to "take it like a man or get out on a mental health discharge." This participant has emotional trauma when she has to go to the VA due to this. Even though many of the participants are seen in a WHC, the association with the VA and military experience is evident. Walking through the door at the VA can cause triggers and flashbacks to unpleasant military experiences. Those WVs who attended a WHC with a dedicated female-only waiting room or a separate entrance for WVs, expressed appreciation for the opportunity to be seen in a safe and stress-free environment.

It is evident in the care of WV who use the VA multiple systems must be in place for a WV to even attend the appointment. For example, a friend or family member to watch children, rides need to be arranged to the facilities, and time off work needs to be scheduled. It is rarely a case of just the WV simply attending their appointment, but also the need to factor in their responsibilities and many times relying on their support system. Because WVs tend to have less social support than civilian women (LaCroix, 2016), the WVs support system is vital for the

health and quality of life. This was evident in this study when several participants had support methods, such as therapy dogs or their husbands present, for emotional support throughout the interview.

Frustrations WVs had with the VA were a high turnover of providers, difficulty making appointments, and feeling like they must fight to receive quality care. Frequent provider turnover appears to lead to a lapse in and delayed care and is consistent with dissatisfaction with the VA. Participants commented that when they were assigned a new provider, they lost motivation to continue with their healthcare plan. However, Participant D and Participant L had only positive things to say about the VA. Participant D commented "*You will not find me saying anything bad about the VA."* Participant D has had the same provider at the VA for the past five years since she retired from the Army. Participant L has had the same provider for three years since she started going to her local VA hospital for care after losing her private insurance. This finding is consistent with research showing a drop in veteran satisfaction scores when VA providers change (Reddy et al., 2015) and could indicate that frequent provider turnover could be associated with greater dissatisfaction with the VA.

WVs in this study also had frustrations with contacting the VA with questions or making appointments. The participants who had this issue were aware they had to sit on hold for lengthy periods or wait days to get a call back from the VA. My HealtheVet is the personal health record for veterans (VA, 2022). This allows veterans to access their health records and appointment notes, and securely message their providers. Recently, appointment scheduling was also added to the platform (Nazi et al., 2018). This tool could be used to decrease the frustrations WVs experience when contacting the VA. However, because veterans who were

younger, more educated, white, married, and had higher incomes were more likely to use technology (Tsai et al., 2012), it may not be equitable to assume all WVs have access or the tools to use the platform.

The final frustration WVs had was the feeling of fighting for quality care. WVs in this study commented that they had to offer suggestions and ask for tests or medications from their providers. In several studies, patient satisfaction has been associated with perceived quality of care (Brown et al., 2010, Fenton, 2012). Because the VA does not allow WVs to choose providers, initially assigned providers might not be the right fit. Additionally, WVs, generally, prefer women providers, and those WVs who are seen in a WHC rate increase satisfaction scores than WV who are not seen in these clinics (Bastian et al., 2014; Bean-Mayberry et al., 2015; Sheahan et al., 2022). WVs quality of care and patient satisfaction could improve if WVs had more options regarding which provider they saw and could decrease WVs requests for new providers.

Attitude toward supplemental private insurance was the final theme identified. The participants who held private insurance were grateful they had the opportunity to have both VA and civilian care. Many WVs used both to achieve their healthcare goals, even paying out of pocket for civilian care. Even though studies have shown that veterans who solely used the VA had higher accessibility to preventative care services than with civilian providers (Anhang et al., 2018; Tummalapalli & Keyhani, 2020; Weeks & West, 2019), the WVs in this study preferred the availability of seeing both VA and civilian providers. The reasons given were financial security and peace of mind. This could indicate the VA is accessible for preventative primary care services but could improve in finding root cause problems for higher acuity veterans.

Participants who also had civilian insurance stated they felt there are employees of the VA system who care about veterans' health but are limited in what they can do based on the larger macrosystem of the VA. Participants appreciated the many programs offered but commented that executing these programs for each individual VA is a challenge. As Participant N stated: "*I feel the people that are there actually care. It's not the individuals, it's the larger system*." In 1992, the VA started focusing on improving the health of WVs through initiatives and policies (VA, 2022). Yet, as seen in this study, WVs are still experiencing negative quality of care, barriers, and frustrations when seeking care at the VA. While the VA policies and implementations surrounding the care of WVs are good in theory, carrying them out on each microsystem of the VA is challenging.

The VA has made policy changes and implementations to provide care for the WV, however, regarding appointment times and accessibility, it seems more suitable for the traditional retired veteran than the working parent. For example, Participant N gets care at the same VA facility as her father, who is 75 and retired. She describes frustrations with getting time off work for her to attend her VA appointments. Conversely, her father has no difficulty making an appointment during the traditional work week and often stays at the facility for hours after his appointment socializing with other veterans. While WVs enjoy the same camaraderie and connection to military service, they may not have the same time luxuries as male veterans. Going to these facilities allows the WV to connect with her military experience, something of which they were all very proud of. Eighteen out of the 20 participants came from a military family. Many can trace military service back several generations, and one participant can trace her family fighting in combat back to the Civil War in 1863. Some participants also had

children that served or are currently serving in the Armed Forces. Pride in military service and connection to the VA was evident throughout the interviews. However, most WVs find it difficult to spend several hours at VA facilities due to competing responsibilities and long wait times of the VA (Washington et al, 2011; Washington et al., 2015; Elnitsky et al., 2013). Despite the negative quality of care, facing barriers, and experiencing frustrations with VA care, most WVs preferred care at the VA over civilian care due to being connected with their military service. This is consistent with literature that generally shows high levels of patient satisfaction with VA care by veterans (Zickmund et al., 2018). Conversely, while often providing higher-quality medical care, civilian providers are not concerned with military service and are often not aware of many of the issues current veterans are facing (Devine et al., 2020). While not all the participants were happy with their care at the VA, most agreed that the VA providers had better awareness of the issues facing WVs today. For WVs, the choice should not be between quality care and care that includes the military context. Both are very important, and VA care should reflect that.

Limitations

There are some limitations to this study. The exclusive context of WVs will affect the possibility of generalizing the other populations and studies. However, the goal and strength of qualitative research is to gain a deep understanding of an unknown topic, not for generalizing to other populations.

Second, confounding variables could affect the results of the perceived satisfaction or dissatisfaction of WVs with the VA. For example, WVs who experience MST have higher rates of gender-based discrimination at VA facilities after military service (MacDonald et al., 2020).

Because of this, the WV may hold a negative opinion of military-related facilities, and this could affect how they answered study questions.

Third, memory bias could affect the answers in the interview because the participants were asked to recall experiences from the past. These memories could have been impacted by two aspects. First, traumatic experiences could affect memory consolidation, and time could impair or enhance the recall of memory. Both could affect current associations with experiences at the VA.

Fourth, self-report bias could have been a factor. The researcher herself is a WV, which she disclosed to the participants when obtaining consent. Participants could have answered questions knowing the researcher was also a WV when describing their thoughts and feelings on the topic based on what they thought the researcher would want to hear.

Finally, in this study, participants had varied health conditions. Some participants used the VA only for their annual appointments, and others used the system every week. The findings could be different if more consistent use of the VA were sought for specific diagnoses.

Implications to Research and Policy

The findings of this study provide the potential to inform future research and policy about the experiences and perspectives of WV who use the VA. A better understanding of this population's views and encounters with the VA can offer providers better insight into caring for the WV and identify ways to support them better. The study found many WVs experience barriers and frustrations when using the system, and some prefer civilian care over the VA to avoid these challenges. However, if the care were more on par, specifically regarding gender-related issues, they expressed that they would prefer the VA as it is essential to be connected to others that understand military service. Further research could be completed to look at a

specific VA or with a specific diagnosis to identify more specific implementation that could take place on the macrosystem level.

Policy changes could include a childcare subsidy for WVs, or drop-in childcare at VA facilities, to increase appointment availability. Recruiting and retaining more female providers at VA facilities through better competitive pay will be critical. Given the rising number of WVs, the VA may need to adapt their traditional male-centered model to provide better accommodations and adequately meet the needs of the WV. Because WVs may have had children while in the military, they might be willing to use drop-in childcare like what is offered on military bases. Offering onsite childcare could remove the barriers many WV have when prioritizing their healthcare.

Due to the competing responsibilities of the WV, the VA could offer patient center appointments to include evening or weekend options to better accommodate the WVs schedule. A study by Dolton & Pathania (2016) found that having primary care available seven days a week increases patient satisfaction with appointment availability, decreases hospital readmission rates, and decreases emergency room visits. This study indicates that better appointment options could provide additional benefits to the VA system and to WVs satisfaction.

The third recommendation is to recruit and retain more providers, specifically females who are trained and experienced in the care of WVs. The WVs who are seen by providers who have extra training in WV- specific care report an increase in comfort level, better privacy, better care, and more willingness to receive follow-up care than what they receive in a primary care clinic (Bean-Mayberry et al., 2003). To increase the number of gender-specific trained

providers the amount female providers, the VA could provide more competitive pay for their providers compared to the private sector (Moreau et al., 2020) and offer additional benefits.

