Study of Barriers for Women Veterans to VA Health Care

Final Report

April 2015

Table of Contents

Appendices

Appendix A: Methodology Report

Appendix B: Pre-notification letter sent to study participants

Appendix C: Sample informational brochure sent to study participants

Appendix D: Questionnaire for the Study of Barriers to Care for Women Veterans

Appendix E: Comparison to the National Survey of Women Veterans (NSWV)

Appendix F: In Their Own Words: What Women Veterans Want VA to Know

1.0 Executive Summary

Purpose

The Women's Health Services of the Department of Veterans Affairs (VA) awarded a contract to Altarum Institute to conduct an independent study of the barriers to comprehensive health care for women who are Veterans in response to Public Law 111-163, Sec. 201-Women Veterans Health Care Matters.

This study will help VA better understand barriers women Veterans face accessing VA care. The data collected will allow the VA to plan and provide better health care for women Veterans and to support reports to Congress about the status of women Veterans health care.

Background

Today, the proportion of female Service members and Veterans is at its highest point in history, with projections for continued growth. At the outset of this research endeavor, the VA Women Veterans Task Force had just released the draft 2012 report "Strategies for Serving Our Women Veterans" noting that the Active Component of the Armed Forces is now 14 percent female and the Reserve Component is 18 percent female, up from just 2 percent in 1950.[1] As those active and reserve military Service Members transition into Veteran status, women now make up the fastest growing cohort within the Veteran community.[2] One source found that approximately 1.8 million (8 percent) of the 22.2 million Veterans were women in 2011.[3] By 2020, these data indicate that women Veterans will comprise nearly 11 percent of the total Veteran population.

As the number of women Veterans increases, the VA continues to prepare for an increasing demand for women Veterans' health care needs. Over the last decade alone, the number of women Veterans using VA health care has nearly doubled.[4] Currently more than 500,000 women have enrolled in the VA health care system. While the attention and effort to serve the female Veteran population have been in place for decades, there have been renewed efforts to understand the current population dynamics and needs, especially as the war efforts in Iraq and Afghanistan draw down to a close.

On July 15-17, 2011, Secretary of Veteran Affairs, Eric Shinseki hosted the National Training Summit on Women Veterans in Washington, DC, to help identify and address the urgent needs of women Veterans stating, "It's not enough to tell me to just do something—

[1] VA Women Veterans Task Force. 2012 report. "Strategies for Serving Our Women Veterans." Accessed on 3/1/2012. Available at http://nuraiitj.appspot.com/www.va.gov/opa/publications/Draft_2012_Women-Veterans_StrategicPlan.pdf

[2] Ibid.

[3] Department of Veterans Affairs, VetPop07, via the National Center for Veterans Analysis and Statistics (NCVAS)

[4] VA Women Veterans Task Force. 2012 report.

just make things better. Tell me the “what” to attack; what do we need to do? What do we need to go after? What do we need to begin putting in place for the next two generations of women Veterans?” Additionally, during the Summit, Secretary Shinseki called for the formation of a Women Veterans Task Force (WVTF) to lead the development of a comprehensive VA action plan to examine gaps and barriers in how the VA serves women Veterans. This interest and support of the VA’s most senior leadership, combined with the capability and commitment available throughout the VA organization will be critical in the ongoing improvements in serving Women Veterans.

The Study of Barriers for Women Veterans to VA Health Care, overseen by the Women Veterans Health Care team, will help the VA better understand the needs of the growing Women Veteran population by examining health care use, preferences, and the barriers Women Veterans face in access to VA care. The results will aid decision-makers in understanding how women interact with the current VA system and identify actionable opportunities for improvement.

Scope

Altarum Institute developed a survey in collaboration with a team from the Women’s Health Services office that builds on the 2009 National Survey of Women Veterans (NSWV). The goal was to collect at least 400 surveys from women who received care in each of the 21 Veteran Integrated Service Networks (VISNs) for a minimum of 8400 completed interviews. This telephone survey took about 45 minutes if all questions were applicable to a respondent, and data were collected about barriers to the provision of comprehensive health to women Veterans in compliance with the requirements of Public Law 111-163, sec. 201.

- In order to be responsive to the legislation requirements, the survey addressed the following barriers (ordered as listed in the Public Law):
- The perceived stigma associated with seeking mental health care services
- The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care
- The availability of childcare while using VA services
- The acceptability of integrated primary care, women’s health clinics or both
- The comprehension of eligibility requirements for, and the scope of services available under hospital care and medical services
- The perception of personal safety and comfort in inpatient, outpatient and behavioral health facilities
- The gender sensitivity of health care providers and staff to issues that particularly affect women
- The effectiveness of outreach for health care services to women Veterans
- The location and operating hours of health care facilities that provides services to women Veterans

Methods

A random sample of 101,100 names of women Veterans for the study (further referred to as the Barriers to Care survey) was extracted from the USVETS database.[5] Of that, 91,972 cases contained valid contact and address information. After removing cases for individuals found to be deceased, the final fieldable sample included 90,154 cases.

To achieve the analytic goals of the study, the sample frame was stratified by VISN and by those who *had used* VA health services and had not used VA's health services in the last 24 months. Altarum anticipated an overall 20 % response rate, with a differential response rate by user/non-user status of 25% and 16.67% respectively. The ultimate fielded sample comprised 64,509 individuals resulting in an overall response rate of 13.2%, well below the initial assumption at project start of an overall response rate of 20%.

The Barriers to Care survey was conducted via Computer Assisted Telephone Interviewing (CATI) using professionally trained female interviewers. To ensure the highest participation rate possible, a pre-notification letter was sent to each eligible woman Veteran in the sample that explained the purpose of the study. Interviewers made up to ten contact attempts to try to achieve a completion.

Following receipt of approval of the instrument and study design by the Office of Management and Budget (OMB) in October 2013, fielding for the survey began on December 10, 2013. Calling ended on August 4, 2014, ahead of schedule, having achieved the desired number of completes in all strata. Total field period was approximately eight months.

Results

Below are highlights of results/findings for the nine established barriers (in the order addressed in the survey and report).

Barrier 1: Comprehension of Eligibility Requirement and Scope of Services

Not surprisingly, a significantly higher percentage of system users reported having received information related to VA services than did non-users. **Only 51% of non-users felt that they had enough information on eligibility for VA services.**

[5] The Department of Veterans Affairs (VA) National Center for Veterans Analysis and Statistics (NCVAS) has among its missions: to provide data and statistics on the veteran population and VA operations; to analyze data on veterans and VA programs to support VA leadership on operational and policy issues facing the Department; and to operate and maintain a web portal providing statistics about veterans and VA programs. A key database for supporting these missions is the **U.S. Veterans Eligibility and Trends Statistics (USVETS) database.** The USVETS is a single, integrated database containing veteran demographic and socioeconomic data providing a comprehensive overview of the veteran population and can be used to support statistical, trend, and longitudinal analysis. USVETS integrates a wide array of Veteran-level demographic, location, and benefits utilization data from all three VA administrations, the DoD, the Social Security Administration, and commercial data sources. USVETS contains information on close to 30 million Veterans, 21 million of which representing currently living Veterans. Of these 21 million living Veterans, USVETS maintains and updates annually the address information on roughly 95% of these Veterans through a SSN matching process with commercially procured data from one of the world's largest purveyors of database marketing services.

As a source of information, **brochures are most preferred by users and non-users alike.** Talking to a VA representative and getting information from family and friends were also popular sources. The overall preference for hard copy versus electronic communication is also re-enforced by the fact that women indicated a **preference for postal mail (46%)** by a significant margin and email (26%) for future communications from VA. Disability level, however, seems to alter the preferred mode of communication considerably. **As disability level increases, the preference for telephone use increases.**

Timing of information delivery seems to support the concept of "early and often". Women would like to receive information both before they separate from service and repeatedly after separation/return from deployment.

Barrier 2: Effect of Outreach Specifically Addressing Women's Health Services

There is a disparity between system users and non-users when assessing receipt of information about Women's Health Services. **Most system users (67%) report having received information on Women's Health Services, compared to only 21% of non-users.** The percentage of women who received this information (for both groups) is lower than the percent having received general VA information. Women from all Service eras reported seeing this information, with pre-Vietnam Veterans reporting the most at 46%, with a declining percentage for each later era.

Across VISNs, there is significant disparity with the percentage reporting having seen information specific to women's care. For users, the range is 56%-83%, and for non-users it is 31%-52%. The lowest VISNs in the user groups do not necessarily correspond to the lowest scoring VISNs in the non-user groups. This may reflect variances within each VISN population, but **may also be attributed to VISNs having disparate programs for communicating to women Veterans within their boundaries.** It would be useful to explore the methods of those VISNs with high levels of awareness and determine if similar methods would be applicable to other VISNs.

Barrier 3: Effect of Driving Distance on Access to Care

The majority of women, whether in urban or rural settings, indicated that finding transportation was not problematic. Overall, only 10% indicated that finding transportation is either very hard or somewhat hard. However, there is an additional burden on those Veterans with higher disability ratings. For women with a 70-100% disability rating, 12% indicate having a very hard or somewhat hard time finding transportation.

Ease of finding transportation was a moderate-strength significant predictor for VA use among current users. Those for whom finding transportation is easy use VA more frequently.

Driving themselves was the clearly preferred mode of transportation across all user groups (80%). The second preferred mode was to have family or friends drive them (14%). There is no significant difference between the transportation preferences of women Veterans living in rural versus urban locations.

Non-users report less difficulty finding transportation (to non-VA sites of care); however, this may be because they select their provider based upon proximity to either home or work, which may mitigate transportation problems. The limited number of VA sites of care (compared to available providers outside the federal system) makes this dynamic an inherent structural component of system design.

Barrier 4: Location and Hours

Of all women who report using the VA system, 72% indicate that they do not utilize the nearest VA facility for Primary Care. This high number of women who bypass their nearest VA for care is likely indicative of the fact that many women who use VA care also utilize non-VA (non-federal) care (64%) and the location of their alternate sites of care have little relationship to the VA location. Of those women who indicate they use VA care for their *primary care*, only 10% indicate that they bypass their nearest VA site of care to go to another VA facility. **The most common reasons for bypassing the nearest VA were *the women's services I need are not available* (16%), and *I do not feel the providers are good* (12%).** The point made by responses to this question is that perception of quality of providers and availability of needed services are the dominant reasons for selecting one VA facility over another, even if it is further away.

The scores are generally very good for women receiving an appointment in the timeframe needed. Availability of Primary Care appointments (typically needed more urgently than routine or mental health appointments) is scored lowest compared to appointing for other types of health care appointments. Percent scored as outstanding (a 5 on a 5-point scale) by appointment type is 36% for primary care, 47% for routine women's services, and 46% for mental health care. Combined 4 and 5 ratings (top-two on the 5-point scale) are 60%, 71% and 70%, respectively.

Analysis showed that *Convenience of Appointments* at VA was a moderate-strength significant predictor. **Women who report that VA has convenient appointment times use VA more frequently.**

Data indicate that morning appointments are most preferred, not necessarily because of a personal scheduling convenience, but rather because as the day goes on, appointments run further and further behind schedule (prevalent theme in respondent comments related to appointing).

Concerns and recommendations about appointing was one of the top three categories for all the respondent comments (receiving thousands of comments). One theme among the appointing comments was that communication and coordination about appointment times was a challenge. **The communication about appointing may be a barrier that needs more attention. Even if satisfactory appointment times are available, if the communication and confirmation of appointments is not handled effectively, patients will be highly dissatisfied and this could discourage use of the VA system.**

Barrier 5: Childcare

More users than non-users report that finding childcare to attend medical appointments is *somewhat hard* or *very hard* (42% for users, 30% for non-users). Women who are not married also have more difficulty finding childcare (39% find it hard/very hard to find childcare versus 29% for married women). Finding care is easier as women get older, and it is slightly easier for women in rural settings.

Data show significant variation in ease of finding childcare across VISNs. Statistically, however, ease with which women can find childcare is *not* associated with user status.

When queried about the possibility of on-site childcare, three out of five women (62% overall) indicated that they would find on-site childcare *very helpful*. Otherwise, more non-users than users reported that on-site child care would be *somewhat helpful* (22% non-users vs. 16% users) and more users than non-users reported that on-site child care would be *not helpful* (22% users vs. 17% non-users). **In general, many women would like on-site childcare, but this is not a significant factor in whether they choose to utilize VA care.**

Barrier 6: Acceptability of Integrated care

This study assessed preferences for gender integrated Comprehensive Primary Care versus Comprehensive Primary Care provided in Clinics for Women only. For this research, Comprehensive Primary Care was defined as one provider who provides all general medical care and routine women's health care such as Pap smears, contraception, and menopause care. **When asked about the importance of receiving care from a clinic just for women, users placed a greater importance on having clinics for women only (60% for users, 47% for non-users).**

While women throughout all demographic categories show a preference for women-only settings, some subsets of the women Veteran population may be particularly sensitive to mixed-gender settings. Women who reported previous unwanted sexual attention preferred women-only clinics slightly more than those who did not have that experience (52% to 48%). **Women who had previously experienced threat or force of sex felt more strongly, with 57% stating it**

was *very important* or *somewhat important* to have women-only clinics (versus 47% who did not have that experience).

Additional comprehensive care features were assessed including *having one provider for primary care and women's services* and *having a female provider for women's specific services*. **With regard to having one single provider for all care, 75% of respondents rated this as *very important* or *somewhat important*.**

The importance of having a *female provider for women's services* may be less important than the other integration of care metrics with 65% of women rating it as *very important* and *somewhat important* but, even though the preference is lower, this is still a strong satisfier for women. Open-ended comments from respondents noted that women's clinics often had only one female provider and that appointments with that provider frequently backed up. **This would indicate a possible shortage of female providers available to provide women-specific care.**

The final metric related to integrated care was whether women Veterans agree with the statement that "*At VA sites of care, women may see a female provider if they want to*." Because this question is asked of both users and non-users, the answers are based as much (if not more) on perception than actual experience. Women who are not using the system reported lower rates of agreement with the statement (59% of non-users vs. 72% of users *somewhat* or *strongly agree*). This finding indicates that perception can be a real barrier for non-users. **Twenty-eight percent of users do not agree with the statement that *they may see a female provider if they want to*.** There are significant differences across VISNs, indicating that some locations may have more or fewer female providers available. For non-users the perception of the ability to choose a female provider is widespread and not location specific.

Barrier 7: Gender sensitivity (users only)

The changing demographic of the VA population makes it imperative that the culture evolve not to simply accommodate women Veterans, but to actively embrace their needs and respond accordingly. To evaluate this, the study included questions about satisfaction on relationships with providers and clinic staff, and with whether women felt respected.

***Satisfaction with provider* for women receiving comprehensive care is good and is fairly consistent across VISNs** regardless of whether it is delivered in a women's specific clinic or in a general primary care clinic. However, within some VISN ratings for *satisfaction with provider* outside of the comprehensive care setting does differ based on type of care and location in which the care is received.

This may indicate that **VA is generally performing well in the provision of gender sensitive care, but some VISNs have primary care clinics which are lagging behind other care settings (comprehensive and women only) in this regard.** This may reflect staffing or staff training challenges, and the unique culture of a women's clinic within VA. As may be expected, **regression analysis found that women who report greater satisfaction with their primary care provider use the VA system more frequently.**

The women Veterans using the VA system who are most satisfied with their primary care provider are those who receive comprehensive care in a women's clinic. As age increases, satisfaction increases. As disability rating increases, satisfaction decreases.

Women reported the highest level of respect from their primary care provider, and increasingly less respect by other providers and office staff, with office staff showing the least amount of respect. Women receiving comprehensive care in a women's clinic report the highest level of respect from all staff; this may indicate the success of dedicated women's clinics within VA, offering a more women-friendly and respectful environment than that of other setting. Older age groups report being treated with more respect than younger age groups. Those with no disability rating report being treated with more respect than those with higher disability ratings.