Conclusion

In conclusion, this study showed that WVs face many barriers and frustrations when obtaining their healthcare from the VA and often place it below many of their other responsibilities. Themes arose looking at the quality of care received, barriers to receiving care at the VA, frustrations with the care received and attitudes towards supplemental private insurance. However, regardless of care received, many participants preferred care at the VA over a civilian facility due to the connection to their military service and most agreed VA providers had better awareness of the issues facing WVs today.

Understanding the experiences and perspectives of WVs use of the VA can inform future policy implementations at the VA to provide options to meet WVs needs better when obtaining care at the VA. Given the projected increase in the amount of WVs and the increased risk of comorbidities, the VA may need to increase policies and initiatives to provide better opportunities for the care of the WV. Future work could be considered to ensure this population has their healthcare needs met when obtaining care from the VA. For example, research could be conducted looking at WVs from a specific region or for a particular diagnosis to assess their experiences, or studies could look at policy implementation barriers at the VA level that might impact care received. Regardless, additional work could be on WVs when receiving care at the VA to allow this population to be offered healthcare without barriers and frustrations.

References

Anhang Price, R., Sloss, E. M., Cefalu, M., Farmer, C. M., & Hussey, P. S. (2018). Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. Journal of general internal medicine, 33(10), 1631-1638.

Bastian, L. A., Hayes, P. M., Haskell, S. G., Atkins, D., Reiber, G. E., LaCroix, A. Z., & Yano, E. M. (2016). Improving our understanding of health issues in older women veterans. *The Gerontologist*, *56*(1), 10-13.

Bean-Mayberry, B. A., Chang, C. C. H., McNeil, M. A., Whittle, J., Hayes, P. M., & Scholle, S. H. (2003). Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. *Journal of General Internal Medicine*, *18*(3), 175-181.

Bloomberg, L.D. & Volpe, M. (2019). *Completing your qualitative dissertation: A roadmap from beginning to end.* (4th ed). Sage.

Boitano, T. K., Powell, M. A., Leath III, C. A., Straughn Jr, J. M., & Scarinci, I. C. (2022). Barriers and facilitators affecting presentation in women with early versus advanced stage cervical cancer. *Gynecologic Oncology Reports*, *40*, 100950.

Browne, K., D. Roseman, D. Shaller, and S. Edgman-Levitan. 2010. Analysis & Commentary Measuring Patient Experience as a Strategy for Improving Primary Care. Health Affairs 29 (5): 921–5.

Chang, A. M., Cohen, D. J., Lin, A., Augustine, J., Handel, D. A., Howell, E., ... & Sun, B. C. (2018). Hospital strategies for reducing emergency department crowding: a mixed-methods study. *Annals of emergency medicine*, *71*(4), 497-505.

Chen, H. Y., Kessler, C. L., Mori, N., & Chauhan, S. P. (2012). Cervical cancer screening in the United States, 1993–2010: Characteristics of women who are never screened. *Journal of women's health*, *21*(11), 1132-1138.

Chrystal, J. G., Frayne, S., Dyer, K. E., Moreau, J. L., Gammage, C. E., Saechao, F., ... & Hamilton, A. B. (2022). Women Veterans' Attrition from the VA Health Care System. Women's Health Issues, 32(2), 182-193. PT turnover is a big issue with attrition for WVs.

Cordasco, K. M., Mengeling, M. A., Yano, E. M., & Washington, D. L. (2016). Health and health care access of rural women veterans: Findings from the national survey of women veterans. *Journal of Rural Health, 32*(4), 397–406.

Creswell, J.W., & Poth, C.N. (2018). *Qualitative inquiry & research design: Choosing among five approaches.* (4th ed). Sage.

Denzin, N. K., & Lincoln, Y. S. (2018). The sage handbook of qualitative research. SAGE.

Department of Veteran Affairs. (2022). *Center for women veterans.* https://www.va.gov/womenvet/

Department of Veteran Affairs. (2022). *How to use My HealtheVet.* https://www.myhealth.va.gov/mhv-portal-web/how-to-use-mhv

Department of Veterans Affairs. (2021). *Women's veterans health care.* https://www.womenshealth.va.gov/outreachmaterials/GeneralHealthandWellness/maternity.asp

Der-Martirosian, C., Cordasco, K. M., & Washington, D. L. (2013). Health-related quality of life and comorbidity among older women veterans in the United States. *Quality of Life Research, 22*, 2749–2756. doi:10.1007/s11136-013-0424-7

Devine, D. T., McMillan, S. C., Kip, K., & Powell-Cope, G. (2020). Quality of life among women veterans. Journal of the American Association of Nurse Practitioners, 32(11), 745-755.

Dolton, P., & Pathania, V. (2016). Can increased primary care access reduce demand for emergency care? Evidence from England's 7-day GP opening. *Journal of Health Economics*, *49*, 193-208.

El Ashmawy, A.-A. H., Dowson, K., El-Bakoury, A., Hosny, H. A. H., Yarlagadda, R., & Keenan, J. (2021). Effectiveness, Patient Satisfaction, and Cost Reduction of Virtual Joint Replacement Clinic Follow-Up of Hip and Knee Arthroplasty. Journal of Arthroplasty, 36(3), 816.

Elnitsky, C. A., Andresen, E. M., Clark, M. E., McGarity, S., Hall, C. G., & Kerns, R. D. (2013). Access to the US department of veterans affairs health system: Self-reported barriers to care among returnees of operations enduring freedom and Iraqi freedom. *BMC health services research*, *13*(1), 1-10.

Fenton, J. J., A. F. Jerant, K. D. Bertakis, and P. Franks. 2012. "The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality." Archives of Internal Medicine 172 (5): 405–11.

Frayne, S. M., Phibbs, C. S., & Friedman, S. A. (2013). Sociodemographic Characteristics and Use of VHA Care and Non-VA Care. *Washington, DC, Department of Veterans Affairs, Women Veterans Health Strategic Health Care Group*.

Harris, L., Gilmore, D., Hanks, C., Coury, D., Moffatt-Bruce, S., Garvin, J. H., & Hand, B. N. (2022). "It was surprisingly equivalent to the appointment I had in person": Advantages and

disadvantages of synchronous telehealth for delivering primary care for autistic adults. Autism: The International Journal of Research & Practice, 26(6), 1573–1580

House Committee on Veterans' Affairs. (2021). *Women veterans task force.* https://veterans.house.gov/women-veterans-taskforce

Katz, M. L., Young, G. S., Reiter, P. L., Battaglia, T. A., Wells, K. J., Sanders, M., ... & Paskett, E. D. (2014). Barriers reported among patients with breast and cervical abnormalities in the patient navigation research program: impact on timely care. *Women's Health Issues*, *24*(1), e155-e162.

LaCroix, A. Z., Rillamas-Sun, E., Woods, N. F., Weitlauf, J., Zaslavsky, O., Shih, R., ... & Reiber, G. (2016). Aging well among women veterans compared with non-veterans in the women's health initiative. *The Gerontologist*, *56*(1),14-26.

Lehavot, K., Der-Martirosian, C., Simpson, T. L., Shipherd, J. C., & Washington, D. L. (2013). The role of military social support in understanding the relationship between PTSD, physical health, and healthcare utilization in women Veterans. *Journal of Traumatic Stress, 26*, 772–775.

Lindseth, A., & Norberg, A. (2022). Elucidating the meaning of life world phenomena. A phenomenological hermeneutical method for researching lived experience. Scandinavian Journal of Caring Sciences, 36(3), 883–890.

MacDonald, S., Judge-Golden, C., Borrero, S., Zhao, X., Mor, M. K., & Hausmann, L. R. (2020). Experiences of perceived gender-based discrimination among women veterans: data from the ECUUN study. *Medical care*, *58*(5), 483.

Marshall, V., Stryczek, K. C., Haverhals, L., Young, J., Au, D. H., Ho, P. M., ... & Sayre, G. (2021). The focus they deserve: improving women veterans' health care access. Women's Health Issues, 31(4), 399-407.

Muirhead, L., Hall, P., Jones-Taylor, C., Clifford, G. D., Felton-Williams, T., & Williams, K. (2017). Critical questions: Advancing the health of female veterans. *Journal of the American Association of Nurse Practitioners*, *29*(10), 571-580.

National Center for Veterans Analysis and Statistics, Department of Veteran Affairs. (2017). *Women veterans report: The past, present, and future of women veterans.* https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf

Nazi, K. M., Turvey, C. L., Klein, D. M., & Hogan, T. P. (2018). A Decade of Veteran Voices: Examining Patient Portal Enhancements Through the Lens of User-Centered Design. Journal of Medical Internet Research, 20(7), 224–241.

O'Malley, A. S. (2013). After-hours access to primary care practices linked with lower emergency department use and less unmet medical need. *Health Affairs*, *32*(1), 175-183.

Oster, C., Morello, A., Venning, A., Redpath, P., & Lawn, S. (2017). The health and wellbeing needs of veterans: a rapid review. *BMC psychiatry*, *17*(1), 1-14.

Polit D, & Beck C. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies, 47*(11), 1451–1458.

Reddy, A., Pollack, C. E., Asch, D. A., Canamucio, A., & Werner, R. M. (2015). The effect of primary care provider turnover on patient experience of care and ambulatory quality of care. JAMA internal medicine, 175(7), 1157-1162.

Saldaña, J. (2013). *The coding manual for qualitative researchers.* Sage Publication.

Tummalapalli, S. L., & Keyhani, S. (2020). Trends in Preventative Health Services for Veterans with Military Coverage Compared to Non-Military Coverage. JGIM: Journal of General Internal Medicine, 35(4), 1330–1333.

Tsai J, Rosenheck RA, Tsai, J., & Rosenheck, R. A. (2012). Use of the internet and an online personal health record system by US veterans: comparison of Veterans Affairs mental health service users and other veterans nationally. Journal of the American Medical Informatics Association, 19(6), 1089–1094.

VHA Directive 1330.01: Health Care for Women Veterans (Veterans Health Administration) (2017).

Washington, D. L., Bean-Mayberry, B., Mitchell, M. N., Riopelle, D., & Yano, E. M. (2011). Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. *Women's Health Issues*, *21*(4), 112-119.

Washington, D. L., Farmer, M. M., Mor, S. S., Canning, M., & Yano, E. M. (2015). Assessment of the healthcare needs and barriers to VA use experienced by women veterans: findings from the national survey of women Veterans. *Medical Care*, *53*(4), 23-31.

Weeks, W. B., & West, A. N. (2019). Veterans health administration hospitals outperform non–veterans health administration hospitals in most health care markets. Annals of Internal Medicine, 170(6), 426-428.

Yin, R. K. (2003). Designing case studies. *Qualitative Research Methods*, *5*, 359-386.

Zhang, X., McJoynt, T., Furst, J. W., & Myers, J. F. (2022). Establishing a Patient-Centered Virtual Care Model Across the Continuum of Care. Journal of Primary Care & Community Health, 1–10.

Zickmund, S. L., Burkitt, K. H., Gao, S., Stone, R. A., Jones, A. L., Hausmann, L. R. M., Switzer, G. E., Borrero, S., Rodriguez, K. L., & Fine, M. J. (2018). Racial, Ethnic, and Gender Equity in Veteran Satisfaction with Health Care in the Veterans Affairs Health Care System. JGIM: Journal of General Internal Medicine, 33(3), 305–331.

Chapter 4: Policy

Manuscript 3: Policy Recommendations for the Improvement of the VA for the Woman Veteran Healthcare

The purpose of this chapter is to look at proposed policy recommendations based on the findings of the dissertation study looking at the experiences and perspectives of women veterans (WVs) use of the Veterans Healthcare Administration (VA). The recommendations are aimed at the VA to obtain better accessibility and retention of WVs. The manuscript has been formatted to the Armed Forces & Society specifications and will be submitted for publication in 2023.

Policy Recommendations for the Improvement of the VA for the Woman Veteran

Abstract

Health equity exists when everyone has a fair and just opportunity to achieve the highest level of health possible. Women veterans (WVs) experience different mental, physical, and quality of life (QOL) outcomes compared to male veterans and civilian women, which may impact their healthcare needs. This article presents policy recommendations for the Veteran Affairs Health Administration (VA) to allow for better health equity for WVs who receive care at VA facilities. Policy implementation could be to provide for childcare onsite or a childcare subsidy, to offer better appointment availability, to hire more female providers and those trained in women-specific care, and to provide better outreach for WVs. The recommendations are aimed at the VA to obtain better accessibility and retention of WVs.

Keywords: *women veterans, female veterans, policy, veteran's health*

Author: Leanne N Anthon

College of Nursing, University of Wisconsin-Milwaukee,

Milwaukee, WI, USA Cunningham Hall 135

1921 E. Hartford Avenue, Milwaukee, WI 53211

lnanthon@uwm.edu

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According to the Centers for Disease Control (CDC; 2022b), health equity exists when everyone has a fair and just opportunity to achieve the highest level of health possible. This

concept is achieved through policy and system changes that address the health disparities that have led to injustice in the healthcare system. (CDC, 2022b). Health equity is a main component of racial and ethnic health disparities; however, it will be used in this paper to identify recommendations for the Veterans Health Administration (VA) to allow for health equity for women veterans (WVs).

WVs comprise 10% of the current VA population, with projections to increase to at least 16% by 2043, making this the fastest-growing demographic of veterans (National Center for Veterans Analysis and Statistics, 2017). Forty percent of WVs treated at the VA are from racial or ethnic minority groups, compared to 23% of male veterans (Frayne et al., 2014). WVs face the same challenges as male veterans but also experience higher mental, physical, and social health disparities that lead to lower quality of life (QOL; Oster et al., 2017). Compared to female non-veterans, WVs report poorer overall health (Lehavot et al., 2012), poorer functional status, poorer mental health, lower QOL (Devine et al., 2019), and less social support (LaCroix, 2016). WVs also experience different QOL outcomes compared to male veterans, which may impact their healthcare needs. For example, compared to male veterans, WVs have significantly lower QOL scores (DeVine, et al., 2019; Katon et al., 2016; Teh et al., 2008), have a higher risk of homelessness (Byrne, 2013), more unemployment (Kleykamp, 2013) and higher divorce rates (Southwell, 2016). WVs also experience higher rates of sexual violence, chronic pain, and combat trauma than male veterans (Der-Martirosian et al., 2013; Lehavot et al., 2013). Finally, injuries from intense physical activity, potential trauma, toxic substance exposure, and military sexual trauma (MST) are commonly found in WVs. These experiences could lead to physical and mental health diagnoses that may require care after the service member has left the military.

The CDC recommends a multifaceted approach to health equity using programs to encourage health strategies, policies to improve population health, data collection to support the advancement of health equity, and a strong infrastructure to support the organization to functionality (CDC, 2022). According to the CDC (2022), these factors should be in place to achieve health equity for many different populations and cohorts. Even though women have served in the military since the Revolutionary War, the first WV-specific initiatives were not implemented at the VA until the 1990s (VA, 2014). The VA may need to increase the policies and initiatives specifically focusing on WVs, to better allow this cohort to have a fair and just opportunity at health.

Background

In general, women in the US have poorer health outcomes than those women of countries with similar income levels and educational opportunities (Short & Zacher, 2022). Women in the US also receive different levels of care based on their gender. For example, several studies found that the level of pain has been underestimated in women compared to men (Chen et al., 2008; Schafer et al., 2016; Zhang et al., 2021), and where coronary artery and stroke symptoms have been misdiagnosed (Maserejian et al., 2009; Newman-Toker et al., 2014). Likewise, research on diseases that primarily affect women is more likely to be underfunded, whereas studies that primarily affect men are more likely to receive funding (Mirin 2021). Indeed, gender bias in civilian medicine presents an ongoing challenge to women's health. However, due to military-related service, WVs may need more complex care to meet their needs than civilian women requiring the VA to be more accommodating to the WV.

The literature on common healthcare issues shows that WVs likely need healthcare support long after leaving military service. For example, in addition to military experiences common in many veterans such as exposure to dangerous toxic substances and the trauma of combat, WVs have higher rates of sexual violence, chronic pain, and combat trauma compared to male veterans (Der-Martirosian et al., 2013; Lehavot et al., 2013). Due to the physicality of military service, WVs experience a higher rate of pain conditions, such as musculoskeletal diagnoses and joint disorders (Frayne et al., 2015; Haskell et al., 2012), with up to 78% of WVs experiencing chronic pain (Haskell et al., 2006). Also, more than 30% of WVs experienced some form of MST while serving in the military (Department of Defense Sexual Assault Prevention and Response Office, 2020; Kelly et al., 2011). WVs who experience MST are at a five to nine-fold increase in the likelihood of experiencing mental health-related diagnoses such as post-traumatic stress disorder (PTSD) compared to those veterans who have not experienced MST (Suris et al., 2007).