The *staff respect* composite shows significant differences by VISN for women receiving primary care, but not comprehensive care, and women receiving comprehensive care received outside of a women's clinic. This indicates that some VISNs have a greater focus on patient-staff interaction than others, whether or not that is related to respect shown to women Veterans.

Barrier 8: Mental Health Stigma

It is imperative that women Veterans in need of behavioral health services can locate the care they need, and are willing to enter the system to access it. Data from this study show that women who use the VA system are 1.85 times more likely (an increased "risk" of 85%) to report depression and 3.63 times more likely to report PTSD than non-users of VA health care(this shows association, not causation).

More than half of women Veterans (52%) indicate they have needed mental health care. Of the system users who self-reported a need for mental health services, 49% indicated they had received mental health care from a Vet Center, and 64% reported they received mental health care from VHA sites of care (questions were not mutually exclusive).

Overall, 24% of women indicated that they were hesitant to seek care for mental health issues, with more users than non-users feeling hesitant (35%

of users vs. 21% of non-users). Differences in levels of hesitancy among users and non-users were also found by Service era, those with self-reported traumatic brain injury (TBI), self-reported depression, and unwanted sexual attention or threat or force of sex. **Reasons for hesitancy to seek care (from any source), in decreasing order, include *I'm worried about medicines used* (62%), *It could negatively affect my job* (54%), *Others would think less of me* (47%), *I prefer spiritual/religious counseling* (40%), *I'm not sure it would help me* (36%), *I would think less of myself* (32%), and *It could affect my relationship with family/spouse* (31%).**

Current social pressures are not the only reason women are hesitant to seek mental health care. **A significantly higher proportion of users, compared to non-users, reported avoiding VA because of past sexual trauma (19% of users vs. 8% of non-users).** Given the historically male dominated culture and patient base in VA facilities, women who already have misgivings about seeking care may be even more hesitant when faced with barriers of both mental health stigma and gender sensitivity issues.

Barrier 9: Safety and Comfort (users only)

Women from all demographic categories expressed agreement that the safety and comfort factors in VA facilities were adequate. But women from earlier Service eras had stronger agreement than more recent eras; those with no disability or lower disability ratings showed higher agreement than those with higher disability rating; and those with no experience of unwanted sexual attention/threat or force of sex showed stronger agreement that VA has adequate safety and comfort.

By Service era, more recent Veterans (OEF/OIF-Present era) felt that facilities were less safe and comfortable overall. By disability rating, satisfaction with safety and comfort steadily decrease as disability level increases. As may be expected, women with experiences of unwanted sexual attention or threat or force of sex feel less safe and comfortable in VA facilities than women who did not have these experiences. Overall, the more comfortable women are with the safety and comfort of a facility, the more likely they are to use VA services.

Only 9% of VA healthcare users indicated they had an inpatient experience at VA within the last 24 months. **Women from the OEF/OIF-Present era reported significantly less satisfaction with safety and comfort compared to women from other eras. The least satisfying experience for this group was with the admissions process.** By disability, those with higher disability ratings (70-100%) felt significantly the least safe and comfortable with the ease and speed of the admissions process. Women with previous experiences of unwanted sexual attention or threat or force of sex felt significantly less safe and comfortable than

women Veterans without those experiences (for almost all measures). **The inpatient measure with which they felt the least comfortable was the ability to secure the door to their room at night.** There were significant differences by VISN.

Additionally, only 3% of women VA healthcare users reported an **inpatient mental health stay** in the previous 24 months**.** The number of women reporting a mental health inpatient stay is too low to assess differences in safety and comfort by VISN, and too low for regression analysis. However, **top concerns identified include the inability to *secure the door to their room at night, having access to a private bathroom*, *showering during their stay,* and the *speed of the admissions process*.**

Respondents were also invited to provide open-ended comments on any aspect of the survey, or even topics not covered by the survey. All comments were captured, analyzed and provided to VHA for further consideration. These comments add dimension to understanding women's experience with the nine barriers, and also help identify additional barriers.

This study highlights some actionable areas where the VA system can invest effort and resources to improve comprehension, access to care and delivery of services in ways that will influence women Veterans' decisions to seek care through VA. The findings also provide insight into future areas of research. Many of the barriers studied could benefit from additional focused research to dig deeper into the factors and identify more specific actions to improve system usage and patient satisfaction. The variation among VISNs on most barriers indicates significant inconsistency in practices and/or resources. Studies to help identify and evaluate best practices would be worthwhile. VA should then establish mechanisms to implement those best practice system-wide, providing additional guidance and support to facilities that lag in the metrics.

2.0 Background

Since the first women Veterans from World War II were granted official Veteran status by Congress in the early 1980s,[6] the Department of Veterans Affairs (VA) and Congress have strategically worked to increase health care services and benefits for women Veterans. This work started with the development of strategic groups such as the Advisory Committee on Women Veterans (established in 1983),[7] the Women Veterans Health Strategic Health Care Group (now office of Women's Health Services) within the Veterans Health Administration (established in1988),[8] and the Center for Women Veterans within the Department of Veterans Affairs (established in 1994).[9] Each has a mission tied to the enhancement of support for women Veterans. The office of Women's Health Services, which provided oversight to this research, addresses the health care needs of women Veterans and works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment.

Today, the proportion of female Service members and Veterans is at its highest point in history, with projections for continued growth. The Department of Veterans Affairs' 2011 Veteran Population model (VetPop2011) estimates that women Veterans now make up about 10% of the 22 million living Veterans[10] and are projected to make up almost 18% of Veterans by 2040.[11] Additionally, between 2000 and 2009 the number of women Veterans accessing health care through VA grew by 83%, yet that represented only 19% of all living women Veterans.[12] As the number of women Veterans increases, VA continues to prepare for providing services that fit women Veterans' growing health care needs.

Over time, studies and evaluations have provided guidance to VA for the development of programs and services for women Veterans. At the VA's Fifth National Training Summit on

[6] U.S. Department of Veterans Affairs. Center for Women Veterans . Advisory Committee on Women Veterans. Reports. 2012. Available at http://www.va.gov/WOMENVET/docs/Final_Advisory_Committee_on_Women_2012_Report.pdf . Accessed on 10/10/2014.

[7] U.S. Department of Veterans Affairs. Center for Women Veterans . Advisory Committee on Women Veterans. Available at http://www.va.gov/womenvet/ACWV.asp. Accessed on 10/10/2014

[8] U.S. Department of Veterans Affairs. Women Veterans Health Care. About the Women Veterans Health Care Program. Available at http://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/about.asp. Accessed on 10/10/2014.

[9] U.S. Department of Veterans Affairs. Center for Women Veterans. Available at http://www.va.gov/womenvet/ . Accessed on 10/10/2014

[10] Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Special reports. Available at http://www.va.gov/vetdata/docs/SpecialReports/Women_Veteran_Profile5.pdf . Accessed on 10/10/2014

[11] Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Quick facts. Available at http://www.va.gov/vetdata/docs/QuickFacts/Population_quickfacts.pdf . Accessed on 10/10/2014

[12] Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Special reports. Available at http://www.va.gov/vetdata/docs/specialreports/final_womens_report_3_2_12_v_7.pdf . Accessed on 10/10/2014

Women Veterans in Washington, DC, in 2011, the progress VA has made in recent years to better serve women Veterans' health care needs was highlighted.[13] Of note were the five areas of improvement in care for women Veterans since 2008:

- The availability of comprehensive primary care for women Veterans at VA sites of care
- The establishment of Women Veteran Program Managers (WVPM) at every VA medical center nation-wide
- A revised VHA Handbook on Health Care Services for Women Veterans
- New women's health education for VA health care providers, and
- Dramatically increased outreach and education services for women Veterans including brochures, posters, blogs and social media, and a dedicated call center for outbound calls about VA health care benefits for women Veterans.

The outreach program was a substantial advancement. In one year alone, from April 2013 to April 2014, the call center made 93,000 outbound calls and received 9,600 inbound calls (inbound calling started in 2013) from women Veterans to discuss services and benefits available through VA.[14] VHA has 140 Healthcare Systems offering Primary Care Services and all of these systems now have at least one Designated Women's Healthcare Provider (DWHP). Additionally, as of April 2014 there are 83 sites of care (in both VA medical centers and Community-Based Outpatient Clinics (CBOCs)) which now have dedicated Women's Health Centers which provide coordinated, high quality comprehensive care to women Veterans.

The list of improvements to women's health care in VA over the last decade shows great progress. However, there are recommendations for improvements to women-specific care and services at VA hospitals and clinics which still need to be addressed.[15,16] Related to these remaining recommendations is a body of literature pertaining to specific barriers that women Veterans face in receiving health care from VA.[17,18,19] In 2010, President Barack Obama signed the Caregivers and Veterans Omni*bus Health Services Act*; within that

[13] http://www.va.gov/WOMENVET/2011Summit/HayesFINAL.pdf
[14] U.S. Department of Veterans Affairs. Women Veterans Health Care. Women Veterans Call Center. Available at http://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/wvcc.asp Accessed on 10/10/2014
[15] http://www.va.gov/opa/publications/draft_2012_women-veterans_strategicplan.pdf
[16] http://www.va.gov/WOMENVET/docs/Final_Advisory_Committee_on_Women_2012_Report.pdf
[17] Vogt D, Bergeron A, Salgado D, Daley J, Ouimette P, Wolfe J. Barriers to Veterans Health Administration Care in a Nationally Representative Sample of Women Veterans. J Gen Intern Med. Mar 2006; 21 (Suppl 3): S19-S25. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513162/ . Accessed on 10/10/2014
[18] Washington DL, Bean-Mayberry B, Riopelle D, Yano EM. Access to care for women veterans: delayed healthcare and unmet need. J Gen Intern Med. 2011 Nov; 26 Suppl 2:655-61. Available at http://www.ncbi.nlm.nih.gov/pubmed/21989618 Accessed on 10/10/2014
[19] Delcher C., Wang Y., Maldonado-Molina M. Trends in financial barriers to medical care for women veterans, 2003-2004 and 2009-2010. Prev Chronic Dis 2013; 10. Available at http://www.cdc.gov/pcd/issues/2013/13_0071.htm Accessed on 10/10/2014

legislation, section 201 of Public Law 111-163 outlines direction for an independent study to evaluate the effect that nine identified barriers have on women Veterans receiving health care through VA. These nine barriers include:

- The perceived stigma associated with seeking mental health care services
- The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care
- The availability of childcare while using VA services
- The acceptability of integrated primary care, women's health clinics or both
- The comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services
- The perception of personal safety and comfort in inpatient, outpatient and behavioral health facilities
- The gender sensitivity of health care providers and staff to issues that particularly affect women
- The effectiveness of outreach for health care services to women Veterans
- The location and operating hours of health care facilities that provides services to women Veterans

By evaluating the effect that these barriers have on women Veterans receiving care from VA, the VA may be able to strategically implement changes to better serve women and increase utilization of services by women Veterans in need of care.

The study called for by Public Law 111-163 section 201, expands upon a previous study conducted by VA. The National Survey of Women Veterans (NSWV) conducted in 2008-2009 surveyed 3,611 women nation-wide about women Veterans' health care needs, experiences with VA health care, and barriers to VA health care.[20] The new study of Barriers to Care for Women Veterans expands upon the initial framework developed for the NSWV with an enhanced design and larger study population. The Barriers to Care study surveyed more than twice the number of women Veterans as NSWV and increased the surveyed population of women Veterans nation-wide by a factor of 2.4.

Altarum Institute, a non-profit organization dedicated to health care systems research[21] was selected as the independent research organization to conduct the study of Barriers to Care for Women Veterans. The study is overseen by the Women's Health Services office, and will provide information to better understand the needs of the growing women Veteran population by examining health care use, preferences, and the barriers women Veterans face in accessing VA care. The results and insights gained from the survey will aid decision-

[20] U.S. Department of Veterans Affairs. Office of Research and Development. The National Survey of Women Veterans by Donna Washington. Available at: http://www.research.va.gov/programs/womens_health/conference2010/washington.cfm. Accessed on 10/10/2014

[21] Altarum Institute http://altarum.org/

makers in identifying actionable opportunities for improvement specific to the needs, issues, and areas of concern for the women Veteran population.

Work began on the Barriers to Care survey in February 2012 and this report summarizes the study findings. Per the Public Law, a copy of this report will be submitted to the Center for Women Veterans, the Advisory Committee on Women Veterans and Congress.

3.0 Methods

This section summarizes the methodology used to create, field, and analyze the Barriers to Care survey. For more information, a detailed review of the methods can be found in Appendix A.

3.1 Survey mode

The Barriers to Care survey was conducted utilizing Computer Assisted Telephone Interviewing (CATI). CATI interviewing has several advantages over other modes of survey administration, including respondent retention that yields higher response rates, adherence to skip patterns, immediate data entry, and fewer barriers to respondents such as a need for internet access or levels of reading proficiency. Retention and survey completion are especially important with longer surveys, such as the one used for this study. To ensure the highest participation rate possible, a pre-notification letter which explained the purpose of the study was sent to each woman Veteran in the sample. Also included within the pre-notification letter was an informational brochure about the VA's women's health services. A copy of the pre-notification letter and informational brochure sent to women Veterans for this study can be found in Appendices B and C.

3.2 Data sources and sampling

To achieve the analytic goals of the study, the sample for the Barriers to Care survey was obtained from the Department of Veterans Affairs database of all known U.S. Veterans, referred to as the USVETS database. The study population was stratified by Veterans Integrated Service Network (VISN) to ensure a specific number of completes within each network. It was further stratified by the user status of women who either *have used* VA health services (heretofore known as 'users') and *have not used* VA's health services (heretofore known as 'non-users') in the last 24 months, based on the most recent update of the USVETS database (FY2012).

In total, a random sample of 101,100 names of women Veterans for the Barriers to Care survey were extracted from the USVETS database and provided to Altarum Institute. This comprised the sample frame from which the final sample would be drawn. After evaluating the quality of the contact information, mailing addresses and telephone numbers, Altarum initially requested a total stratified random sample of 73,500 women Veterans to be drawn from this sample frame, with equal representation across VISNs, but disproportionately split between user and non-user populations as response rates among these populations were

expected to be different. The study aimed to collect a minimum of 8,400 completed interviews: 400 per VISN, with 200 users and 200 non-users within each VISN.

Before fielding, Altarum worked with an outside service to update the contact information, addresses and phone numbers, for women Veterans selected in the sample. At the completion of fielding, target objectives were met or exceeded for every strata. Response rates increased during the latter half of the fielding cycle leading to a reduction in sample size requirements and fielding levels. The total fielded sample comprised 64,509 individuals and 8,532 completed cases were collected– exceeding the target objective of 8,400 cases by 132 cases.

3.3 Questionnaire development, content, and testing

Alarum Institute developed a survey in collaboration with the Women's Health Services office to address the nine barriers stated in Public Law 111-163, sec. 201 and build upon the 2009 National Survey of Women Veterans (NSWV). Questions were developed *a priori* from current literature and in consultation with other VA stakeholders and subject matter experts in women's health. Response scales and questions from existing surveys were used where possible and appropriate. The near-final instrument was tested with six eligible women Veterans (three users of VA health care and three non-users), using cognitive interviewing techniques. Eligible women Veterans were recruited via social media (Veteran-related group pages on Facebook) and the placement of flyers in local VA Women's Health Clinics. Altarum used the feedback from these interviews to revise question wording and response options to help make the material more understandable and relevant to the respondents.

The final questionnaire included 92 questions (some of which were multi-part). Filter questions (yes/no response) were developed to guide respondents through each section of the survey. Within each section, respondents were asked a series of closed-ended questions. Questions not well supported by the literature had an *other-specify* answer choice. One open-ended question at the end of the survey allowed women Veterans to report, in their own words, anything else upon which they wished to comment. The survey includes questions related to each of the nine barriers to care as well as questions related to women Veterans' preferences, experiences, and attitudes towards VA initiatives. A copy of the Barriers to Care questionnaire can be found in Appendix D.

The Office of Management and Budget (OMB) approved the survey in October 2013. The OMB Control number is 2900-0795. Internal Review Board (IRB) approval was received in November 2013.