However, depression is the most reported condition by WVs (Frayne et al., 2018). Brown et al. (2019) conducted a study looking at Gulf War WVs and found that 45.3% of female veterans experienced depression compared to 26.1% of male veterans. These results are consistent with the study completed by Adams et al. (2021), which found rates of depression being 46% in females compared to 21% in males and higher incidences of psychotropic medication prescriptions in the use of mental health services. Depression also occurs in WVs with other diagnoses such as anxiety, PTSD, reproductive issues, and osteoporosis (Bastian et al., 2016; Brown et al., 2019) and is a risk factor for suicide (Kumpula et al., 2019). Depression affects WVs QOL and can cause functional decline and behavioral problems, and it affects WVs

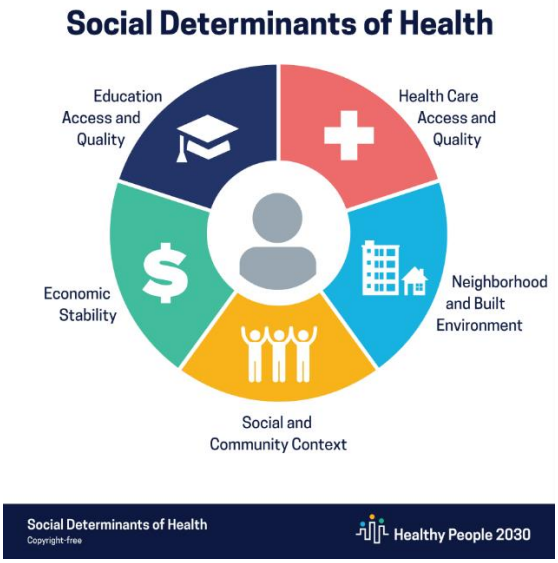
at a greater incidence than male veterans (Bastian et al., 2016; Katon et al., 2016). Because suicide is a prominent risk factor for depression, finding effective ways to meet the needs of WVs depression could decrease the incidences of suicide and increase QOL in the WV population. The rate of suicide among WVs who use the VA has increased from 14.4 per 100,000 to 17.3 per 100,000 between 2001 and 2014, with the rate of suicide among WVs twice that of nonveteran women (Department of Veteran Affairs, 2018). Additionally, WVs have less social support than civilian women (Campbell et al., 2020).

WVs also experience gender and racial discrimination when receiving care at VA facilities. Klap et al. (2018) found that 25% of WVs experienced harassment, including inappropriate and unwanted comments by male veterans at VA facilities. WVs who experienced harassment were more likely to have delayed or missed care recommendations. MacDonald et al. (2020) found that non-Hispanic white WVs experienced higher rates of gender-based discrimination compared to Hispanic and African American WVs. The experiences of nonwhite patients who perceived the presence of racial bias have been shown to lead to a lack of preventative care, delays, underutilization in seeking care, poor compliance, and lack of provider trust (Burgess et al., 2008; Casagrande et al., 2007; Jacobs et al., 2014; Trivedi & Ayanian, 2006). Finally, Compared to LGBTQ women and heterosexual women, WVs in a sexual minority group experience a higher rate of mental health diagnoses, sleep problems, smoking, and poor physical health (Blosnich et al., 2013). Being in a sexual minority is also associated with increased health disparities (Graham et al., 2011) and may increase the incidence of delayed or missed care. For these reasons, the VA needs to be proactive to ensure that WVs are receiving quality and equitable care.

While the VA provides many healthcare-related services, such as surgeries, trauma care, mental health services, orthopedics, pharmacy, radiology, and physical therapy (Department of Veteran Affairs, 2021), they lack support for women-specific care. Due to the historically large numbers of male veterans, the VA has had to adjust to provide care for the increasing number of WVs. For example, a 2015 study found a lack of providers trained in women's health and women-specific services (Cordasco et al.). Most VA facilities care for general gynecological services, such as pap smears and contraceptive prescriptions, but refer WVs to community providers for more complex services, such as maternity care and fertility treatments.

Another factor affecting the care of WVs is social determinants of health (SDOH). SDOH are the factors that affect health, such as a person's economic stability, neighborhood, education level, social status, and access to health care (CDC, 2022). Figure 1 below shows the elements of SDOH and the categories into which each determinant falls (Healthy People, 2030). These factors contribute to the health of an individual based on the opportunities and accesses they have, their quality of life, and health risks.

Figure 4.1 Social Determinants of Health



The concept of intersectionality can be described as how the connection between social categories such as race, class, and gender combine to form a person's identity. Because WVs are not exclusively members of only a race, gender, or sexual identity, the blend of these factors makes up who the WV is. Along with SDOH, intersectionality plays a part in the healthcare of WVs. Minority status, and gender discrimination, put WV at an increased risk of sexual violence victimization and can impact a WVs use of VA services. These increased risk variables indicate the need for specific approaches in the healthcare of WVs (Calasanti & King, 2015) to ensure they have the same resources and opportunities as civilian women.

Along with the common mental and physical diagnoses, the VA needs to incorporate SDOH and intersectionality into the care of the WV. The previously described factors play a role in the health of the WV and should be considered when initiatives and policies are being implemented.

Problem

In recent years, the VA has attempted to increase the accessibility and services provided to the growing number of WVs who get care from the VA. However, many WVs continue to face barriers, challenges, and frustrations when receiving care at the VA. Studies have shown that WVs still experience trouble with access to care, care coordination, lack of continuity, and gender-specific care (Chafreau, 2019; Katon et al., 2018; Kotzias, et al 2019; Sheahan et al., 2022). Because only 37% of WVs are enrolled patients with the VA, it can be assumed the remaining 63% of WVs are receiving their care outside of the VA healthcare system (Bastian et al., 2016; Mattocks et al., 2018) or not obtaining healthcare services at all. Additionally, Friedman et al. (2011) found that 30% of WVs who seek healthcare at the VA left within the first three years of use, which raises important questions about whether the quality of care is meeting the needs of these women.

One issue WVs have with receiving care from the VA is competing responsibilities like childcare which results in WV delaying or missing care (Boitano et al., 2022, Chen et al., 2012; Katz et al., 2014). Because WVs who are parents are three times more likely to be a single parent, (Muirhead, 2017), they may not have a spouse or partner to rely on for childcare help. A recent study looked at the experiences and perspectives of WVs with the VA healthcare system and found many of the participants who were parents often delayed their own healthcare issues because they did not have childcare, and often ended up in the Emergency Department (ED) due to the progression of a health condition (Anthon, 2023). Issues related to childcare are a significant factor preventing WVs from seeking care at the VA (Marshall et al, 2021; Tsai, David, Edens, & Crutchfield, 2013).

The second issue WVs may face when receiving care from the VA is difficulty finding time during the traditional clinic week for appointments. The growing number of WVs today are younger and have more competing responsibilities such as childcare, school, and employment making access to primary and specialty care a challenge for many (Marshall et al, 2021). Additionally, compared to civilian women, WVs work more hours per week and more weeks per year (Nanda et al., 2016), indicating the need for more flexible appointment offerings. Participants in the study by Anthon (2023) found VA facilities ranged from one to 3.5 hours away from the WVs residence. One participant in this study expressed frustration when she had to justify to her place of employment taking a whole day off of work to make one appointment. Due to the availability of appointments offered by the VA and the common aspect of having to drive long distances to get to the nearest facility, WVs have difficulty fitting in VA appointments during the traditional work week due to competing responsibilities.

The third issue WVs may face is the lack of women providers, especially those trained in WVs health. Several studies have found that WVs report a lack of providers trained in women-specific areas (Chrystal et al., 2022; Cordasco et al., 2015; Marshall et al., 2021; Moreau et al, 2020). Due to the historically large male presence at the VA, and the large number of WVs who have experienced MST, many WVs prefer to be seen by a female provider (Moreau et al., 2020; Washington et al., 2007), who may be more sensitive to women's issues. Additionally, many WVs feel they get lowered standards of care at the VA regarding women-specific issues (Anthon, 2023). Recruiting and increasing the number of women providers could help ease WVs hesitancies when receiving this care at the VA and improve retention and health quality.

The final issue WVs may face when receiving care from the VA is the lack of outreach to the individual WV. Currently, WVs may receive emails from the nationwide Women's Health Clinic or veterans integrated services network (VISN) specific areas which may not be geographically applicable. Information provided in these mass emails is not generalizable and may include programs that are not specific to the locality. Because WVs have less social support than civilian women (Campbell et al., 2020), fellowship and camaraderie may be helpful for this cohort to continue to achieve their highest level of health.

Recommendations

The VA has created several programs to assist WVs with healthcare utilization to decrease these issues. Some programs in place to help meet the needs of WVs include the Center for Women Veterans (CWV), which helps serve as an advocate for the transformation and responsible treatment of WVs (Department of Veterans Affairs, 2022) and the Women's Health Primary Care Providers (WH-PCP) where WVs can receive care from female providers for primary care and specialty services. In addition, the Women Veterans Call Center was created for WVs to speak with staff specializing in female-specific services, so the WV can better understand their healthcare options and benefits (Department of Veterans Affairs, 2021). The House Committee on Veteran's Affairs has a Women Veterans Task Force to develop policies that explicitly support WVs through outreach, oversight, and legislation (Women Veterans Task Force, 2021).

Maternity Care Coordination (MCC) through the VA was created in 2012 to assist WVs with pre and postnatal care paid for by the VA but provided by community partners. In 2018, the VA also created the Maternity Care Coordinator Telephone Care Program (MCC-TCP) to

better assist these WV coordinating VA and non-VA care. Recently, the Protecting Moms Who Served Act was passed in 2022 to facilitate access to community resources to address social determinants of health, including nutrition and housing assistance, identifying mental and behavioral health risk factors in the prenatal and postpartum periods, and providing follow-up treatment options. This bill also includes funding for clinical training to understand better the needs of pregnant and postpartum WV, which may be affected or exacerbated by military service and the transition back to civilian life.

The VA is attempting to better the care and services offered to WVs. However, many programs are being implemented or revised, while the WV is still facing barriers and frustrations with their VA care. Below are four simple recommendations that the VA could implement to help achieve health equity with WVs. These recommendations include offering childcare or a childcare subsidy to WVs, offering better appointment availability to include the growing number of working WVs, recruiting and maintaining quality female providers, and providing better outreach for the WV population.

Recommendation #1-Offer Childcare Subsidy to WVs

The first recommendation is to offer childcare or a childcare subsidy for WVs. Compared to other countries, the United States has the least number of work-family policies in place for working adults (Guo & Browne, 2022). Since women in general are the primary caregivers for young children (Guo & Browne, 2022), are responsible for most of the unpaid family and housework (OCED, 2017). Given the rising number of WVs, the VA may need to adapt their traditional male-centered model to provide better accommodations and adequately meet the needs of the WV. Because WVs may have had children while in the military, they might be

willing to use drop-in childcare like what is offered on military bases. Offering onsite childcare could remove the barriers many WV have when prioritizing their healthcare.

Additionally, offering a childcare subsidy for WVs to use their childcare provider of choice could also be beneficial. Because WVs make a median wage of $41,761(Duffin, 2022), offering a subsidy for childcare similar to how the VA offers travel pay reimbursement (VA, 2022b) could be an option to help WVs have a fair and just opportunity to achieve the highest level their highest level of health. Offering childcare or a subsidy would correlate to the economic stability component of the SDOH.

Recommendation #2- Increased Appointment Availability

Due to the competing responsibilities of the WV, the VA could offer patient center appointments to include evening or weekend options to better accommodate the WVs schedule. Although the VA announced in 2016 the goal of increasing staff to accommodate all veterans with evening or weekend appointments (Department of Veteran Affairs, 2016), the WVs in current literature have not yet been affected by these initiatives, and working full time is a barrier for delayed or missed care (Boitano et al., 2022; Cordasco et al., 2016).

A study by Dolton & Pathania (2016) found that having primary care available seven days a week increases patient satisfaction with appointment availability, decreases hospital readmission rates, and decreases emergency room visits. This study indicates that better appointment options could provide additional benefits to the VA system and to WVs satisfaction.

Increasing appointment availability would also improve SDOH for the WV. Allowing the WV the opportunity to make appointments outside of working hours would correlate to

economic stability and access to care for the WV, allowing this cohort better opportunities at health.

Recommendation #3- Increased Female Providers with Competitive Pay

The third recommendation is to recruit and retain more providers, specifically females who are trained and experienced in the care of WVs. The WVs who are seen by providers who have extra training in WV specific care report an increase in comfort level, better privacy, better care, and more willingness to receive follow-up care than what they receive in a primary care clinic (Bean-Mayberry et al., 2003). To increase the number of gender-specific trained providers the amount female providers, the VA could provide more competitive pay for their providers compared to the private sector (Moreau et al., 2020) and offer additional benefits. For example, the Child Care Subsidy Program (CCSP) is a VA nationwide benefit that helps VA employees reduce the cost of childcare (VA, 2019) which assists VA employees in reducing the cost of childcare. Another option is for the VA to offer additional training for current providers on the needs of WVs. Programs like these could recruit and retain high-quality providers for WVs and would correlate to better access to care for WV.

Recommendation #4 Improved Outreach for WVs

The final recommendation would be to provide better outreach for specific regions for WVs so they feel connected with others who share similar experiences (Chrystal et al, 2022). For example, a Facebook or email group for WVs who are enrolled in a specific VA or outpatient facility. WVs would like more peer-to-peer support programs that are geographically attainable (Moreau et al, 2020). More personalized information may allow the WV to have better access to care, support groups, and classes and feel better connected with their healthcare team.

Currently, WV lack the support of those who show acceptance, empathy, and concern compared to both male veterans and civilian women (Campbell et al., 2019). Because a lack of social support has been shown to correlate with poor chronic disease and physical inactivity (Lindsay-Smith et al., 2017), WV could increase their social support systems to decrease these risk of such disparities (Campbell et al., 2019).

Providing opportunities to increase the WVs support system is correlated with both the social and community context and educational access of the SDOH. In the virtual age we live in, the VA could facilitate support groups online or could offer in-person coffee hours at facilities to provide education on WV-specific topics and could build better camaraderie for the WV.

Conclusion

This paper examined how the VA can improve health equity for WVs. WVs experience additional physical and mental health challenges compared to male veterans and civilian women. In addition to military service, the aspects of the WVs identity, such as her race, gender, and sexual identity, along with her SDOH all play a factor in the health of the WV. The combination of these factors may play a role for the WV in obtaining or continuing with care at VA facilities.

While the VA has put many programs in place in recent years, the growing number of WVs will demand more care, time, and attention and these facilities. Continued work needs to be completed. Recommendations to enhance the care of the WV at the VA would be to offer on-site childcare or a childcare subsidy at all VA facilities, to increase appointment availability, to increase the number of female providers and those specifically trained in WVs health issues,

and to improve the outreach for the WV. The VA may need to make additional changes to ensure that WVs' needs are met.

The CDC states everyone should have the opportunity to be as healthy as possible (CDC, 2020). Because VA policies can help VA providers better care for WVs who need specific expertise and knowledge (Strong et al., 2018), the VA should implement policies to better care for the WV. The increasing number of younger WVs leaving the military may need expert care to address their unique needs. This care needs to incorporate their SDOH, intersectionality, and military experiences that all play a role in health equity for WVs.

References

Adams, R. E., Hu, Y., Figley, C. R., Urosevich, T. G., Hoffman, S. N., Kirchner, H. L., Dugan, R. J., Boscarino, J. J., Withey, C. A., & Boscarino, J. A. (2021). Risk and protective factors associated with mental health among female military veterans: results from the veterans' health study. BMC *Women's Health, 21*(1), 1–10.

Bastian, L. A., Hayes, P. M., Haskell, S. G., Atkins, D., Reiber, G. E., LaCroix, A. Z., & Yano, E. M. (2016). Improving our understanding of health issues in older women veterans. *The Gerontologist*, *56*(1), 10-13.

Bean-Mayberry, B. A., Chang, C. C. H., McNeil, M. A., Whittle, J., Hayes, P. M., & Scholle, S. H. (2003). Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. *Journal of General Internal Medicine*, *18*(3), 175-181.

Blosnich, J., Foynes, M. M., & Shipherd, J. C. (2013). Health disparities among sexual minority women veterans. *Journal of Women's Health*, *22*(7), 631-636.

Boitano, T. K., Powell, M. A., Leath III, C. A., Straughn Jr, J. M., & Scarinci, I. C. (2022). Barriers and facilitators affecting presentation in women with early versus advanced stage cervical cancer. *Gynecologic Oncology Reports*, *40*, 100950.

Brown, M. C., Sims, K. J., Gifford, E. J., Goldstein, K. M., Johnson, M. R., Williams, C. D., & Provenzale, D. (2019). Gender-based differences among 1990-1991 gulf war era veterans: Demographics, lifestyle behaviors, and health conditions. *Women's health issues*, *29,* S47–S55.

Burgess, D. J., Ding, Y., Hargreaves, M., Van Ryn, M., & Phelan, S. (2008). The association between perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community sample. *Journal of Health Care for the Poor and Underserved*, *19*(3), 894-911.

Byrne, T., Montgomery, A. E., & Dichter, M. E. (2013). Homelessness among female veterans: A systematic review of the literature. *Women & Health*, *53*(6), 572-596.

Calasanti, T., & King, N. (2015). Intersectionality and age. In *Routledge handbook of cultural gerontology* (pp. 215-222). Routledge.

Campbell, S. B., Gray, K. E., Hoerster, K. D., Fortney, J. C., & Simpson, T. L. (2021). Differences in functional and structural social support among female and male veterans and civilians*. Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 56*(3), 375–386.

Casagrande, S. S., Gary, T. L., LaVeist, T. A., Gaskin, D. J., & Cooper, L. A. (2007). Perceived discrimination and adherence to medical care in a racially integrated community. *Journal of General Internal Medicine*, *22*(3), 389-395.

Center for Disease Control. (2022). *Social determinant of health: Know what affects health.* https://www.cdc.gov/socialdeterminants/index.htm

Center for Disease Control. (2022b). *What is health equity* https://www.cdc.gov/healthequity/whatis/index.html

Chanfreau, C. C., Washington, D. L., Chuang, E., Brunner, J., Darling, J. E., Canelo, I., Yano, E. M., & Chanfreau-Coffinier, C. (2019). Exploring the association of care fragmentation and patient ratings of care quality: A mediation analysis of women Veterans' experience with VA care. Health Services Research, 54(4), 816–826.

Chen, H. Y., Kessler, C. L., Mori, N., & Chauhan, S. P. (2012). Cervical cancer screening in the United States, 1993–2010: Characteristics of women who are never screened. *Journal of women's health*, *21*(11), 1132-1138.

Chen, E. H., Shofer, F. S., Dean, A. J., Hollander, J. E., Baxt, W. G., Robey, J. L., ... & Mills, A. M. (2008). Gender disparity in analgesic treatment of emergency department patients with acute abdominal pain. *Academic Emergency Medicine*, *15*(5), 414-418.