3.4 Fielding

The Barriers to Care survey began fielding in December 2013 and was completed in August 2014. The study was performed utilizing Computer Assisted Telephone Interviewing (CATI), with a pre-notification letter mailed at least five days before calls were placed to each woman Veteran. The pre-notification letter (on VA letterhead and signed by the director of

the VA Women's Health Services) and Caller ID of "VA WOMENS STUDY" added to the legitimacy of the survey. The first pre-note mailings were sent out on December 4, 2013, and fielding was completed on August 2, 2014.

Two screener questions were used to determine survey eligibility. The woman Veteran had to indicate that she was a woman who had either:

a. Ever served in the active U.S. armed forces, or
b. A National Guard/Reserve member who was called to active duty through a Federal Order and completed a full call-up period

The woman Veteran also had to indicate she was not currently employed by the Department of Veterans Affairs to be eligible for the survey.

Given the sensitive nature of some of the questions in the survey, such as experience of military sexual trauma, only women interviewers were used. Additionally, all interviewers received extensive training and monitoring during interviews and passed a low-level VA clearance background check. Respondents were read an introductory script about the survey and asked for verbal permission to start the interview. Respondents had the option to skip any question that they felt uncomfortable with. Also, an agreement was put in place with The Veterans Crisis Line to allow study interviewers to provide a "warm transfer" for any respondent showing signs of distress and agreeing to be transferred to the Crisis Line. This protocol was only used one time during the fielding period. Interviewers could also provide the Crisis Line number to respondents in the event they desired the phone number.

To obtain a completion, up to 10 contact attempts at various times of the day, during different days of the week were attempted with each potential respondent. A completed case was defined as one where the respondent was taken through the entire instrument, receiving all applicable questions based on skip patterns. Of the 92 total questions, some questions were specific to users of VA health care; non-users were skipped to the next section. The survey took an average 45 minutes to complete, with non-users receiving a shorter survey.

The sample was organized into batches and replicates, each representative of the sample as a whole, so that fielding could be controlled and dynamic. With this method only the minimum number women Veterans necessary were contacted to achieve 200 completed cases per strata without going significantly over the 8,400 target.

3.5 Statistical analysis of results

The stratified sample design used for this study required a typical four-stage weighting design for response data. This included calculation of: 1) base weights, the inverse of the probability of selection for a given individual from within the population; 2) non-response weights, the inverse of the response probabilities measured through logistic regression; 3) post stratification weights to correct the interim weights to come into alignment, as applicable, with the populations they represent; and 4) final weights equal to the product of

the base, non-response, and post stratification weights. Because estimation is used when calculating results with weights, 95% confidence intervals are shown for all results.

Altarum employed survey specific analysis techniques as contained within Stata, SAS-callable SUDAAN, and SAS which incorporate the complex survey design and weighting scheme contained within the Barriers to Care survey. Several statistical tests were used to analyze results. Questions with response options that are nominal (i.e. no order), such as modes of communication, were assessed via Rao-Scott chi-square analysis. Questions with ordinal or continuous response options (i.e. order of magnitude) such as level of satisfaction were assessed via t-tests or ANOVA. P-values for each of these types of assessments are indicated in tables and graphs to show the level of statistical significance. P-values ≤ 0.001 are notated with the symbol ‡. P-values ≤ 0.01 are notated with the symbol †. P-values ≤ 0.05 are notated with the symbol *. Lastly, logistic and linear regression was used to assess the relationship between barriers to care and user status or amount of VA health care use. Where appropriate, odds ratios or point estimates are shown.

While many questions in the survey assessed a woman Veteran's relationship with VA, one question was used to define user status for analyses. This question was "In the past 24 months, have you received any care in a VA site of care?" (yes or no). Women Veterans who indicated *no* or *don't know* to this question were taken through the survey as a non-user.

Where appropriate, barriers to care are measured by subgroups of interest. Subgroups may include VISN, Service era, rurality/urbanity of the woman Veteran's residence, age groups, occupational groups, past experience with sexual trauma. VISN and rurality/urbanity of the woman Veteran's residence were established through variables drawn from our sample data, whereas the remainder of the variables are the result of questions asked in the Barriers to Care survey.

The Health Insurance Portability and Accountability Act (HIPAA) contains a privacy rule that regulates the use and disclosure of Protected Health Information (PHI). Typically the aggregation of responses for analysis and reporting is adequate to prevent the sharing of PHI. However, when subpopulation data has a very small N, it is possible that respondent identities could be compromised if their responses where included. Therefore, to ensure compliance with the HIPAA Privacy Rule, we will not show separate results for respondents over the age of 80 due to the small N for this group.

3.6 Comparison to the National Survey of Women Veterans

As required by the Public Law, the Barriers to Care survey was designed to build upon previous research done by VA. The National Survey of Women Veterans (NSWV) was conducted in 2008-2009 and collected 3,611 completed surveys. Like the Barriers to Care survey, the NSWV was conducted by Computer Assisted Telephone Interviewing (CATI). While the Barriers to Care survey was designed to facilitate comparisons to the NSWV, there are some distinct differences in study design.

The purpose of the NSWV was two-fold: (1) to quantify women Veterans' health care needs, experiences with VA health care, and barriers to VA health care use across different periods of military service; and (2) to assess women Veterans' preferences for potential actions to address those barriers to care. To meet this purpose, the survey instrument included validated scales to screen for depression, anxiety disorders, Post-Traumatic Stress Disorder, and alcohol abuse or dependence, as well as questions about the respondent's self-reported health care needs, perception of the VA hospital or clinic environment, and the quality and availability of health care services for women. In contrast, the Barriers to Care survey is designed to specifically evaluate the nine identified barriers to care as stated in the Public law resulting in a targeted focus on these barriers to care with less emphasis on clinical indicators of health status and health care needs.

The sample for the NSWV survey was stratified by current VA ambulatory care use (VA user; VA non-user) and three periods of military service (pre-Vietnam era; Vietnam era to present, excluding OEF/OIF; and OEF/OIF). OEF/OIF women Veterans were oversampled. Users of VA care were identified through the National Patient Care Databases for FY07 Qtr 4 – FY08 Qtr 3, while non-users were identified through multiple sources including records from the VHA National Enrollment Database (NED), Veterans Benefits Administration (VBA), and the Department of Defense (DoD) Defense Enrollment and Eligibility Record System (DEERS) database. The Barriers to Care survey selected all potential users (inpatient and outpatient) and non-users of VA care from the USVETS database and stratified the sample by user status and Veterans Integrated Service Network, oversampling for non-users.

Both surveys, the NSWV and the Barriers to Care survey, stratified the sample by use/non-use of VA care, but ultimately conducted analyses using self-reported user status obtained from respondents through the survey instrument. In the NSWV survey, user status was defined as receiving care from VA in the past 12 months, while the Barriers to Care survey defined user status as receiving care from VA in the past 24 months. The NSWV selected 12 months to reduce recall bias, while the Barriers to Care survey selected 24 months to capture the experiences and opinions of women Veterans who may rely on VA for health care, but receive care infrequently.

A comparative analysis of applicable results from the NSWV and Barriers to Care survey is found in Appendix E.

4.0 Limitations

When interpreting the results from the Barriers to Care survey, it is important to recognize the assumptions and limitations of the methods and the data.

Altarum Institute worked with VA employees who oversee the VA's USVETS database to obtain the sample for the Barriers to Care survey. USVETS extracted a representative random sample of all eligible women Veterans by designated strata. We assumed that the initial weights and sampling probabilities supplied with the sampling frame were accurate with the initial weights summing to the corresponding strata population totals of eligible

women veterans, and the overall initial weight totals representative of the national level of eligible women veterans. Using these assumptions and data, Altarum created weights for response data to allow for the opinions and experiences of survey respondents to represent the national population of all women Veterans as a whole. Final weights allow for national level estimates as well as VISN and user/non-user group specific estimates and analyses.

An important feature of the Barriers to Care survey design was the stratification of the sample by user status and VISN. Before fielding, Altarum Institute worked with an outside service to update the contact information for eligible women Veterans to achieve the best possible response rate. Address information, when available from data updates, was assumed to be the most representative current address information for the sample population. With each update, data showed that some women Veterans had a change in VISN assignment, which was based on home ZIP code. For women Veterans who had a change in VISN assignment, the change in VISN for those women was also assumed to hold true for the populations they represent. Analogously, for those indicating a difference in user/non-user status relative to VA records, it was assumed that such status changes were also reflective of the populations represented by these individuals. In total, any changes detected by individuals were assumed to hold true in the same proportion to the populations they represent.

With respect to fielding operations, fielding of the survey did not span an entire calendar year. Fielding began in December 2013 and concluded in August 2014. Results for the fielding period are assumed to be representative of the year as a whole were operations to have continued for a full calendar year. Further, the results are assumed to be unbiased with no unaccounted for seasonal variation that might otherwise have been obtained.

VISN assignment at the time of fielding was used for statistical analyses to assess, geographically, the level at which women Veterans encountered barriers to care. The experience of barriers equally or unequally across VISNs might influence how, and where, VA would institute changes to overcome these barriers. However, it is very possible that survey responses reflect attitudes about care received in a previous location (VISN) for women Veterans who recently moved at the time of fielding or Veterans who received care many years ago. It is assumed that the impact of VISN changes is minimal and does not impact the national assessment. While this limitation is important, it remains that women Veterans living in their present VISN at the time of fielding had these experiences previously or currently and a review or update of current policies locally are still recommended to ensure that these barriers have been addressed.

There is some inconsistency between VA-reported use and self-reported use of VA care. Of those women who had a VA record of receipt of care in the past 24 months, 78% also self-reported receiving health care services at VA. However, 21% of VA identified users of VA health care did not report receiving care. In contrast, there was a higher level of agreement between the number of women who reported no receipt of care and had no record of VA care in the USVETS database: a 95% match.

User status for this report is defined based on one question within the survey as to whether or not a respondent received care from VA within the past 24 months. Multiple questions about use of VA care in the survey served as internal validity checks, and some women Veterans appeared to not identify themselves as users when they should have, or vice versa. Women Veterans who did not identify themselves as users via this question, or who indicated they did not know if they received care in the past 24 months, were taken through the survey as a non-user. Thus, the study team did not impute or correct these inconsistencies, but rather carried-out the analysis using the respondent's self-reported user status.

5.0 Results

This section reviews unique data captured by the Barriers to Care survey. Based on methodology, results from this survey are generalizable to the greater woman Veteran population.

5.1 Response Rate

As described in the methodology, the Barriers to Care survey aimed to achieve 8,400 completes across 21 VISNs and, within each VISN, have an equal number of responses from users and non-users of VA health care in the past 24 months. The target was met for each stratum for a total of 8,532 completed surveys. We included responses above the 200 required for each stratum if respondents were already actively engaged in the survey process when that stratum hit its target responses.

In total 64,345 potential respondents were contacted for the survey. Of these respondents, 23,772 (36.9%) were ineligible to participate due primarily to non-working numbers or not passing the survey's eligibility criteria. Another 24,565 (38%) were deemed to be of unknown eligibility as the woman Veteran could not be reached via telephone because the phone was either not answered or the call was blocked – thus, it was not possible to determine if the woman Veteran herself had been reached. One-quarter of the sample, representing 16,058 cases, were deemed to be eligible respondents. Of these 16,508 eligible respondents, 53% (8,532 women Veterans) completed the survey; this is known as the cooperation rate.

Exhibit 1: Disposition Information

Disposition	Total Counts
Complete	8,532
Partial	1,771
Refusal	5,345
Other eligible	410
Unknown eligibility	24,565
Not eligible	23,722
Total sample	64,345

The simple response rate (SRR), also known as a 'raw' response rate, is the proportion of completes out of the total fielded sample. The SRR for this survey was 8,532 out of 64,345 or 13%. The adjusted response rate, as established by the Council of American Survey Research Organizations (CASRO), also takes into account cases of unknown eligibility in its calculation. Using the CASRO definition, which defines response rate as the proportion of completed interviews out of the number of eligible reporting units in the sample, the Barriers to Care survey yielded an adjusted response rate of 21% ((8,532/(8,532 + 1,771 + 5,345 + 410 + 24,565) = 8,532/40,623). A similar calculation is used to determine the CASRO refusal rate, which for this survey was 13% (5,345/40,623). The contact rate for this survey, which is the proportion of all cases in which some responsible household member was reached, is 40% ((8,532 + 1,771 + 5,345 + 410)/40,213) = 16,058/40,213). Exhibit 1 displays the detailed disposition information for this survey.

Additional analysis of the SRR using logistic regression showed that the likelihood of completing a survey increased with age of the respondent; and the Service Branch of the respondent was a significant predictor of the respondent's propensity to answer the survey, with women Veterans from the Air Force, Army and Coast Guard the most likely to respond and those from Navy the least likely to respond. Response rates also varied substantially by both VISN and user status. Users had higher response rates than non-users (data available upon request).

There is a 95% confidence that results are accurate within 1.1% of the true population results had a census been taken. Accuracy declines as smaller groups are analyzed, with margin of error increasing to +/- 4.9% by VISN, and +/- 6.9% by VISN and User Status. Results by question are generally more confident (lower variance) when responses are at the extreme ends (e.g., 90% or greater responding *yes*, 10% or less *no*) compared to when responses are more equally split (e.g., 50/50 *yes* vs. *no*).

5.2 User status of respondents

A key factor of the Barriers to Care survey was the identification of users and non-users of VA health care in order to ask women Veterans from both groups about potential barriers to care. User status was available through the sample data and was used in the sampling plan; however, survey questions and analysis are based on self-reported user status so that women could answer questions only about care which they remembered receiving. Exhibit 2 displays the comparison between women's user status, as recorded in the VA database USVETS, and self-reported user status.

Exhibit 2: Comparison of VA-reported user status (as assigned in USVETS database) to respondents' self-reported User status

VA-assigned User status from USVETS	Respondent indicated User	Respondent indicated Non-user
VA-assigned User	78%	22%
VA-assigned Non-user	5%	95%

Of those women who had a VA record of receipt of care in the past 24 months, 78% also self-reported receiving health care services at VA. However, 22% of VA identified users of VA health care did not report receiving care. In contrast, there was a higher level of agreement between the number of women who reported no receipt of care and had no record of VA care in the USVETS database: a 95% match. A few questions in the survey acted as an internal validation of user status, although survey respondent answers were not corrected during administration or changed for analysis. For example, survey respondents were also asked to report their last date of care at VA. Exhibit 3 displays the last self-reported date of care from VA by user status. In the exhibit, one can view some inconsistencies in respondents' answers about use of VA health care. For example 269 women reported a date of VA health care that falls within 24 months of the survey date, but who did not report that care in the previous question, thus going through the questionnaire as a non-user. Also, 144 respondents reported their most recent receipt of VA care more than 24 months ago, yet they indicated they received more recent care in the previous question and went through the questionnaire as a user. These inconsistencies were not corrected for in analysis as the key question 'have you received care at VA in the past 24 months' determined skip patterns for the remainder of the questionnaire. Rather, these inconsistencies are pointed out for consideration in the ensuing analysis of barriers to care by user status.

Exhibit 3: Self-reported most recent date of care at a VA site of care

Most recent visit to a VA site of care	User Population (N)	Users (wt%)	Users (95% CI)	Non-user Population (N)	Non-users (wt%)	Non-users (95% CI)
2014	198,590	56%	(54 - 58)	24,690	2%	(2 - 3)
2013	138,422	39%	(37 - 41)	22,804	2%	(2 - 3)
2010-2012	11,478	3%	(3 - 4)	53,803	5%	(5 - 6)
2000-2009	1,071	0%	(0 - 1)	124,477	12%	(11 - 13)
Before 2000	172	0%	(0 - 0)	125,004	12%	(11 - 13)
Never	3,565	1%	(1 - 2)	701,235	67%	(65 - 68)

** Unreliable estimates. Coefficient of variation is ≥ 0.30

Looking more closely at Exhibit 3, 67% of non-users indicated they had never used VA health care services, while 33% had some experience in the past, but no recent care at VA. Exhibit 4 displays the proportion of women indicating they have never used VA, non-users who reported never receiving VA health care, who also reported enrollment with VA or application for benefits. A total of 39% of women who have never used VA reported previously applying for benefits through VA (including non-health care benefits) and 6% reported current enrollment with VA, but who have not yet received health care treatment. The proportion of never users who have had no interaction with VA is the total number of non-users minus those reporting associations with VA (100% - 39% - 6%) or 55%. The experiences of non-users –those with past receipt of health care, current enrollment, or no association with VA –are also important for consideration of the ensuing data.