Chrystal, J. G., Frayne, S., Dyer, K. E., Moreau, J. L., Gammage, C. E., Saechao, F., ... & Hamilton, A. B. (2022). Women Veterans' Attrition from the VA Health Care System. *Women's Health Issues*, *32*(2), 182-193.

Cordasco, K. M., Mengeling, M. A., Yano, E. M., & Washington, D. L. (2016). Health and health care access of rural women veterans: Findings from the national survey of women veterans. *Journal of Rural Health, 32*(4), 397–406.

Department of Defense Sexual Assault Prevention and Response Office. (2020). *Department of Defense Annual Report on Sexual Assault in the Military, Fiscal Year 2020.* https://www.sapr.mil/sites/default/files/DOD_Annual_Report_on_Sexual_Assault_in_the_Military_FY2020.pdf

Department of Veterans Affairs. (2016). Top VA health care official announces initiatives and progress made to improve access to care [Press release].

Department of Veteran Affairs. (2022). *VA Capitol Health Care Network.* https://www.va.gov/VISN5/about/history.asp

Department of Veterans Affairs. (2018). *VA national suicide data report 2005-2015.* www.mentalhealth.va.gov/suicide_prevention /Suicide-Prevention-Data.asp.

Department of Veteran Affairs. (2022b). *VA travel pay reimbursement.* https://www.va.gov/health-care/get-reimbursed-for-travel-pay/

Department of Veterans Affairs. (2021). *Women's veterans health care.* https://www.womenshealth.va.gov/outreachmaterials/GeneralHealthandWellness/maternity.asp

Der-Martirosian, C., Cordasco, K. M., & Washington, D. L. (2013). Health-related quality of life and comorbidity among older women veterans in the United States. *Quality of Life Research, 22*, 2749–2756. doi:10.1007/s11136-013-0424-7

Devine, D. T., McMillan, S. C., Kip, K., & Powell-Cope, G. (2020). Quality of life among women veterans. *Journal of the American Association of Nurse Practitioners*, *32*(11), 745-755.

Duffin, E. (2022). *Median income of veterans U.S. by gender, 2021.* https://www.statista.com/statistics/186056/earnings-of-veterans-in-the-us-by-gender/#:~:text=In%202020%2C%20the%20median%20income%20of%20female%20veterans,States%20in%202020%2C%20by%20gender%20%28in%20U.S.%20dollars%29

Frayne, S. M., Phibbs, C. S., & Friedman, S. A. (2013). Sociodemographic Characteristics and Use of VHA Care and Non-VA Care. *Washington, DC, Department of Veterans Affairs, Women Veterans Health Strategic Health Care Group*.

Friedman, S. A., Phibbs, C. S., Schmitt, S. K., Hayes, P. M., Herrera, L., & Frayne, S. M. (2011). New women veterans in the VHA: A longitudinal profile. *Women's Health Issues*, *21*(4), 103-111.

Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. *Washington, DC: Institute of Medicine*, *10*, 13128.

Guo, J., & Browne, C. V. (2022). Women's employment, work-life balance policies, and inequality across the life course: a comparative analysis of Japan, Sweden and the United States. Journal of Women & Aging, 34(3), 294–308.

Haskell, S. G., Heapy, A., Reid, M. C., Papas, R. K., & Kerns, R. D. (2006). The prevalence and age-related characteristics of pain in a sample of women veterans receiving primary care. *Journal of Women's Health*, *15*(7), 862-869.

Haskell, S. G., Ning, Y., Krebs, E., Goulet, J., Mattocks, K., Kerns, R., & Brandt, C. (2012). Prevalence of painful musculoskeletal conditions in female and male veterans in 7 years after return from deployment in Operation Enduring Freedom/Operation Iraqi Freedom. *The Clinical Journal of Pain*, *28*(2), 163-167.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Katon, J. G., Ma, E. W., Sayre, G., Zephyrin, L. C., Cordasco, K. M., Yano, E. M., & Fortney, J. C. (2018). Women Veterans' Experiences with Department of Veterans Affairs Maternity Care: Current Successes and Targets for Improvement. Women's Health Issues, 28(6), 546–552.

Katz, M. L., Young, G. S., Reiter, P. L., Battaglia, T. A., Wells, K. J., Sanders, M., ... & Paskett, E. D. (2014). Barriers reported among patients with breast and cervical abnormalities in the patient navigation research program: impact on timely care. *Women's Health Issues*, *24*(1), e155-e162.

Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: Interpersonal violence, PTSD, and mental health in women veterans. *Research in nursing & health*, *34*(6), 457-467.

Klap, R., Darling, J. E., Hamilton, A. B., Rose, D. E., Dyer, K., Canelo, I., ... & Yano, E. M. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs medical centers and impacts on delayed and missed care. *Women's Health Issues*, *29*(2), 107-115.

Kleykamp, M. (2013). Unemployment, earnings and enrollment among post 9/11 veterans. *Social science research*, *42*(3), 836-851.

Kotzias, V., Engel, C. C., Ramchand, R., Ayer, L., Predmore, Z., Ebener, P., Haas, G. L., Kemp, J. E., & Karras, E. (2019). Mental Health Service Preferences and Utilization Among Women Veterans in Crisis: Perspectives of Veterans Crisis Line Responders. Journal of Behavioral Health Services & Research, 46(1), 29–42.

Kumpula, M. J., Wagner, H. R., Dedert, E. A., Crowe, C. M., Day, K. T., Powell, K., Batdorf, W. H., Shabana, H., Kim, E., & Kimbrel, N. A. (2019). An evaluation of the effectiveness of evidence-based psychotherapies for depression to reduce suicidal ideation among male and female veterans. *Women's Health Issues, (29),*103–111.

LaCroix, A. Z., Rillamas-Sun, E., Woods, N. F., Weitlauf, J., Zaslavsky, O., Shih, R., ... & Reiber, G. (2016). Aging well among women veterans compared with non-veterans in the women's health initiative. *The Gerontologist*, *56*(1),14-26.

Lehavot, K., Der-Martirosian, C., Simpson, T. L., Shipherd, J. C., & Washington, D. L. (2013). The role of military social support in understanding the relationship between PTSD, physical health, and healthcare utilization in women Veterans. *Journal of Traumatic Stress, 26*, 772–775.

Lindsay Smith, G., Banting, L., Eime, R., O'Sullivan, G., & Van Uffelen, J. G. (2017). The association between social support and physical activity in older adults: a systematic review. *International Journal of Behavioral Nutrition and Physical Activity*, *14*(1), 1-21.

Lopez, N. and V. L. Gadsden. 2016. Health Inequities, Social Determinants, and Intersectionality. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201612a

MacDonald, S., Judge-Golden, C., Borrero, S., Zhao, X., Mor, M. K., & Hausmann, L. R. (2020). Experiences of perceived gender-based discrimination among women veterans: data from the ECUUN study. *Medical care*, *58*(5), 483.

Maserejian, N. N., Link, C. L., Lutfey, K. L., Marceau, L. D., & McKinlay, J. B. (2009). Disparities in physicians' interpretations of heart disease symptoms by patient gender: results of a video vignette factorial experiment. *Journal of women's health*, *18*(10), 1661-1667.

Mattocks, K. M., Yano, E. M., Brown, A., Casares, J., & Bastian, L. (2018). Examining women Veteran's experiences, perceptions, and challenges with the veterans choice program. *Medical Care*, *56*(7), 557-560.

Marshall, V., Stryczek, K. C., Haverhals, L., Young, J., Au, D. H., Ho, P. M., ... & Sayre, G. (2021). The focus they deserve: Improving women veterans' health care access. *Women's Health Issues*, *31*(4), 399-407.

Mirin, A. A. (2021). Gender disparity in the funding of diseases by the US National Institutes of Health. *Journal of Women's Health*, *30*(7), 956-963.

Moreau, J. L., Dyer, K. E., Hamilton, A. B., Golden, R. E., Combs, A. S., Carney, D. V., ... & Klap, R. (2020). Women veterans' perspectives on how to make Veterans Affairs healthcare settings more welcoming to women. *Women's Health Issues*, *30*(4), 299-305.

Muirhead, L., Hall, P., Jones-Taylor, C., Clifford, G. D., Felton-Williams, T., & Williams, K. (2017). Critical questions: Advancing the health of female veterans. *Journal of the American Association of Nurse Practitioners*, *29*(10), 571-580.

Nanda, N., Shetty, S., Ampaabeng, S., Techapaisarnjaroenkij, T., Patterson, L., & Garasky, S. (2016). *Women veteran economic and employment characteristics*. https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/WomenVeteranEconomicandEmploymentCharacteristics.pdf#:~:text=The%20second%20most%20common%20reason%20for%20women%20veterans,have%20higher%20earnings%20than%20women%20non-veterans%2C%20at%20%2427%2C300.

National Center for Veterans Analysis and Statistics, Department of Veteran Affairs. (2017). *Women veterans report: The past, present, and future of women veterans.* https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf

Newman-Toker, D. E., Moy, E., Valente, E., Coffey, R., & Hines, A. L. (2014). Missed diagnosis of stroke in the emergency department: a cross-sectional analysis of a large population-based sample. *Diagnosis*, *1*(2), 155-166.

Organization for Economic Co-operation and Development Staff. (2017). *The pursuit of gender equality: An uphill battle*. OECD.

Oster, C., Morello, A., Venning, A., Redpath, P., & Lawn, S. (2017). The health and wellbeing needs of veterans: a rapid review. *BMC psychiatry*, *17*(1), 1-14.

Schäfer, G., Prkachin, K. M., Kaseweter, K. A., & de C Williams, A. C. (2016). Health care providers' judgments in chronic pain: the influence of gender and trustworthiness. *Pain*, *157*(8), 1618-1625.

Sheahan, K.L., Goldstein, K.M., Than, C.T. *et al.* Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings. *J GEN INTERN MED* **37** (Suppl 3), 791–798 (2022).

Short, S. E., & Zacher, M. (2022). Women's health: Population patterns and social determinants. Annual Review of Sociology, 48, 277–298.

Southwell, K. H., & MacDermid Wadsworth, S. M. (2016). The many faces of military families: Unique features of the lives of female service members. *Military Medicine*, *181*(suppl_1), 70-79.

Strong, J.D., Crowe, B.M. & Lawson, S. Female Veterans: Navigating Two Identities. Clin Soc Work J 46, 92–99 (2018).

Suris, A., & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, & Abuse*, *9*(4), 250-269.

Teh, C. F., Kilbourne, A. M., McCarthy, J. F., Welsh, D., & Blow, F. C. (2008). Gender differences in health-related quality of life for veterans with serious mental illness. *Psychiatric Services*, *59*(6), 663-669.

Trivedi, A. N., & Ayanian, J. Z. (2006). Perceived discrimination and use of preventive health services. *Journal of general Internal Medicine*, *21*(6), 553-558.

Tsai, J., David, D. H., Edens, E. L., & Crutchfield, A. (2013). Considering childcare and parenting needs in Veterans Affairs mental health services. *Evaluation and Program Planning*, *39*, 19-22.

US Department of Veteran Affairs. (2019). *VA Child Care Subsidy Program.* https://www.va.gov/ohrm/worklifebenefits/vachildcare.asp

US Department of Veteran Affairs. (2014). *Women Veterans Issues A Historical Perspective.* https://www.va.gov/womenvet/docs/20yearshistoricalperspective.pdf

VHA Directive 1330.01: Health Care for Women Veterans (Veterans Health Administration) (2017).

Wakefield, M., Williams, D. R., & Le Menestrel, S. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academy of Sciences.

Washington, D. L., Kleimann, S., Michelini, A. N., Kleimann, K. M., & Canning, M. (2007). Women veterans' perceptions and decision-making about Veterans Affairs health care. *Military Medicine*, *172*(8), 812-817.

Zhang, L., Losin, E. A. R., Ashar, Y. K., Koban, L., & Wager, T. D. (2021). Gender biases in estimation of others' pain. *The journal of pain*, *22*(9), 1048-1059.

Chapter 5: Conclusion

Dissertation Review

This final chapter aims to summarize the dissertation work regarding the experiences and perspectives of women veterans (WVs) use of the Veterans Health Administration (VA).

WV's sacrifice more than just their time, energy, and comfort during military service. For example, in addition to military experiences common in many veterans, such as exposure to dangerous toxic substances and the trauma of combat, WVs have higher rates of sexual violence, chronic pain, and combat trauma compared to male veterans (Der-Martirosian et al., 2013; Lehavot et al., 2013). Chronic pain is one of the leading conditions in US military veterans. It affects veterans at a 40% higher rate than nonveterans, with female veterans experiencing a higher incidence of severe chronic pain than male veterans (Nahin, 2017). The presence of chronic pain has been associated with increased psychiatric conditions, poor sleep quality, and decreased QOL (Nahin, 2017; Seidl et al., 2015). Due to the physicality of military service, WVs experience a higher rate of pain conditions, such as musculoskeletal diagnoses and joint disorders (Frayne et al., 2015; Haskell et al., 2012). Up to 78% of female veterans experience chronic pain (Hasket et al., 2006), making this diagnosis a priority for WVs healthcare.

Of the 2.03 million WVs, only 755,807 were enrolled in the VA healthcare system for 2019 (Congressional Research Service, 2021). Because only 37% of WVs are enrolled patients with the VA, it can be assumed they are receiving their care outside of the VA healthcare system (Bastian et al., 2016; Mattocks et al., 2018) or not obtaining healthcare services at all. Additionally, Friedman et al. (2011) found that 30% of WVs who seek healthcare at the VA left within the first three years of use, indicating WVs are underutilizing the VA healthcare system. Looking at the experiences and perspectives of WVs with the VA could improve healthcare

outcomes and meet their needs. WVs may experience many barriers to receiving care at the VA. For example, one in five female veterans delayed or went without healthcare in the past year due to difficulties getting off work, caregiver responsibilities, or transportation issues (Cordasco et al., 2016). The diagnosis of MST and lack of gender-sensitive care may also contribute to the delay or refusal of WVs to seek care (Washington et al., 2011b). In a recent study, one in four WVs experienced gender-based discrimination by male veterans at a VA facility (Klap et al., 2019), providing a reason for WVs to delay or refuse care at the VA based on negative gender-based experiences (MacDonald et al., 2020). Due to the high instance of MST (Gilmore et al., 2016) and because the VA is still male-dominated, WVs may be uncomfortable seeking care at VA facilities (Klap et al., 2019), and they may associate their previous negative military experiences with the current VA system. This could result in WVs dropping out of VA care or delaying seeking needed care if they feel uncomfortable with that environment (Washington et al., 2011).

Compared to male veterans, WVs who use the VA report lower QOL, lower access to care, lower satisfaction with services, and greater care non-compliance (Bean-Mayberry et al., 2003; Kimerling et al., 2011; Runnals, et al., 2014). This puts WVs at risk for adverse health outcomes and decreased QOL (Klap et al., 2019). Therefore, improving VA services is not just making things better in an abstract way. It will prevent deaths and help WVs live meaningful lives. From this review, it is clear being a WV can increase the risk of healthcare disparities; the intersection of these concepts could also pose a bigger problem for WVs. Clearly, WVs have unique, under-researched healthcare needs that should be the focus of more intense investigations. Research is inadequate in the WV population, and ongoing studies are critical to

improving their health outcomes, the QOL, and identifying areas of improvement in the VA system.

Discussion

Given the lack of research regarding WVs use of the VA, this study explored the experiences of WVs who have sought or are seeking care from the VA through open-ended questions and a qualitative, inductive approach. Twenty WVs participated in two, one-hour interviews with the researcher. The WVs interviewed have used the VA for at least six months and were all currently enrolled patients of the VA.

The WVs in the study all had access to healthcare and were active in their health care journeys. All WVs used a VA provider for their annual checkup, some used the VA more frequently throughout the year, and others used the VA in combination with civilian care. While the study did not identify specifically if being a WV had a negative implication to the participants health, it did show that the WVs had access and options when it comes to their healthcare. The accessibility and feasibility of using the VA is a hinderance to some participants and they also use civilian providers.

Following data collection, coding was conducted to identify themes to better analyze the data. The experiences of WVs in this study who use the VA were both positive and negative. Those who had positive things to say had more consistent providers and were closer to VA facilities than those who had negative things to say. Positive aspects of the VA included close monitoring of care, experienced providers, and the ability to have virtual appointments. Negative care included lack of gender-specific care. Barriers to receiving care from the VA were related to lack of appointment offerings and difficulty attending face-to-face appointments due

to competing responsibilities such as childcare and work. Frustrations with the system included high turnover of providers, difficulty making appointments, and feelings of having to fight for quality care. Attitudes towards supplemental insurance included appreciation for having the opportunity to have both VA and civilian care for more thorough care and as a financial security.

While specific diagnoses were not evaluated in this study, the presence of co-morbidities among WVs is common both in literature and in this study. Sheahan et al., (2020) found that WVs who use VA primary care have higher comorbidities than male veterans including MST, PTSD, diabetes, cancers, hyperlipidemia, and alcohol and nicotine use. Consistent findings were found in this study with the WVs who shared their diagnoses. As Participant K stated, "*I'm a vet so I know my lifespan is gonna be shorter. I know with PTSD, I'm looking at this, and I can check diabetes off my list, so now I just its just, hey, I'm almost at the veteran trifecta. I just need a heart attack now and I'm good."* Even though studies have shown that veterans who solely used the VA had higher accessibility to preventative care services than with civilian providers (Anhang et al., 2018; Tummalapalli & Keyhani, 2020; Weeks & West, 2019), the WVs in this study preferred the availability of seeing both VA and civilian providers, which could improve their current health status. The reasons given for seeing both VA and civilian providers were financial security and more thorough care received in the private sector. This could indicate the VA is accessible for preventative primary care services but could improve in finding root cause problems for higher acuity veterans.