Exhibit 4: History of application or enrollment for benefits through VA or VHA for respondents reporting never having used VA care

Applied for benefits or currently enrolled with VHA	Never User Population (N)	Never Users (wt%)	Never Users (95% CI)
Ever applied for any benefits through VA	273,009	39%	(37 - 41)
Currently enrolled with VHA	41,574	6%	(5 - 7)

Lastly, when reviewing results by user status the reader must keep in mind that the percentages shown in this report are weighted, allowing the responses of the respondents of the Barriers to Care survey to represent expected responses of other women Veterans like themselves nation-wide. In the description of the response rate above, it was noted that current users of VA health care were more likely to respond to the survey than non-users. The weighting adjustment corrected for this increased likelihood to respond, and the weighted responses now reflect proportions of the user and non-user population if one were to extend these responses to represent all users and all non-users nation-wide. Exhibit 5 displays the unweighted distribution of users and non-users in the response dataset as well as the weighted population total estimates and corresponding percentages of users and non-users. Once weighting was taken into account, the response dataset had a higher proportion of non-users than users.

Exhibit 5: Unweighted versus weighted percentages of self-reported User status

Self-reported User status	Respondent N	Weighted, Population N	Weighted %
Users	3,887	355,632	24.3%
Non-users	4,616	1,106,755	75.7%

5.3 Respondent characteristics

Exhibits 6-8 display weighted demographics (i.e. estimated demographics of the total women Veteran population) overall and by user status. In some ways the women Veteran users and non-users of VA health care are similar in their characteristics. Overall, most users and non-users of VA health care tended to be between 25-54 years of age, White, and had completed some college course work. Otherwise, users and non-users had many significantly different characteristics. Differences discussed below are all significant at $p \leq 0.001$.

Looking more closely at age, users of VA health care tended to be older, with more respondents in each age bracket over 35 years of age compared to non-users. By Service era, more users were from the Pre-Vietnam era and OEF/OIF to Present era than were non-users. Related to health and fitness, more non-users reported *excellent* and *very good* health and mental health compared to users and in contrast more users reported *fair* and *poor* health and mental health. Also, more users reported combat experience compared to non-users, and more users had a disability rating.

Related to home life, users and non-users differed by marital status with more users being divorced and more non-users being married. Also, more non-users reported having dependent children under the age of 17 in the home. Financially, user and non-user populations tended to differ with more non-users being employed with higher reported incomes than users. Also, users and non-users had significant differences in types of health insurance or coverage with more users than non-users reporting Medicare health coverage. Related to health care coverage, significantly more users than non-users reported being uninsured for health care at some point in the past 24 months, and being homeless at some point in the past 24 months.

Exhibit 6: Respondent demographics, overall and by user status

Respondent demographics	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Age at time of interview ‡						
18-24	1%	(1 - 2)	1%	(0 - 1)	1%	(1 - 2)
25-34	19%	(18 - 20)	19%	(17 - 21)	19%	(18 - 21)
35-44	27%	(26 - 29)	22%	(20 - 24)	29%	(28 - 31)
45-54	27%	(26 - 28)	28%	(26 - 30)	27%	(25 - 28)
55-64	18%	(17 - 19)	20%	(19 - 22)	18%	(17 - 19)
65-74	5%	(4 - 5)	7%	(6 - 8)	4%	(3 - 5)
75-80+	2%	(2 - 3)	3%	(3 - 4)	2%	(2 - 3)
Race/Ethnicity						
American Indian or Alaskan Native	4%	(4 - 5)	5%	(4 - 6)	4%	(4 - 5)
Asian	2%	(1 - 2)	1%	(1 - 2)	2%	(2 - 3)
Black or African American ‡	23%	(22 - 24)	28%	(26 - 30)	21%	(20 - 23)
Native Hawaiian/Other Pacific Islander	1%	(1 - 1)	1%	(1 - 2)	1%	(1 - 1)
White or Caucasian ‡	71%	(70 - 72)	67%	(65 - 69)	72%	(71 - 74)
Other	5%	(4 - 5)	4%	(3 - 5)	5%	(4 - 6)
Hispanic, Latino or Spanish *	10%	(9 - 11)	9%	(8 - 10)	11%	(9 - 12)
Education						
Less than a High School Graduate or GED	**	**	**	**	**	**
High School Graduate or GED	8%	(7 - 8)	7%	(6 - 8)	8%	(7 - 8)
Trade/Vocational or Tech Training after High School	5%	(4 - 6)	5%	(4 - 6)	5%	(4 - 6)
Some college or an Associate's degree	42%	(41 - 44)	44%	(42 - 46)	42%	(40 - 44)
Bachelor's degree	27%	(26 - 29)	27%	(25 - 29)	28%	(26 - 29)
Graduate degree	18%	(17 - 19)	17%	(15 - 18)	18%	(17 - 19)
Marital status ‡						
Married/Living as married	53%	(51 - 54)	40%	(38 - 42)	57%	(55 - 59)

Respondent demographics	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Domestic partnership/civil union	3%	(3 - 4)	4%	(3 - 5)	3%	(3 - 4)
Divorced	22%	(21 - 23)	29%	(27 - 30)	20%	(19 - 21)
Separated	3%	(2 - 3)	4%	(3 - 5)	3%	(2 - 3)
Widowed	4%	(3 - 4)	5%	(4 - 6)	3%	(3 - 4)
Never married	15%	(14 - 16)	19%	(18 - 21)	14%	(13 - 15)
Self-Reported General Health Status ‡						
Excellent	13%	(12 - 14)	8%	(7 - 9)	15%	(14 - 16)
Very good	35%	(34 - 36)	26%	(24 - 28)	38%	(36 - 39)
Good	32%	(31 - 33)	35%	(33 - 37)	32%	(30 - 33)
Fair	16%	(15 - 17)	24%	(22 - 26)	13%	(12 - 14)
Poor	4%	(4 - 5)	8%	(7 - 9)	3%	(3 - 4)
Self-Reported Mental Health Status ‡						
Excellent	25%	(23 - 26)	18%	(16 - 19)	27%	(25 - 28)
Very good	35%	(34 - 36)	25%	(23 - 27)	38%	(36 - 40)
Good	26%	(24 - 27)	31%	(29 - 33)	24%	(22 - 25)
Fair	12%	(12 - 13)	21%	(19 - 23)	10%	(9 - 11)
Poor	3%	(2 - 3)	6%	(5 - 7)	2%	(1 - 2)

‡ $p \leq 0.001$ * $p \leq 0.05$ ** Unreliable estimates. Coefficient of variation is ≥ 0.30

Exhibit 7: Respondent demographics (continued), overall and by user status

Respondent demographics (continued)	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Employment status ‡						
Employed for wages or salary	59%	(58 - 61)	41%	(39 - 43)	65%	(64 - 67)
Self-employed	5%	(4 - 6)	5%	(4 - 5)	5%	(4 - 6)
Unable to work/disabled	7%	(7 - 8)	17%	(16 - 19)	4%	(4 - 5)
Unemployed and looking for work/recently laid off	6%	(5 - 7)	8%	(7 - 10)	5%	(5 - 6)
A full time homemaker	5%	(4 - 6)	4%	(3 - 5)	6%	(5 - 6)
A full time student	4%	(4 - 5)	7%	(6 - 8)	3%	(3 - 4)
Retired	10%	(10 - 11)	16%	(14 - 17)	9%	(8 - 10)
A full time caregiver to a child or adult parents	1%	(1 - 1)	1%	(1 - 2)	1%	(0 - 1)
A volunteer	1%	(1 - 1)	1%	(1 - 2)	1%	(0 - 1)
Other	1%	(1 - 2)	1%	(0 - 1)	1%	(1 - 2)
Have dependent children aged 17 or younger at home ‡						
Yes	40%	(39 - 42)	31%	(29 - 33)	43%	(42 - 45)
No	60%	(58 - 61)	69%	(67 - 71)	57%	(55 - 58)

Respondent demographics (continued)	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Uninsured for health care at any time in the last 24 months †						
Yes	18%	(16 - 19)	20%	(18 - 22)	17%	(15 - 18)
No	83%	(81 - 84)	80%	(78 - 82)	83%	(82 - 85)
Type of Health Insurance						
VA health coverage ‡	13%	(12 - 13)	49%	(47 - 51)	2%	(1 - 2)
Employer-based or private insurance ‡	57%	(56 - 59)	33%	(31 - 35)	65%	(63 - 66)
TRICARE	28%	(27 - 29)	26%	(24 - 28)	29%	(27 - 30)
MEDICAID	3%	(3 - 4)	3%	(2 - 4)	3%	(3 - 4)
MEDICARE ‡	11%	(10 - 11)	18%	(16 - 19)	9%	(8 - 9)
Other *	4%	(3 - 4)	3%	(2 - 4)	4%	(4 - 5)
Total Household Income ‡						
$10,000 or less	6%	(5 - 7)	9%	(8 - 11)	5%	(4 - 6)
$10,001 to $20,000	8%	(8 - 9)	15%	(14 - 17)	6%	(6 - 7)
$20,001 to $30,000	11%	(10 - 12)	18%	(16 - 19)	8%	(7 - 9)
$30,001 to $40,000	12%	(11 - 13)	16%	(14 - 17)	11%	(10 - 12)
$40,001 to $50,000	11%	(11 - 12)	11%	(10 - 13)	12%	(10 - 13)
$50,001 to $100,000	33%	(32 - 35)	23%	(21 - 25)	37%	(35 - 38)
Over $100,000	18%	(17 - 19)	8%	(7 - 10)	21%	(20 - 23)
Homeless at any time in the last 24 months ‡						
Yes	2%	(2 - 2)	4%	(3 - 5)	1%	(1 - 2)
No	98%	(98 - 98)	96%	(95 - 97)	99%	(98 - 99)

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

Exhibit 8: Respondent service-related demographics, overall and by user status

Respondent Service-related demographics	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Service era ‡						
Pre-Vietnam	2%	(2 - 3)	4%	(3 - 4)	2%	(2 - 2)
Vietnam - OEF/OIF	60%	(59 - 61)	55%	(53 - 57)	61%	(60 - 63)
OEF/OIF - Present	37%	(35 - 38)	40%	(38 - 42)	36%	(34 - 37)
Undetermined	1%	(1 - 1)	1%	(1 - 2)	1%	(1 - 1)
Branch of Service						
Army †	49%	(48 - 50)	52%	(50 - 54)	48%	(46 - 50)
Marine Corps *	6%	(5 - 7)	7%	(6 - 8)	6%	(5 - 6)
Navy	21%	(20 - 22)	20%	(19 - 22)	21%	(19 - 22)
Air Force ‡	25%	(24 - 26)	22%	(20 - 24)	26%	(24 - 27)
Coast Guard *	2%	(1 - 2)	1%	(1 - 2)	2%	(2 - 2)
Combat Experience ‡						
Yes	23%	(22 - 24)	33%	(31 - 35)	20%	(19 - 21)

Respondent Service-related demographics	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
No	77%	(76 - 78)	67%	(65 - 69)	80%	(79 - 81)
Grade at time of Exit from Military Service ‡						
Junior Enlisted	50%	(48 - 51)	46%	(44 - 48)	51%	(49 - 52)
Senior Enlisted	34%	(33 - 36)	42%	(40 - 44)	32%	(31 - 34)
Junior Officer	8%	(7 - 8)	6%	(5 - 7)	8%	(7 - 9)
Senior Officer	5%	(4 - 6)	4%	(3 - 5)	5%	(5 - 6)
Undetermined	3%	(3 - 4)	3%	(2 - 3)	4%	(3 - 4)
Disability Rating ‡						
None	74%	(73 - 75)	37%	(35 - 39)	85%	(84 - 86)
0%	1%	(1 - 1)	1%	(1 - 2)	1%	(0 - 1)
10%	5%	(4 - 5)	7%	(6 - 8)	4%	(3 - 5)
20%	3%	(2 - 3)	5%	(4 - 6)	2%	(2 - 3)
30%	4%	(3 - 4)	8%	(7 - 9)	2%	(2 - 3)
40%	3%	(2 - 3)	6%	(5 - 7)	2%	(1 - 2)
50%	2%	(2 - 2)	5%	(4 - 6)	1%	(1 - 1)
60%	2%	(2 - 3)	5%	(4 - 6)	1%	(1 - 2)
70%	2%	(2 - 3)	6%	(5 - 7)	1%	(1 - 1)
80%	2%	(2 - 2)	6%	(5 - 7)	1%	(0 - 1)
90%	1%	(1 - 1)	3%	(3 - 4)	0%	(0 - 0)
100%	3%	(3 - 3)	11%	(9 - 12)	1%	(0 - 1)

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

5.4 Type and location of health care services received by respondents

In addition to asking all respondents about their receipt of health care at a VA site of care in the past 24 months, the Barriers to Care survey also asked about receipt of care through non-VA (fee basis) care (paid for by VA but provided in the community). Exhibit 9 displays self-reported use of non-VA (fee-basis) care and other community care in the past 24 months by user status. Of all non-users, 77% reported receiving care completely outside the federal system (which we will refer to as non-federal care), and 1% reported receipt of non-VA (fee-basis) care, yet did not indicate receipt of care at a VA site of care. Of all users, 40% reported receiving non-VA (fee-basis) care through VA in addition to VA care, and 59% reported receiving other non-Federal care unaffiliated with VA. This suggests that about three out of every five women Veteran patients are receiving care in multiple locations, either due to a need or preference.

At various points in the survey users of VA health care were asked for details about the amount and type of health care received in the past 24 months. In contrast to the 59% of users who received some care outside the federal system and 40% of users who received some non-VA (fee-basis) care in Exhibit 9, the majority of users (66%) reported that they

received *All* or *Most* of their health care at a VA site of care in the past 24 months (Exhibit 10).

Exhibit 9: Self-reported use of health care services within or outside of VA in the past 24 months: by self-reported VA user status

Type of self-reported health care	Users (pop%)	Users (95% CI)	Non-Users (pop%)	Non-Users (95% CI)
Non-VA(Fee-Basis) care in past 24 months	40%	(38 - 42)	1%	(1 - 1)
Non-Federal care in past 24 months	59%	(57 - 61)	78%	(76 - 79)

Among all the types of health care services received at a VA site of care, the most frequently accessed type was *primary care*, with 85% self-reporting having received this type of care. Beyond that, types of care received (in descending order) are *routine women's health services (*typically preventive exams*)* (65%), *specialty care* (47%), *mental health care* (40%), *emergency department care* (30%), *gynecology referral services* (28%), *some other type of care not listed* (24%), *inpatient care* (15%), and *maternity care* (2%) (Exhibit 11).

Exhibit 10: VA Users Self-reported Amount of Care at a VA Site in the last 24 Months

Amount of health care received at a VA site of care in the last 24 months	Population N	Users (pop%)	Users (95% CI)
All	126,864	36%	(34 - 38)
Most	104,032	30%	(28 - 31)
Some	59,478	17%	(15 - 19)
Little	52,475	15%	(13 - 17)
None	8,834	3%	(2 - 4)

Exhibit 11: VA Users Self-Reported Care Type Received at or Paid for by VA

Self-reported care received at a VA site of care or paid for by VA	VA care (pop%)	VA care (95% CI)	Fee basis care (pop%)	Fee basis care (95% CI)
Primary care	85%	(84 - 87)	36%	(33 - 39)
Routine women's health services	65%	(63 - 67)	51%	(48 - 54)
Gynecology referral services	28%	(26 - 29)	17%	(15 - 19)
Maternity care	2%	(2 - 3)	7%	(5 - 9)
Inpatient care	15%	(14 - 17)	14%	(11 - 16)
Emergency department care	30%	(29 - 32)	22%	(19 - 24)
Mental health care services	40%	(38 - 42)	13%	(11 - 15)
Specialty care	47%	(45 - 49)	37%	(34 - 40)
Other	24%	(23 - 26)	13%	(11 - 15)

Note: color gradation shows high versus low proportions of self-reported care with high proportions in dark green and low proportions in light green

Self-reported use of non-VA (fee-basis) care (Exhibit 11) indicates that 51% accessed routine women's health services[22], followed by 37% accessing *specialty care*, 36% *primary care* , 22% *emergency department care* (22%), 17% *gynecology referrals* , 14% *inpatient care*, 13% *mental health care*, 13% *other types of care*, and 7% receiving *maternity care*. The data show that more maternity care is provided through VA's fee-basis services than at VA sites of care (7% compared with 2% respectively).

Very few women indicated that they received maternity care at a VA site of care (2%) or through non-VA (fee-basis) care (7%) (Exhibit 11). Of the women who did report receiving maternity care through non-VA (fee-basis) care, over half continued to receive post pregnancy care at VA (56%) (Exhibit 12).

Exhibit 12: Users Reports of VA Care Post Pregnancy

Received care at VA since pregnancy	Fee basis users (% of maternity care patients)	Fee basis users (95% CI)
Yes	56%	(42 - 69)
No	42%	(29 - 55)

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Vet Centers are part of a VA program, outside of the VHA system, that offers mental health services to Veterans. Of the users who reported receiving mental health care through the VHA, 48% also received care through a Vet Center. Of users who reported receiving mental health care on a VA fee-service basis, 51% reported also receiving care through a Vet Center (Exhibit 13).

Exhibit 13: Comparison of mental health care received at a Vet Center for users also receiving mental health care at a VHA site of care or through fee-basis care

Also received mental health care at a Vet Center	Receiving Mental Health care at VA (pop%)	Receiving Mental Health care at VA (95% CI)	Receiving Mental Health care non-VA (Fee basis) (pop%)	Receiving Mental Health care non-VA (Fee basis) (95% CI)
Yes	51%	(46 - 55)	48%	(44 - 53)
No	49%	(45 - 54)	52%	(47 - 56)

Today, a key feature of improved VA care for women Veterans is the availability of a dedicated Women Veterans Program Manager (WVPM) at each VA site of care. In the Barriers to Care survey, women were asked about their experiences with WVPMs. Ninety percent of users reported not utilizing the services of a Women's Veterans Program Manager (WVPM) at a VA facility. The 10% of women who did use a WVPM, however, were satisfied with the service. Sixty-nine percent of these women *strongly agreed* that the WVPM was helpful (Exhibit 14).

[22] This result of 51% in this category is questionable and may be the results of respondents misinterpreting what fee-basis routine women's health services consist of. In actuality, very few women receive routine women's health services on a fee-basis arrangement. It is possible that women included receipt of mammograms when answering this question.

Exhibit 14: Self-reported users' experience with a Women's Veterans Program Manager (WVPM)

WVPM experiences	Users (pop%)	Users (95% CI)
Worked with a WVPM at a VA facility		
Yes	10%	(9 - 12)
No	90%	(88 - 91)
Found the WVPM helpful with getting health care services		
Strongly agree	69%	(63 - 75)
Somewhat agree	16%	(12 - 20)
Neither agree nor disagree	**	**
Somewhat disagree	**	**
Strongly disagree	6%	(3 - 10)

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

5.5 Barriers to Care

The primary aim of the Barriers to Care survey is to respond to the Public Law and measure the effect that nine identified barriers to care have had on women Veterans' use of VA health care services. This section provides a detailed review of each of the barriers identified in the Public Law and measured through the survey. The survey also sought to assist VA in mitigating these barriers, thus some survey questions address opinions and attitudes about courses of action that VA might consider to eliminate or reduce the impact of a barrier.

5.5.1 Comprehension of Eligibility Requirements and Scope of Services

One of the most commonly recognized barriers to VA care for women Veterans is that many women don't even know whether or not they are eligible for care. Eligibility is based on a number of factors and for women Veterans without a service-connected disability, their eligibility status may change over time as their life circumstances change. Questions in the Barriers to Care survey sought to measure how well women Veterans know their eligibility status and how VA can help improve knowledge about eligibility and services.

Questions about comprehension of eligibility and scope of available services were asked as a series regarding: receipt of information, source of information, helpfulness of information, and having as much information as one would like.

---Barriers to Care Survey Questions related to this Section---

C1(A-D). Do you recall receiving information about ...

A. "the ELIGIBILITY REQUIREMENTS for VA health care services."
B. "the Health services at the VA that are AVAILABLE to you."
C. "the Health services at the VA that are available to WOMEN veterans specifically."

D. "HOW TO GET health care services at the VA."

1. YES
2. NO ---> QC4(A-D)

C2(A-D). Did you get this information from ... *(Select all that apply)*

1. Health provider,
2. Newspaper, magazine, or on television,
3. Friends, family, or another veteran,
4. Website or blog,
5. Talking to a VA representative, or
6. Brochure or other handout from the VA?
9. *None of* the *above (not read aloud)*

IF ONLY 1 OPTION SELECTED THEN GO TO QC4(A-D)
ONLY OPTIONS SELECTED IN QC2 WILL BE PRESENTED IN QC3

C3(A-D). Which of these sources of information was the MOST helpful to you in understanding your VA benefits?

C4(A-D). Do you have as much information as you would like about...

1. Yes, I have enough
2. No, I need a little more
3. No, I need a lot more

Overall Experience of Comprehension of Eligibility as a Barrier

Exhibit 15 displays the proportion of women who reported receiving information about VA eligibility requirements, health services at VA, and how to get health care services at VA (once enrolled). Overall, 74% - 78% of users reported receiving information on these three knowledge areas, while only 30% to 36% of non-users reported receiving information. Similarly, when asked if they had as much information as they would like about the three knowledge areas (Exhibit 16), 75% - 78% of users said *yes*, they had sufficient information on eligibility and scope of services. Interestingly, a higher proportion of non-users indicated that they had sufficient information about VA eligibility and scope of services (45% - 51%) compared to the proportion of non-users who reported actually receiving this information.

Experience of Comprehension of Eligibility as a Barrier by Service era and VISN

When viewed by Service era, women from the Vietnam to pre-OEF/OIF era are the group with the lowest proportion reporting having as much information as they would like about eligibility and scope of services (49% - 54%), compared with OEF/OIF to present era Veterans with 58% - 63% and Pre-Vietnam era Veterans with 68% - 73% (Exhibit 17). By VISN, more users than non-users report having as much information as they would like; this

trend is seen both across VISNs and within VISNs for each of the three knowledge areas (Exhibit 18).

Helpful Sources of Information

Women were asked about the source of information that was most helpful in understanding eligibility and scope of services. To this question users and non-users alike mostly reported *a brochure* as the most helpful source of information (39% of users and 49% of non-users), followed by *talking to a VA representative* (26% of users and 21% of non-users), and *family friends or another Veteran* (10% of both users and non-users). Fewer women, users and non-users alike, reported *websites or blogs* or a *health provider* as the most helpful source of information about eligibility and services (Exhibit 19). Similar trends in identifying the most helpful sources of information are found by Service era (Exhibit 20).

Exhibits 15 – 20 display percentages colored with green and yellow tones. Receipt and understanding of information is the goal of VA, therefore higher percentages are shown in green, and lower percentages in yellow.

Exhibit 15: Self-reported receipt of information about eligibility, health services available, and how to get health care at VA, overall and by user status

Type of information received	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Eligibility requirements for VA health care services ‡	46%	(45 - 48)	78%	(76 - 80)	36%	(34 - 38)
Health services at the VA that are available to me ‡	43%	(42 - 44)	79%	(77 - 81)	31%	(30 - 33)
How to get health care services at the VA ‡	41%	(40 - 42)	74%	(72 - 76)	30%	(29 - 32)

‡ p ≤ 0.001

Key Findings: more users than non-users report receiving information about VA eligibility and services.

Exhibit 16: Having enough information about eligibility, health services available, and how to get health care at VA, overall and by user status

Type of information	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Eligibility requirements for VA health care services ‡	58%	(56 - 59)	78%	(76 - 80)	51%	(49 - 52)
Health services at the VA that are available to me ‡	55%	(54 - 56)	75%	(73 - 77)	49%	(47 - 50)
How to get health care services at the VA ‡	53%	(52 - 54)	77%	(75 - 78)	45%	(44 - 47)

‡ p ≤ 0.001

Key findings: Most users of VA health care report they have sufficient information on VA eligibility and services. The proportion of non-users who have sufficient information is higher than the proportion of non-users who reported actually receiving information.

Exhibit 17: Having enough information about eligibility, health services available, and how to get health care at VA by service era

Type of information	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - Pre OEF/OIF (pop%)	Vietnam - Pre OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
Eligibility requirements for VA health care services ‡	73%	(64 - 80)	54%	(52 - 55)	63%	(61 - 65)
Health services at the VA that are available to me ‡	70%	(62 - 77)	51%	(49 - 52)	61%	(59 - 64)
How to get health care services at the VA ‡	68%	(60 - 75)	49%	(47 - 51)	58%	(56 - 61)

‡ p ≤ 0.001

Key Findings: more women from the Pre-Vietnam era report having enough information about VA eligibility and services than women from other Service eras.

Exhibit 18: Having enough information about eligibility, health services available, and how to get health care at VA by VISN

VISN	User eligibility ‡	Non-user eligibility †	User services available ‡	Non-user services available *	User how to get health care ‡	Non-users how to get health care ‡
VISN 01 ‡	91%	56%	87%	51%	89%	46%
VISN 02 ‡	79%	55%	77%	56%	78%	52%
VISN 03 ‡	72%	39%	73%	35%	73%	32%
VISN 04 ‡	78%	52%	80%	52%	86%	51%
VISN 05 ‡ * †	76%	57%	68%	54%	69%	51%
VISN 06 ‡ ‡ †	70%	47%	71%	45%	70%	39%
VISN 07 ‡	70%	46%	66%	45%	69%	39%
VISN 08 ‡	82%	42%	77%	42%	76%	38%
VISN 09 ‡	81%	49%	77%	49%	76%	46%
VISN 10 ‡	86%	53%	79%	48%	87%	50%
VISN 11 ‡	80%	47%	72%	45%	77%	43%
VISN 12 ‡	75%	42%	76%	40%	77%	40%
VISN 15 ‡	77%	52%	68%	46%	74%	41%
VISN 16 ‡	81%	50%	78%	49%	77%	43%
VISN 17 ‡	74%	54%	70%	50%	74%	48%
VISN 18 ‡	82%	54%	76%	56%	80%	52%
VISN 19 ‡	80%	54%	76%	51%	74%	50%
VISN 20 ‡	88%	55%	87%	51%	86%	51%
VISN 21 ‡	77%	54%	73%	53%	76%	46%
VISN 22 ‡	82%	56%	77%	50%	81%	50%
VISN 23 ‡	80%	59%	82%	55%	77%	54%

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

Key Findings: within each VISN there is a significant difference between the proportion of users and non-users reporting having enough information about VA eligibility and services. Across VISNs there are differences in the proportion of users and non-users (independently) who have enough information.

Exhibit 19: Most helpful source of information for VA eligibility overall and by user status

Source of information ‡	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
A health provider	5%	(4 - 6)	10%	(8 - 11)	2%	(1 - 2)
A newspaper magazine or television	1%	(0 - 1)	**	**	**	**
Friends, family, or another Veteran	10%	(9 - 11)	10%	(9 - 12)	10%	(8 - 12)
A website or blog	7%	(6 - 8)	6%	(5 - 8)	8%	(6 - 10)
Talking to a VA representative	23%	(21 - 24)	26%	(24 - 28)	21%	(19 - 23)
A brochure or other handout from the VA	45%	(43 - 47)	39%	(37 - 41)	49%	(46 - 52)
None of the above	10%	(9 - 11)	8%	(7 - 10)	11%	(9 - 13)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Key Findings: most women, user and non-user alike, report that a brochure or VA handout is the most helpful to understanding VA eligibility and benefits. Talking to a VA representative is the second most highly rated source of information.

Exhibit 20: Most helpful source of information for eligibility by service era

Source of information ‡	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - Pre OEF/OIF (pop%)	Vietnam - Pre OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
A health provider	7%	(4 - 10)	5%	(4 - 6)	4%	(3 - 5)
A newspaper magazine or television	**	(0 - 3)	1%	(0 - 1)	**	(0 - 1)
Friends, family, or another Veteran	12%	(8 - 18)	11%	(10 - 13)	9%	(7 - 11)
A website or blog	**	(0 - 2)	7%	(6 - 8)	8%	(6 - 10)
Talking to a VA representative	20%	(14 - 27)	21%	(19 - 23)	24%	(22 - 27)
A brochure or other handout from the VA	44%	(35 - 52)	45%	(42 - 47)	45%	(42 - 48)
None of the above	17%	(11 - 27)	10%	(8 - 11)	10%	(8 - 12)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Key Findings: most women, across Service eras, report that a brochure or VA handout is the most helpful to understanding VA eligibility and benefits. Talking to a VA representative is the second most highly rated source of information.

Women Veterans' Preferences: Modes of Communication

In an effort to gather information that would help VA improve outreach and communication with women Veterans about eligibility for health care services, women were asked about preferred methods for receiving from VA and when it would be most helpful to receive that information. Preferences for both users and non-users were highest for *mail* (47% overall), followed by *e-mail* (26% overall). At the user/non-user level, a higher percentage of users than non-users indicated a preference for receiving future information via *telephone* (33% of users vs. 17% of non-users) (Exhibit 21). When looking at preferred information delivery methods by Service era and disability level, the same trend is seen with the most preferred

methods being, in decreasing order, *mail*, *e-mail*, and *telephone*. The only group who did not support *e-mail* as a communication option was women from the pre-Vietnam Era (Exhibit 22). By disability level, the preferred method of telephone increased as disability level increased (Exhibit 23). While more 'modern' communication methods (social media, websites or blogs) and broadcast communication methods (newspapers, magazines or television) were offered as response options, few women selected those methods as a preferred mode of future communication from VA. This data presents some good options for effective future communication between VA and prospective enrollees.

Exhibit 21: Preferred method to receive information from VA, overall and by user status

Desired information source for more information on eligibility for VA health care ‡	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Telephone	21%	(20 - 22)	33%	(31 - 34)	17%	(16 - 19)
Mail	47%	(45 - 48)	41%	(39 - 43)	49%	(47 - 50)
E-mail	26%	(25 - 27)	22%	(20 - 24)	27%	(26 - 29)
Through a website or blog	3%	(3 - 4)	3%	(2 - 3)	3%	(3 - 4)
Newspapers, magazines, or on television	1%	(1 - 2)	1%	(1 - 1)	1%	(1 - 2)
Through social media	2%	(1 - 2)	1%	(1 - 2)	2%	(1 - 2)

‡ p ≤ 0.001

Key Findings: most women, users and non-users alike, would like to receive information by mail, followed by e-mail and telephone.

Exhibit 22: Preferred method to receive information from VA by service era

Desired information source for more information on eligibility for VA health care ‡	No disability (pop%)	No disability (95% CI)	0-30% (pop%)	0-30% (95% CI)	40-60% (pop%)	40-60% (95% CI)	70-100% (pop%)	70-100% (95% CI)
Telephone	19%	(18 - 20)	23%	(20 - 26)	25%	(22 - 29)	33%	(29 - 36)
Mail	48%	(46 - 50)	45%	(41 - 48)	47%	(42 - 51)	39%	(36 - 43)
E-mail	26%	(25 - 28)	28%	(24 - 31)	23%	(19 - 27)	23%	(19 - 26)
Through a website or blog	3%	(3 - 4)	2%	(1 - 3)	3%	(2 - 5)	3%	(2 - 5)
Newspapers, magazines, or on television	1%	(1 - 2)	**	**	**	**	1%	(1 - 2)
Through social media	2%	(1 - 2)	2%	(1 - 3)	1%	(0 - 2)	1%	(1 - 2)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Key Findings: most women, from all Service eras, would like to receive information by mail, followed by e-mail and telephone.