The CDC states everyone should have the opportunity to be as healthy as possible (CDC, 2020). Being a patient at a VA facility may require unique barriers such as waiting on hold for

long periods of time to make an appointment, having to drive long distances to the nearest VA hospital or outpatient facility, or other personal responsibilities such as childcare, family and work commitments, which may be hard for the WV to accommodate. It appears WVs must overcome these barriers when enrolled in VA healthcare and do not have the same healthcare access or accommodations as civilian women. These hurdles could account for low number of women who use the VA and for the high amount of those who leave shortly after establishing care (Bastian et al., 2016; Friedman et al, 2011; Mattocks et al., 2018).

Policy Recommendations

Because VA policies can help VA providers better care for WVs who need specific expertise and knowledge, (Strong et al., 2018), the VA could do more with implementing policies to better accommodate the WV. The increasing number of younger WVs who are leaving the military may need expert care to address their unique needs. This care needs to incorporate social determinants of health (SDOH), intersectionality, and military experiences that may all play a role in their health equity. Recommendations could be implemented by the VA to help achieve health equity with WVs. These recommendations include offering childcare or a childcare subsidy to WVs, offering better appointment availability to include the growing number of working WVs, recruiting and maintaining quality female providers, and providing better outreach for the WV population.

Study Limitations

There are some limitations to this study. The exclusive context of WVs will affect the possibility of generalizing the other populations and studies. However, the goal and strength of qualitative research is to gain a deep understanding of an unknown topic, not for generalizing to other populations.

Second, confounding variables could affect the results of the perceived satisfaction or dissatisfaction of WVs with the VA. For example, WVs who experience MST have higher rates of gender-based discrimination at VA facilities after military service (MacDonald et al., 2020). Because of this, the WV may hold a negative opinion of military-related facilities, and this could affect how they answered study questions.

Third, memory bias could affect the answers in the interview because the participants were asked to recall experiences from the past. These memories could have been impacted by two aspects. First, traumatic experiences could affect memory consolidation, and time could impair or enhance the recall of memory. Both could affect current associations with experiences at the VA.

Fourth, self-report bias could have been a factor. The researcher herself is a WV, which she disclosed to the participants when obtaining consent. Participants could have answered questions knowing the researcher was also a WV when describing their thoughts and feelings on the topic based on what they thought the researcher would want to hear.

Finally, in this study, participants had varied health conditions. Some participants used the VA only for their annual appointments, and others used the system every week. The findings could be different if more consistent use of the VA were sought for specific diagnoses.

Conclusion

This research study has provided important insights into the experiences and perspectives of WVs use of the VA. Given the projected increase in the amount of WVs and the increased risk of comorbidities, the VA may need to increase policies and initiatives to provide better opportunities for the care of the WV. The actual needs of WVs include the opportunity to

be seen in healthcare communities where they are comfortable and free from barriers, and frustrations, and receive high quality care. Decreasing these barriers and improving the frustrations surrounding care at the VA could allow WVs to achieve a higher level of health.

References

Anhang Price, R., Sloss, E. M., Cefalu, M., Farmer, C. M., & Hussey, P. S. (2018). Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. Journal of general internal medicine, 33(10), 1631-1638

Bastian, L. A., Hayes, P. M., Haskell, S. G., Atkins, D., Reiber, G. E., LaCroix, A. Z., & Yano, E. M. (2016). Improving our understanding of health issues in older women veterans. *The Gerontologist*, *56*(1), 10-13.

Bean-Mayberry, B. A., Chang, C. C. H., McNeil, M. A., Whittle, J., Hayes, P. M., & Scholle, S. H. (2003). Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. *Journal of General Internal Medicine*, *18*(3), 175-181.

Center for Disease Control. (2022). *Social determinant of health: Know what affects health.* https://www.cdc.gov/socialdeterminants/index.htm

Congressional Research Service. (2021). *Veterans health administration: Gender-specific health care services for women veterans.* https://crsreports.congress.gov/product/pdf/IF/IF11082#:~:text=It%20includes%20not%20only%20reproductive,health%20care%20system%20in%20FY2019.

Cordasco, K. M., Mengeling, M. A., Yano, E. M., & Washington, D. L. (2016). Health and Health Care Access of Rural Women Veterans: Findings from the National Survey of Women Veterans. *Journal of Rural Health, 32*(4), 397–406.

Der-Martirosian, C., Cordasco, K. M., & Washington, D. L. (2013). Health-related quality of life and comorbidity among older women veterans in the United States. *Quality of Life Research, 22*, 2749–2756. doi:10.1007/s11136-013-0424-7.

Friedman, S. A., Phibbs, C. S., Schmitt, S. K., Hayes, P. M., Herrera, L., & Frayne, S. M. (2011). New women veterans in the VHA: A longitudinal profile. *Women's Health Issues*, *21*(4), 103-111.

Frayne, S. M., Phibbs, C. S., & Friedman, S. A. (2014). Sociodemographic Characteristics and Use of VHA Care and Non-VA Care. *Washington, DC, Department of Veterans Affairs, Women Veterans Health Strategic Health Care Group*.

Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., Simpson, T., Carter, M. E., Blais, R. K., & Gundlapalli, A. V. (2016). Military sexual trauma and co-occurring posttraumatic stress disorder, depressive disorders, and substance use disorders among returning Afghanistan and Iraq veterans. *Women's Health Issues, 26*(5), 546–554.

Haskell, S. G., Heapy, A., Reid, M. C., Papas, R. K., & Kerns, R. D. (2006). The prevalence and age-related characteristics of pain in a sample of women veterans receiving primary care. *Journal of Women's Health*, *15*(7), 862-869.

Hasket, S. G., Ning, Y., Krebs, E., Goulet, J., Mattocks, K., Kerns, R., & Brandt, C. (2012). Prevalence of painful musculoskeletal conditions in female and male veterans in 7 years after return from deployment in Operation Enduring Freedom/Operation Iraqi Freedom. *The Clinical Journal of Pain*, *28*(2), 163-167.

Kimerling, R., Bastian, L. A., Bean-Mayberry, B. A., Bucossi, M. M., Carney, D. V., Goldstein, K. M., ... & Frayne, S. M. (2015). Patient-centered mental health care for female veterans. *Psychiatric Services*, *66*(2), 155-162.

Klap, R., Darling, J. E., Hamilton, A. B., Rose, D. E., Dyer, K., Canelo, I., ... & Yano, E. M. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs medical centers and impacts on delayed and missed care. *Women's Health Issues*, *29*(2), 107-115.

Lehavot, K., Der-Martirosian, C., Simpson, T. L., Shipherd, J. C., & Washington, D. L. (2013). The role of military social support in understanding the relationship between PTSD, physical health, and healthcare utilization in women Veterans. *Journal of Traumatic Stress, 26*, 772–775.

Lindseth, A., & Norberg, A. (2022). Elucidating the meaning of life world phenomena. A phenomenological hermeneutical method for researching lived experience. Scandinavian Journal of Caring Sciences, 36(3), 883–890.

MacDonald, S., Judge-Golden, C., Borrero, S., Zhao, X., Mor, M. K., & Hausmann, L. R. (2020). Experiences of perceived gender-based discrimination among women veterans: data from the ECUUN study. *Medical care*, *58*(5), 483.

Mattocks, K. M., Yano, E. M., Brown, A., Casares, J., & Bastian, L. (2018). Examining women Veteran's experiences, perceptions, and challenges with the veterans choice program. *Medical Care*, *56*(7), 557-560.

Mattocks, K. M., & Yehia, B. (2017). Evaluating the veterans choice program: Lessons for developing a high-performing integrated network. *Medical Care*, *55*, 1-3.

Nahin R.L. (2017). Severe pain in veterans: the impact of age and sex, and comparisons to the general population. *Journal of Pain. 18*(3):247-254.

Seidl, J. N. T., Pastorek, N. J., Lillie, R., Rosenblatt, A., Troyanskaya, M., Miller, B. I., ... & Linck, J. (2015). Factors related to satisfaction with life in veterans with mild traumatic brain injury. *Rehabilitation Psychology*, *60*(4), 335.

Sheahan, K.L., Goldstein, K.M., Than, C.T. et al. Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings. J GEN INTERN MED 37 (Suppl 3), 791–798 (2022).

Strong, J.D., Crowe, B.M. & Lawson, S. Female Veterans: Navigating Two Identities. Clin Soc Work J 46, 92–99 (2018).

Tummalapalli, S. L., & Keyhani, S. (2020). Trends in Preventative Health Services for Veterans with Military Coverage Compared to Non-Military Coverage. JGIM: Journal of General Internal Medicine, 35(4), 1330–1333.

Washington, D. L., Bean-Mayberry, B., Mitchell, M. N., Riopelle, D., & Yano, E. M. (2011). Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. *Women's Health Issues*, *21*(4), 112-119.

Washington, D. L., Bean-Mayberry, B., Riopelle, D., & Yano, E. M. (2011b). Access to care for women veterans: Delayed healthcare and unmet need. *Journal of General Internal Medicine*, *26*(2), 655.

Weeks, W. B., & West, A. N. (2019). Veterans health administration hospitals outperform non–veterans health administration hospitals in most health care markets. Annals of Internal Medicine, 170(6), 426-428.