Exhibit 23: Preferred method to receive information from VA by disability level

Desired information source for more information on eligibility for VA health care ‡	No disability (pop%)	No disability (95% CI)	0-30% (pop%)	0-30% (95% CI)	40-60% (pop%)	40-60% (95% CI)	70-100% (pop%)	70-100% (95% CI)
Telephone	19%	(18 - 20)	23%	(20 - 26)	25%	(22 - 29)	33%	(29 - 36)
Mail	48%	(46 - 50)	45%	(41 - 48)	47%	(42 - 51)	39%	(36 - 43)
E-mail	26%	(25 - 28)	28%	(24 - 31)	23%	(19 - 27)	23%	(19 - 26)
Through a website or blog	3%	(3 - 4)	2%	(1 - 3)	3%	(2 - 5)	3%	(2 - 5)
Newspapers, magazines, or on television	1%	(1 - 2)	**	**	**	**	1%	(1 - 2)
Through social media	2%	(1 - 2)	2%	(1 - 3)	1%	(0 - 2)	1%	(1 - 2)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Key Findings: most women, at all disability levels, would like to receive information by mail, followed by e-mail and telephone. As disability rating increases, the preference for telephone communication increases.

Women Veterans' Preferences: Timing of Communication

Lastly, women provided input on their preferences for the timing of information delivery from VA. Overall, women reported a desire to receive information about VA eligibility and services prior to separation from the military (41%) and repeatedly after separation or post deployment (43%) (Exhibit 24). There were no significant differences in preferred time to receive information by user status, and the level of responses by Service era were not sufficient for analysis.

Exhibit 24: Preferred time to receive information from VA

When to provide information on eligibility for VA health care	Overall (pop%)	Overall (95% CI)
Prior to separation from the military	41%	(38 - 43)
Shortly after separation or post deployment (less than a year)	13%	(12 - 15)
One year after separation or post deployment	3%	(2 - 4)
Repeatedly on an annual basis after separation or post deployment	43%	(41 - 46)

Key Findings: overall women would like to receive information about VA eligibility and services prior to separation from the military and repeatedly (annually) after separation.

5.5.2 Effectiveness of outreach about women's health services

Related to receipt of information on *eligibility* is a separate barrier about women Veterans' *knowledge of the women's health services* that VA provides. In the same question group as comprehension of eligibility and services, women Veterans were also asked about their receipt of information about women's health services, the most helpful source of information

and whether they had as much information as they would like about women's services provided by VA. As mentioned in the background section, VA is engaging in a large outreach effort to try and educate women Veterans about services available to them through VA, especially related to women's health services. This section will seek to evaluate the effectiveness of outreach efforts to date.

---Barriers to Care Survey Questions related to this Section---

C1(A-D). Do you recall receiving information about ...

A. "the ELIGIBILITY REQUIREMENTS for VA health care services."
B. "the Health services at the VA that are AVAILABLE to you."
C. "the Health services at the VA that are available to WOMEN veterans specifically."
D. "HOW TO GET health care services at the VA."

1. YES
2. NO ---> QC4(A-D)

C2(A-D). Did you get this information from ... *(Select all that apply)*

1. Health provider,
2. Newspaper, magazine, or on television,
3. Friends, family, or another veteran,
4. Website or blog,
5. Talking to a VA representative, or
6. Brochure or other handout from the VA?
9. *None of* the *above (not read aloud)*

IF ONLY 1 OPTION SELECTED THEN GO TO QC4(A-D)
ONLY OPTIONS SELECTED IN QC2 WILL BE PRESENTED IN QC3

C3(A-D). Which of these sources of information was the MOST helpful to you in understanding your VA benefits?

C4(A-D). Do you have as much information as you would like about...

1. Yes, I have enough
2. No, I need a little more
3. No, I need a lot more

Overall Experience of Outreach Regarding Women's Services as a Barrier

Fewer women report having received information about women's health services specifically compared to the number of women reporting receipt of information about VA eligibility and

services in general. Overall, 67% of users and 21% of non-users reported receiving information about women's health services (Exhibit 25), compared with 74% - 78% of users and 30% to 36% of non-users who reported receiving information on the eligibility, services, and how to receive health care at VA (Exhibit 15).

Exhibit 25: Self-reported receipt of information about VA health services available for women specifically, overall and by user status

Type of information	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Health services at the VA that are available to women veterans specifically ‡	33%	(31 - 34)	67%	(65 - 69)	21%	(20 - 23)

‡ p ≤ 0.001

Experience of Outreach Regarding Women's Services as a Barrier by Demographics and VISN

By Service era, more pre-Vietnam era women have received information about women's health services than women from other eras (46%), followed by OEF/OIF to present Veterans (36%), and lastly Vietnam to OEF/OIF Veterans (30%) (Exhibit 26). Again, as seen with information about eligibility and services, more women report having as much information as they would like than the number of women who actually reported receiving information (68% for users and 42% for non-users) (Exhibit 27). Mirroring receipt of information about women's health services, the proportion of women reporting having enough information by Service era decreases in order of pre-Vietnam era, OEF/OIF-present era, and Vietnam - OEF/OIF era (Exhibit 28). Significant differences in having enough information on women's health services are seen across VISNs and within VISNs (Exhibit 29).

Exhibit 26: Self-reported receipt of information about VA health services available for women specifically by service era

Type of information	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - Pre OEF/OIF (pop%)	Vietnam - Pre OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
Health services at the VA that are available to women veterans specifically ‡	46%	(39 - 53)	30%	(29 - 31)	36%	(34 - 38)

‡ p ≤ 0.001

Exhibit 27: Having enough information about VA health services available for women specifically, overall and by user status

Type of information	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Health services at the VA that are available to women veterans specifically ‡	49%	(47 - 50)	68%	(66 - 70)	42%	(41 - 44)

‡ p ≤ 0.001

Exhibit 28: Having enough information about VA health services available for women specifically by service era

Type of information	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - OEF/OIF (pop%)	Vietnam - OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
Health services at the VA that are available to women veterans specifically ‡	65%	(57 - 72)	46%	(44 - 47)	53%	(50 - 55)

‡ p ≤ 0.001

Exhibit 29: Having enough information about VA health services available for women specifically by VISN

VISN	User have information on VA women's services ‡	Non-user has information on VA women's services
VISN 01 ‡	80%	43%
VISN 02 ‡	78%	49%
VISN 03 ‡	62%	31%
VISN 04 ‡	76%	45%
VISN 05 †	63%	47%
VISN 06 ‡	61%	39%
VISN 07 ‡	57%	39%
VISN 08 ‡	74%	36%
VISN 09 ‡	73%	44%
VISN 10 ‡	72%	45%
VISN 11 ‡	60%	40%
VISN 12 ‡	70%	40%
VISN 15 ‡	70%	40%
VISN 16 ‡	68%	41%
VISN 17 *	56%	45%
VISN 18 ‡	71%	44%
VISN 19 ‡	68%	45%
VISN 20 ‡	83%	45%
VISN 21 ‡	69%	46%
VISN 22 ‡	69%	45%
VISN 23 ‡	69%	52%

‡ p ≤ 0.001 * p ≤ 0.05

Helpful Sources of Information

The most helpful sources of information about women's health services at VA were *a brochure* (49% overall), *talking to a VA representative* (19% overall) and, for users, *a health provider* (26%) (Exhibit 30). The same trends in most helpful information source are seen by Service era (Exhibit 31).

Exhibit 30: Most helpful source of information for VA health services available for women specifically overall and by user status

Source of information ‡	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
A health provider	15%	(14 - 16)	26%	(24 - 28)	4%	(3 - 5)
A newspaper magazine or television	1%	(0 - 1)	**	**	**	**
Friends, family, or another Veteran	6%	(4 - 7)	3%	(2 - 4)	8%	(6 - 10)
A website or blog	5%	(4 - 7)	4%	(3 - 5)	7%	(5 - 9)
Talking to a VA representative	19%	(17 - 20)	21%	(19 - 24)	16%	(13 - 18)
A brochure or other handout from the VA	49%	(47 - 51)	42%	(39 - 44)	56%	(53 - 60)
None of the above	6%	(5 - 7)	4%	(3 - 5)	8%	(7 - 10)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 31: Most helpful source of information for VA health services available for women specifically by service area

Source of information ‡	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - Pre OEF/OIF (pop%)	Vietnam - Pre OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
A health provider	11%	(7 - 15)	15%	(13 - 17)	15%	(13 - 17)
A newspaper magazine or television	**	**	**	**	**	**
Friends, family, or another Veteran	6%	(2 - 12)	5%	(4 - 7)	6%	(4 - 8)
A website or blog	0%	NA	4%	(3 - 6)	7%	(5 - 10)
Talking to a VA representative	19%	(13 - 27)	16%	(14 - 18)	22%	(19 - 25)
A brochure or other handout from the VA	52%	(43 - 61)	51%	(48 - 54)	46%	(42 - 49)
None of the above	**	**	7%	(6 - 9)	4%	(3 - 6)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Sources of Information that Predict Having Sufficient Information About Women's Health Services

A logistic regression model was created to further assess the effectiveness of outreach about women's health services. The logistic regression model predicted whether women Veterans had enough information about VA health services available to women Veterans specifically, using the most helpful source of information as a predictor and controlling for demographic variables. This model did not assess VA user status, which is the outcome used for other logistic regressions in this report. The reference group was if a website was the most helpful source of information. Veterans who had spoken with a VA representative were more likely to say they had enough information about women's services from VA than

those who had the most help from a website (Wald[23] = 8.0, *p* = 0.005, odds ratio = 0.5). Veterans who had spoken to friends, family, or other Veterans were *less* likely to say they had enough information than those who had the most help from a website (Wald = 5.3, *p* = 0.02, odds ratio = 2.2), although causality cannot be established; a lack of information may lead Veterans to speak to friends and family. Talking to a provider was marginally more likely to be associated with having enough information (Wald = 3.0, *p* = 0.08, odds ratio = 0.7). The other sources were not associated at all, though this may be in part from a low frequency of occurrence.

Exhibit 32: Effect of most helpful source of information on having enough information about VA Women's Services

Most Helpful Source of Information:	Odds Ratio	Wald Statistic	p–value	More/less likely to have enough info than reference
Information Reference Group: Website	N/A	19.84	0.0059	Significant Variable Effect
Source: VA Representative	0.52	8.04	0.0046	More likely
Source: Friends/Family/Other Veterans	2.19	5.26	0.0218	Less likely
Source: Health Provider	0.71	2.97	0.0851	Marginally more likely
Source: Brochure or Handout from VA	0.8	2.12	0.1453	No effect
Source: None	1.95	0.58	0.4464	No effect
Source: Newspaper/Magazine/Television	0.96	0.02	0.8938	No effect

5.5.3 Effect of driving distance on access to care

Another known barrier to care outlined in the Public Law is the effect that driving distance has on access to VA health care. In the Barriers to Care survey both users and non-users of VA health care were asked about their typical drive time to their Primary Care site, as well as other details about drive time and transportation, to determine the level at which women Veterans are experiencing this barrier today. Drive time to Primary Care was measured on a scale from 1 to 5 where 1 was 'less than 15 minutes' and 5 was 'more than an hour'.

---Barriers to Care Survey Questions related to this Section---

E3. Thinking about where you usually go for primary care, how long does it typically take you to get there?

1. Less than 15 minutes

[23] A Wald Chi Square is a measure of a variable's effect size in a logistic regression, similar to a t or F-score in a linear regression. The larger the Wald statistic, the more that predictor variable has a relationship with the outcome variable. A small Wald and low p-value indicate little or no relationship between the two variables. If a Wald score is significant (a p-value under .05), the odds ratio provides the direction of the relationship.

2. 15-29 minutes
3. 30-44 minutes
4. 45-60 minutes
5. More than one hour

IF QB9 <> YES THEN GO TO QE7

E4. Is the VA site of care nearest you where you normally get your primary care?

1. YES --> QE6
2. NO

IF QE4 = YES OR QE4 = DK THEN GO TO QE6; IF QE4 = REF THEN GO TO QE7

E5. We are interested in why you do not receive primary care services at your nearest VA site of care. Please select the answer that BEST describes why you do not get VA care at the VA site of care nearest you. Is it because...

1. The women's services I need are not available,
2. The hours I want are not available,
3. I do not feel the providers are good,
4. I am unable to choose whether my provider is a man or woman, or
5. Some other reason? (specify)

E6. This question asks about transportation for you to get to your VA SITE OF CARE. Would you say that finding transportation to your medical care is...

1. Very easy,
2. Somewhat easy,
3. Neither easy, nor hard,
4. Somewhat hard, or
5. Very hard?

E7. This question asks about transportation for your medical care to a NON-VA health care site of care. Would you say that finding transportation to your medical care is...

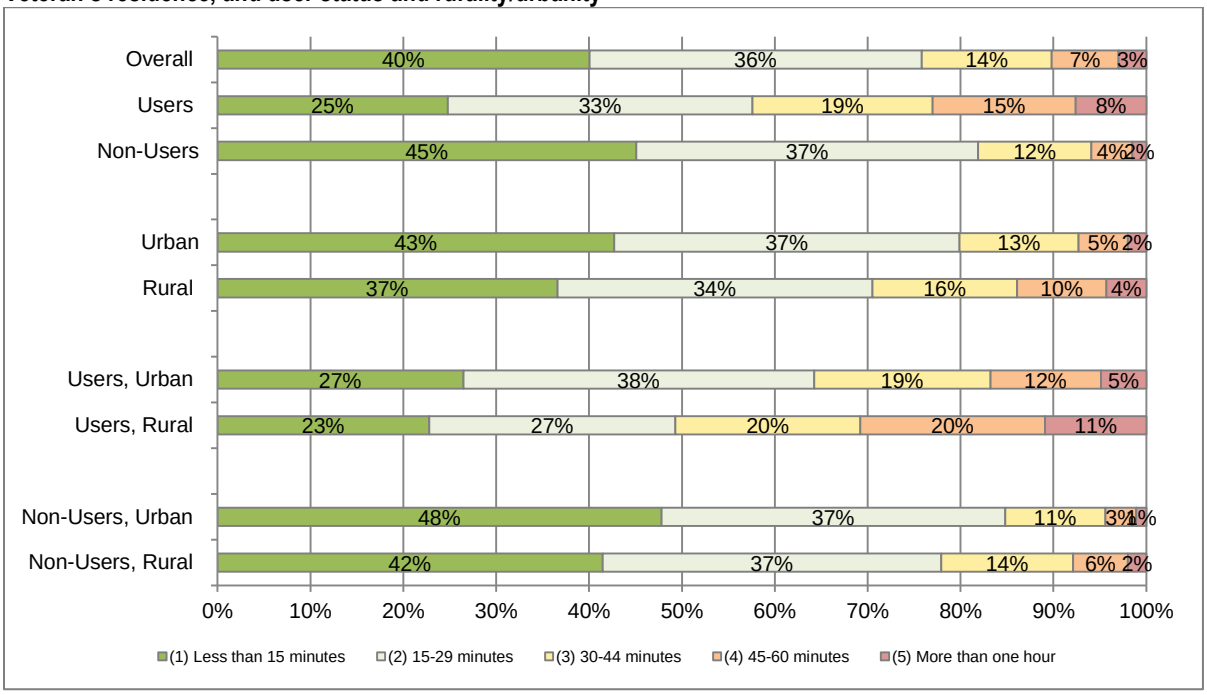
1. Very easy,
2. Somewhat easy,
3. Neither easy, nor hard,
4. Somewhat hard, or
5. Very hard?

Overall Experience of Driving Distance as a Barrier

A total of 82% of non-users and 58% of users reported a typical drive time of *less than 15 minutes* to *15-29 minutes* to their Primary Care, which may be at a VA or non-VA location.

Differences between users and non-users were smaller when urban versus rural locations of the women Veterans were accounted for. Among users and non-users, more women Veterans living in urban locations reported easier drive times than those in rural locations. Exhibit 33 shows reported drive time in colored bars going from green to yellow to red. Since less drive time is favorable, the color-scheme goes from green (shortest) to red (longest).

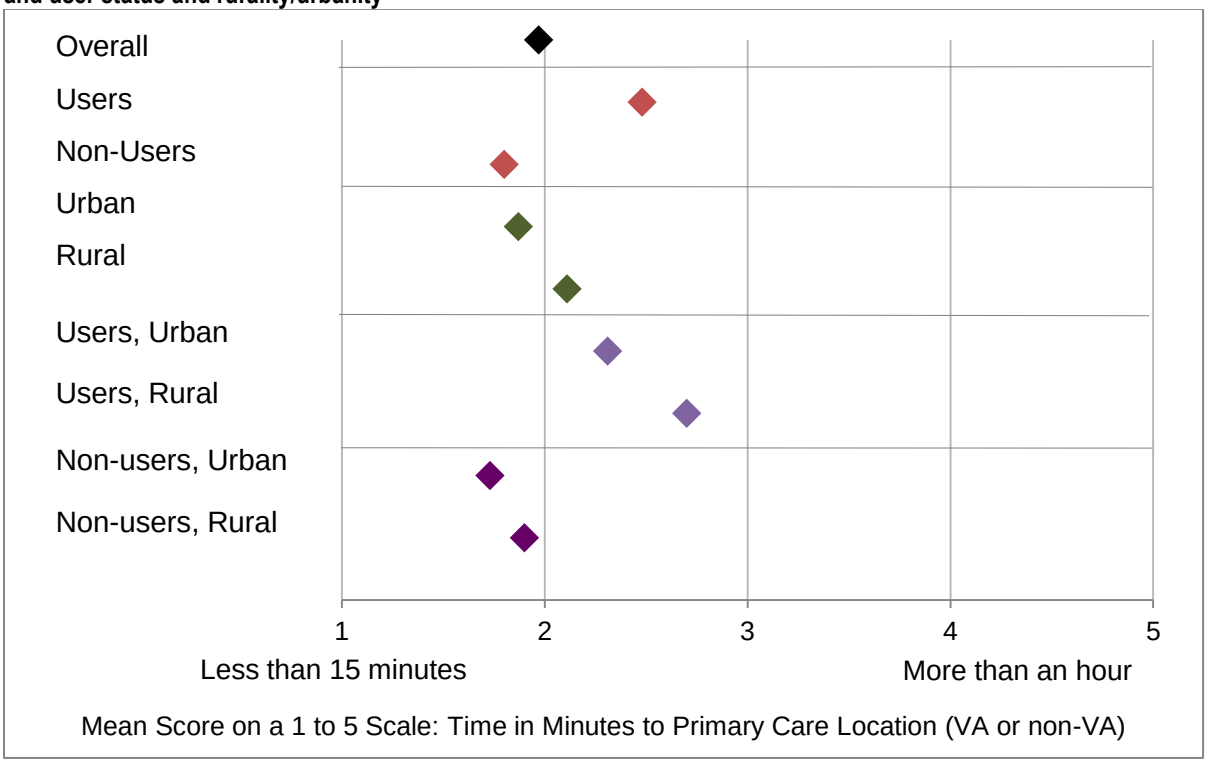
Exhibit 33: Typical drive time in minutes to Primary Care, overall and by user status, rurality/urbanity of the Veteran's residence, and user status and rurality/urbanity



Reading this chart: Since less drive time is favorable, the color-scheme goes from green (shortest commute time) to red (longest commute time).
Key Findings: More non-users of VA health care report shorter drive times than users.

The acceptability or definition of 'short' versus 'long' drive times can be subjective. Therefore, to not limit the scope of the analysis, the mean drive time for women Veterans was also reviewed. Exhibit 34 shows the mean drive time score for several comparison groups noted with unique paired color indicators. On average, users and non-users of VA health care report a typical drive time of less than 30-44 minutes to their Primary Care location with users reporting a longer drive time to Primary care than non-users and women living in rural areas reporting longer drive times than women living in urban areas.

Exhibit 34: The mean drive to Primary Care, overall and by user status, rurality/urbanity of the Veteran's residence, and user status and rurality/urbanity



Reading this chart: Comparison groups have the same colored markers.
Key Findings: Overall, users report longer drive times to Primary Care than non-users; women living in rural areas report longer drive times to Primary Care than women living in urban areas.

5.5.3.1 Users of VA health care and transportation to VA sites of care

Overall Experience of Transportation to VA Care as a Barrier

For users of VA health care, 83% report that finding transportation to their VA appointments is *somewhat easy* or *very easy* (Exhibit 35). On the same rating scale, 84% of users reported that finding transportation to appointments at a non-VA (fee basis) site of care was *somewhat easy* or *very easy*. The mean scores indicate the same findings, although differences for users between ease of getting to VA and non-VA sites of care are statistically significant -- with users reporting having an easier time getting to their non-VA sites of care.[24] Mean score for ease of getting to VA sites of care is 1.63; while mean score for ease of getting to non-VA sites of care is 1.57 (95% CI 0.03 – 0.1).

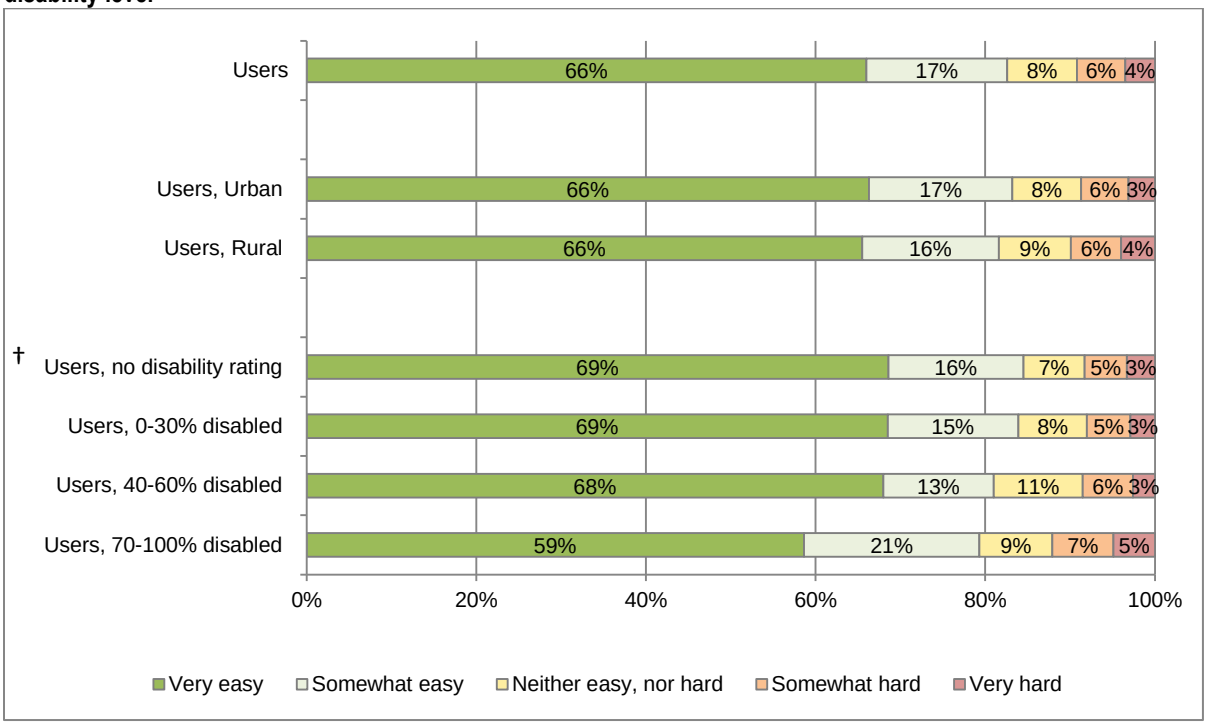
Experience of Transportation to VA Care as a Barrier by Location and Disability Level

Among users, there were significant differences in the difficulty of finding transportation to VA care by disability rating. A total of 12% of Women with a 70-100% disability rating indicated it was *somewhat* or *very hard* to find transportation to care, compared to 8-9% reported by women with lower disability ratings. There were no significant differences by

[24] Only 36% of users report receiving ALL their care through the VA, therefore most users access care both within and outside the VA system.

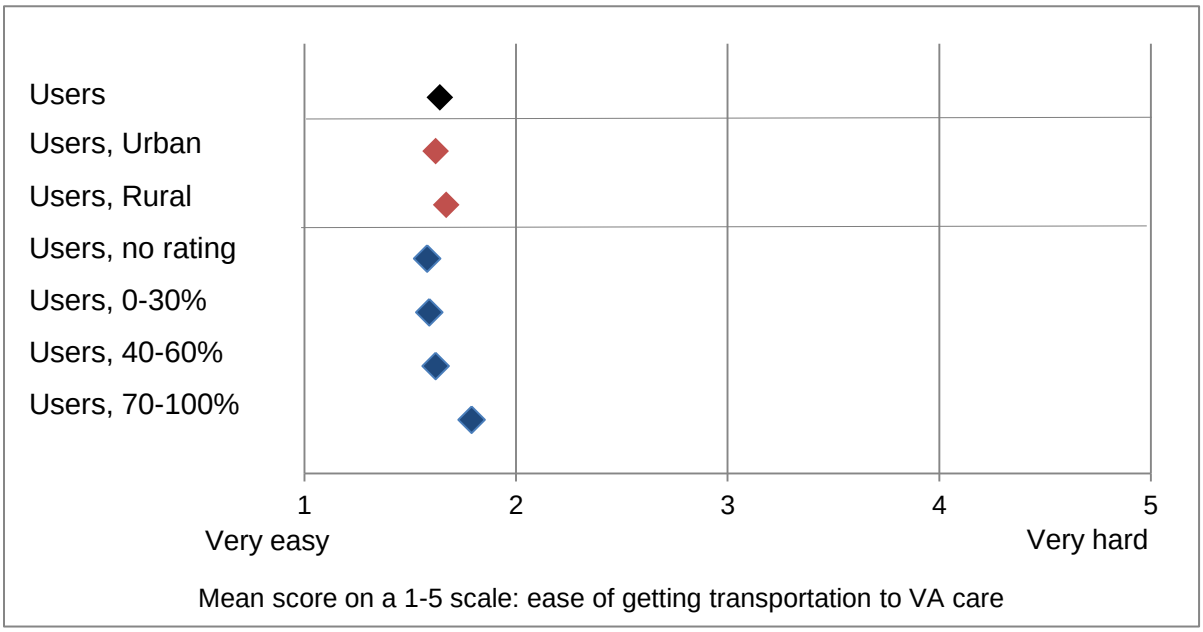
urbanity/rurality of the Veteran's residence (Exhibit 35) and no significant differences by VISN. Looking at the mean score, the same trend appears: the more disabled the woman, the more difficulty she has in finding transportation to VA care (Exhibit 36).

Exhibit 35: Users' ease of finding transportation to VA care, by rurality/urbanity of the respondent's residence and disability level



† $p \leq 0.01$

Exhibit 36: Mean score for Users' ease of finding transportation to VA care by rurality/urbanity of the Veteran's residence and disability level



Additionally, a linear regression model was used to predict the amount of VA care used (ranging from "None" to "All" on a five point scale) using ease of transportation to VA (from "Very Easy" to "Very Hard" on a five point scale) as a predictor, while also controlling for demographic variables. This model was a good fit, explaining 20% of the variance in frequency of use (Model F=22.1, r^2adj = .20). Ease of transportation to VA was a moderate strength significant predictor (Estimate coefficient= 0.06, F = 7.8, p = 0.0052), with those finding transportation to VA easiest using VA more frequently.

Users' Preferred Modes of Transportation to VA Care

In order to assist VA in researching possible ways to reduce barriers to care based on transportation, users of VA health care were asked what their preferred mode of transportation to care is. Overall, users indicated a preference for driving themselves (80%), followed by having a family member or friend drive them (14%). There were no significant differences between the transportation preferences of women Veterans living in rural versus urban locations (Exhibit 37).

Exhibit 37: Users' preferred mode of transportation to VA care

Mode of transportation preferred to get to a VA site of care	Users (pop%)	Users (95% CI)	Users, Urban (pop%)	Users, Urban (95% CI)	Users, Rural (pop%)	Users, Rural (95% CI)
Drive yourself	80%	(79 - 82)	79%	(77 - 81)	82%	(80 - 84)
Have a family member, friend, or significant other drive you	14%	(13 - 16)	13%	(11 - 15)	15%	(13 - 17)
Take public transportation	2%	(2 - 3)	4%	(3 - 5)	1% †	(0 - 1)
Use shuttle services	2%	(2 - 2)	2%	(2 - 3)	2%	(1 - 2)
Other	1%	(1 - 2)	1%	(1 - 2)	1%	(1 - 1)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

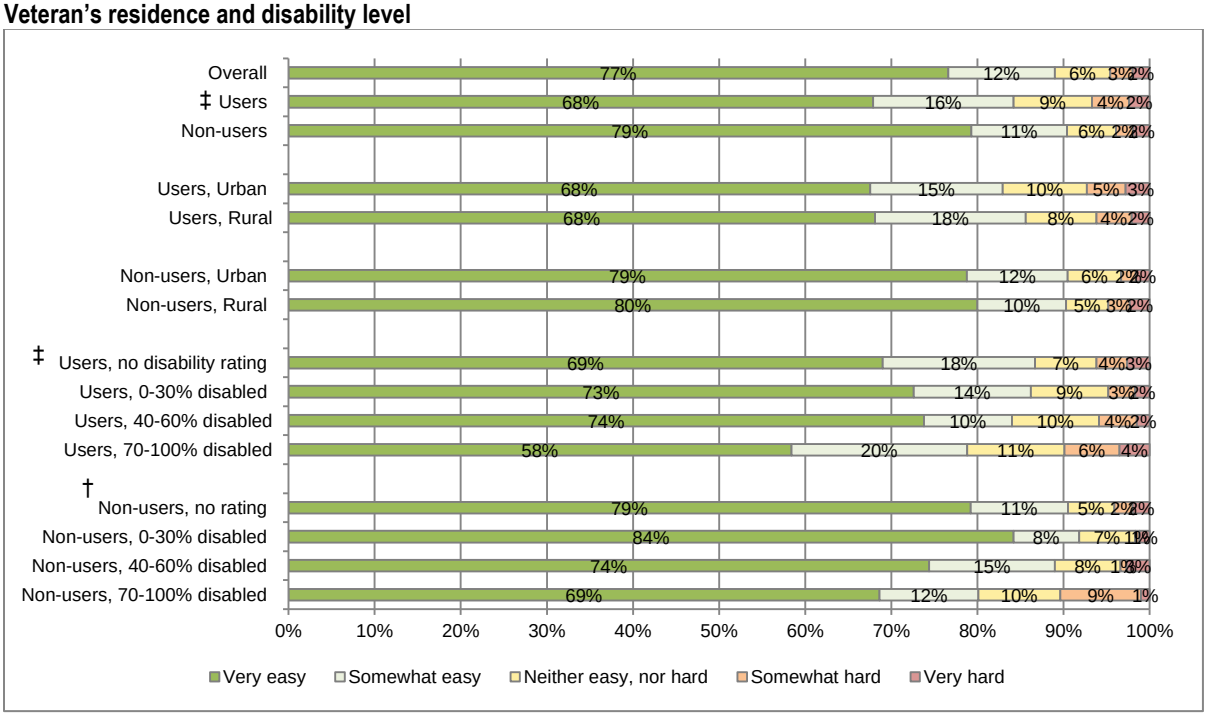
5.5.3.2 Users and Non-users of VA health care and transportation to non-Federal sites of care

Overall Experience of Transportation to Non-Federal Sites of Care as a Barrier

Both users and non-users of VA health care were asked to rate the level of difficulty finding transportation to a non-federal site of care. In Exhibit 38, significant differences can be seen by user status and within the user and non-user groups by disability. Similar to drive time discussed above, non-users reported less difficulty finding transportation to care than users (90% easy or somewhat easy for non-users, versus 84% for users) and across user status those with more severe disabilities reported more difficulty finding transportation.

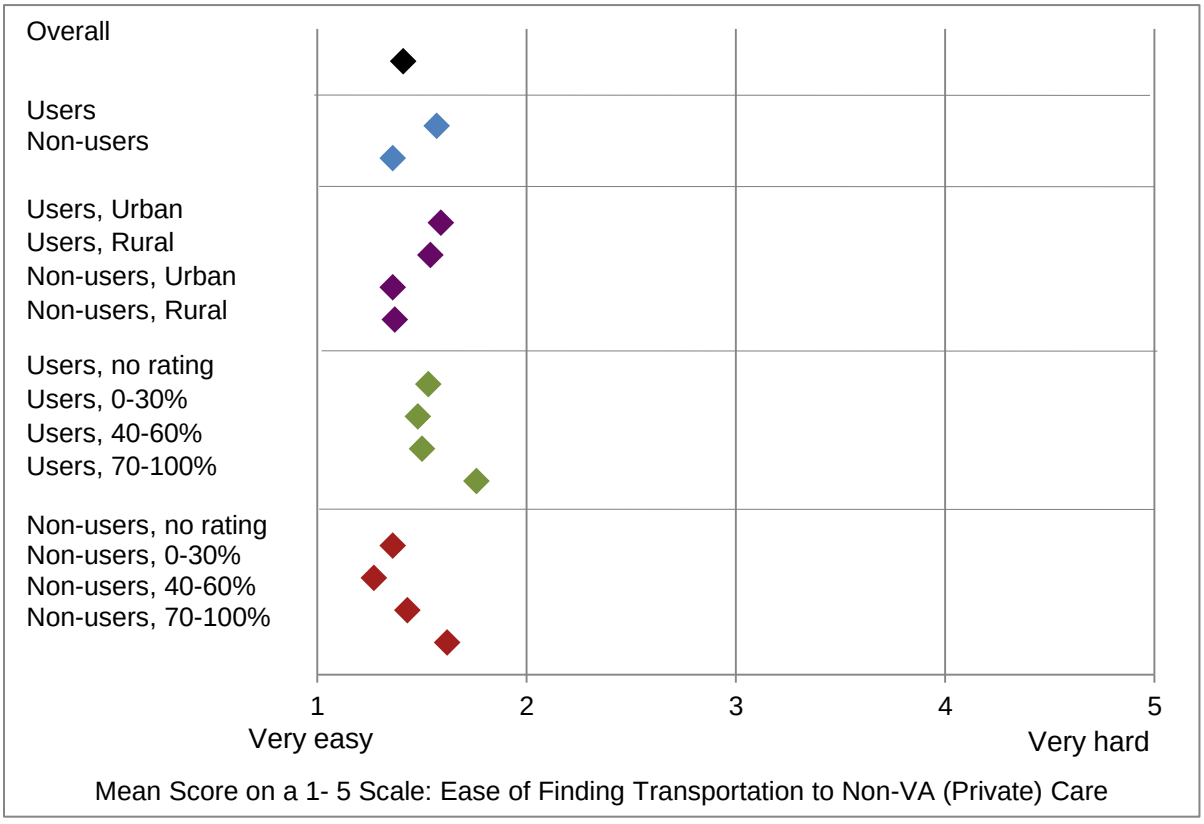
Looking at the mean score for level of difficulty finding transportation, the same trend appears where non-users have an easier time finding transportation to care than users, and the higher the disability rating, the more difficult it is to find transportation to care (Exhibit 39).

Exhibit 38: Users and non-users' ease of finding transportation to non-Federal care, by rurality/urbanity of the Veteran's residence and disability level



‡ $p \leq 0.001$

Exhibit 39: Mean score for users and non-users' ease of finding transportation to non-Federal care by rurality/urbanity of the Veteran's residence and disability level



Experience of Transportation to Non-Federal Sites of Care as a Barrier by VISN

There are also significant differences in mean score for ease of finding transportation for care by VISN and user status and VISN and urbanity/rurality of the Veteran's residence (Exhibits 40 and 41). The tables use color shading, green for easy to yellow for difficult, in order to view which VISNs have more or less difficulty compared to each other and between user/non-user and urban/rural.

Exhibit 40: Mean score for Users and Non-users' ease of finding transportation to non-Federal care by VISN

VISN	User mean *	Non-user mean ‡
VISN 01	1.39	1.39
VISN 02 ‡	1.68	1.30
VISN 03	1.77	1.60
VISN 04	1.51	1.36
VISN 05 ‡	1.88	1.39
VISN 06	1.53	1.42
VISN 07 ‡	1.64	1.35
VISN 08 *	1.58	1.39
VISN 09 *	1.64	1.41
VISN 10	1.47	1.39
VISN 11 ‡	1.65	1.31
VISN 12 †	1.47	1.26
VISN 15	1.63	1.27
VISN 16	1.57	1.48
VISN 17 †	1.54	1.27
VISN 18	1.58	1.37
VISN 19 ‡	1.57	1.21
VISN 20	1.46	1.35
VISN 21	1.50	1.46
VISN 22 *	1.60	1.36
VISN 23 ‡	1.47	1.19

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

Reading the table: Mean scores are shaded from dark green to light yellow. Scores closer to 1 (very easy to find transportation) is preferable and colored in dark green. Scores closer to 5 (very hard to find transportation) are colored in light green to yellow. Key Findings: Some users have a harder time finding transportation than other users looking across all VISNs. Within VISNs some users have a harder time finding transportation to care than non-users. In some VISNs there is no difference between transportation to care and user status.

A logistic regression model was built to predict VA user status using ease of transportation to non-VA sites of care as a predictor, while also controlling for demographic variables. This model was a poor fit, and transportation needs were not significantly associated with VA user status (Wald = 1.4, $p = 0.24$, odds ratio = 0.954). Transportation to non-VA sites of care had no effect on VA user status.

Exhibit 41: Mean score for Urban and Rural ease of finding transportation to non-Federal care by VISN

VISN	Urban mean ‡	Rural mean *
VISN 01	1.30	1.53
VISN 02	1.43	1.37
VISN 03	1.63	1.71
VISN 04	1.46	1.30
VISN 05	1.49	1.38
VISN 06	1.39	1.53
VISN 07	1.49	1.36
VISN 08	1.44	1.45
VISN 09 *	1.34	1.59
VISN 10	1.43	1.35
VISN 11	1.41	1.32
VISN 12	1.34	1.25
VISN 15	1.27	1.41
VISN 16	1.50	1.51
VISN 17	1.36	1.29
VISN 18	1.36	1.50
VISN 19	1.27	1.28
VISN 20	1.31	1.43
VISN 21	1.52	1.40
VISN 22	1.41	1.41
VISN 23	1.18	1.31

$p \leq 0.001$ * $p \leq 0.05$

Reading the table: Mean scores are shaded from dark green to light yellow. Scores closer to 1 (very easy to find transportation) is preferable and colored in dark green. Scores closer to 5 (very hard to find transportation) are colored in light green to yellow. Key Findings: Some users have a harder time finding transportation than other users looking across all VISNs. Within VISNs some users have a harder time finding transportation to care than non-users. In some VISNs there is no difference between transportation to care and user status.

5.5.4 Location and hours

Location and hours, together, constitute another barrier identified for evaluation in the Public Law. In developing the Barriers to Care survey, VA officials stated that if the user travels beyond her nearest VA facility to receive health care at a more distant facility this is an indication of a possible access or service issue. All women Veterans were asked about preferred appointment times, while users of VA health care were also asked about their experiences with appointing.

---Barriers to Care Survey Questions related to this Section---

E3. Thinking about where you usually go for primary care, how long does it typically take you to get there?

1. Less than 15 minutes
2. 15-29 minutes
3. 30-44 minutes
4. 45-60 minutes
5. More than one hour

IF QB9 <> YES THEN GO *TO QE7*

E4. Is the VA site of care nearest you where you normally get your primary care?

1. YES --> QE6
2. NO

IF QE4 = YES OR QE4 = DK THEN GO TO QE6; IF QE4 = REF THEN GO TO QE7

E5. We are **interested in why you do not receive primary care services at your nearest VA site of care. Please select the answer that BEST describes why you do not get VA care at the VA site of care nearest you. Is it because...**

1. The women's services I need are not available,
2. The hours I want are not available,
3. I do not feel the providers are good,
4. I am unable to choose whether my provider is a man or woman, or
5. Some other reason? (specify)

……...

E18. In GENERAL, does your VA site of care have appointment times that are convenient for you to get care?

1. YES
2. NO

E19. We are interested in what appointment times are MOST convenient for you to receive health care. In GENERAL, which of the following appointment times do you prefer? Would you say...

1. Mornings,
2. Afternoons,
3. Evenings, or
4. Weekends?

……...

CK.INTRO.QE14

IF QE9A <> YES AND QE9B <> YES AND QE9D <> YES AND QE9G <> YES THEN GO TO QE18.

INTRO.QE14

This next set of questions will ask about your experiences getting or attempting to get appointments for the [primary care/women-specific health care/maternity care/mental health care] that you received at a VA site of care.

ASK ONLY THE ITEMS ANSWERED YES TO IN QE9

E(14-17). [First.../How about...] [how would you rate your experience in the past 24 MONTHS getting an appointment as soon as you thought you needed it for.../(your experience in the past 24 MONTHS getting an appointment as soon as you thought you needed it for...)])

14. "Primary care"
15. "Routine women's services"
16. "Maternity care“
17. "Mental health care"

(IWER: IF NECESARRY, PROBE: "Using a scale from 1 to 5, where 1 is poor and 5 is outstanding.")

1	2	3	4	5
POOR				OUTSTANDING

Overall Experience of Location as a Barrier

Of the users who usually receive their Primary Care at VA sites of care, 10% reported *not* using their nearest VA for Primary Care. There were no significant differences by VISN.

Women who reported bypassing their nearest VA site of care were then asked follow-up questions to ascertain why they travel further for care. This survey question was original to the Barriers to Care survey and a response option list was not supported by the literature. Thus VA researchers included an 'other-specify' response option to capture any and all responses to this question. Exhibit 42 displays the proportion of responses chosen by users of VA health care. The most commonly chosen response option was the *other-specify* (67%) in which case the interviewer recorded their response in a few words; otherwise, the most common reasons for bypassing the nearest VA were *the women's services I need are not available* (16%), and *I do not feel the providers are good* (12%). The most common, researcher coded other-specify responses included *I am happy with my outside provider* (22% of other), *the services I need are not available* (21% of other), *the nearest VA is too far away* (11% of other), and *difficulty getting an appointment* (10% of other) (Exhibit 43).

Exhibit 42: Reasons why users of Primary Care at VA do not use their nearest site of care for Primary Care

Why Users of VA health care do not use their nearest VA for primary care	Users (pop%)	Users (95% CI)
The women's services I need are not available	16%	(11 -23)
The hours I want are not available	3%	(1 - 6)
I do not feel the providers are good	12%	(8 - 17)
I am unable to choose whether my provider is a man or a woman	2%	(1 - 4)
Other	67%	(60 - 74)

Exhibit 43: Other-specify responses to why users of VA health care do not use their nearest site of care for Primary Care

Most common other-specify response to: Why Users of VA health care do not use their nearest VA for primary care	Users (% of other)	Users (95% CI)
Other (many different responses)	25%	(17 - 35)
I am happy with my outside provider	22%	(16 - 30)
The services I need are not available	21%	(14 - 30)
The nearest VA is too far away or difficult to travel to	11%	(7 - 17)
Difficulty getting an appointment	10%	(6 - 18)
Repeat of closed-ended response	8%	(4 - 15)
I am not eligible for VA care beyond my service related disability	3%	(1 - 10)

Key findings: of the 10% of users who reported bypassing their nearest VA, 67% indicated some other reason why. These open-text responses were coded by researchers and are listed here.

Overall Experience of Hours as a Barrier

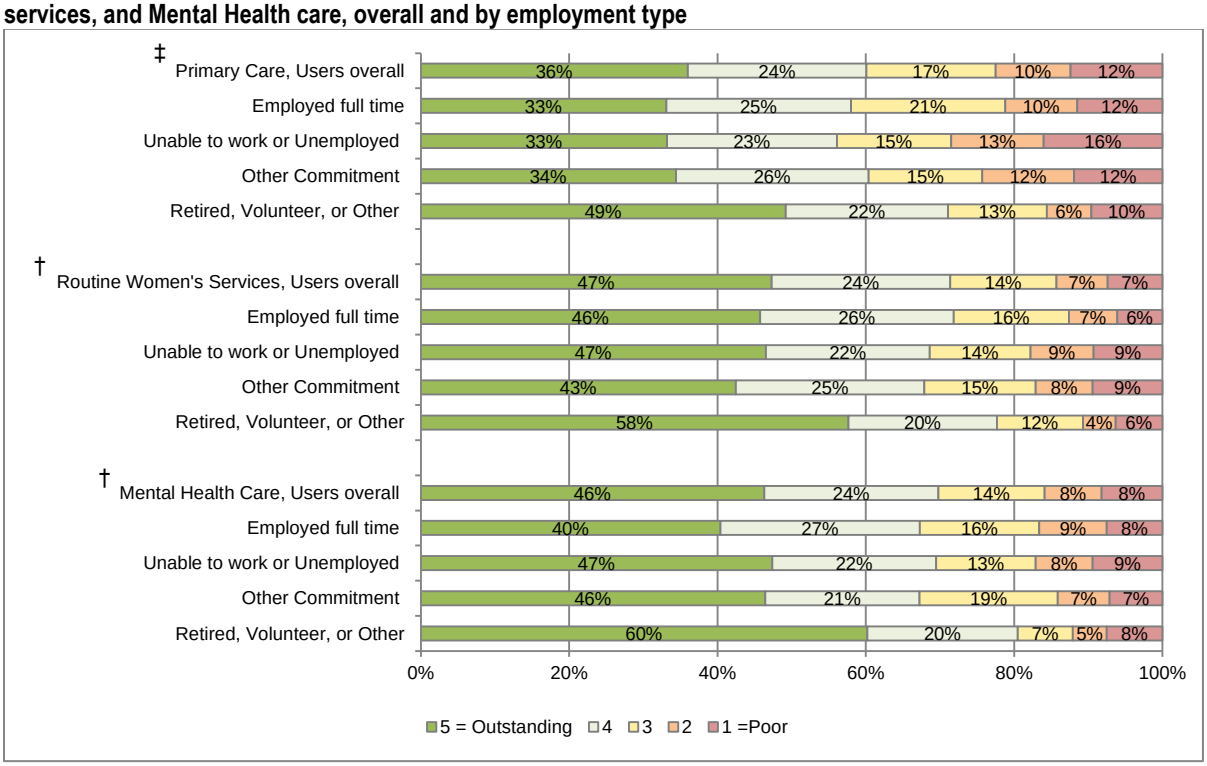
In another section in the survey, users were asked to rate their experience getting appointments for four types of care received, if applicable. These care types included *Primary care*, *routine women's services*, *maternity care*, and *mental health care*. There were not enough users reporting having received *maternity care* (65 survey responses) to support any in-depth analysis.

On a five point scale where 1 is *poor* and 5 is *outstanding,* users of VA health care rated their experience getting an appointment as soon as they thought they needed it. Overall 60% of women rated their experience a 4 or 5 for *Primary Care*, 71% rated a 4 or 5 for *routine women's services*, and 70% rated a 4 or 5 for *mental health care* appointments.

Experience of Hours as a Barrier by Demographics

Significant differences were found when reviewing satisfaction scores for getting an appointment as soon as needed by employment type: a grouped variable created by researchers out of the many employment types listed in the survey. In Exhibit 44 the scale of experiences getting an appointment by care type and employment group are shown with 5 (outstanding) in green going to 1 (poor) in red. In each of these care types, women in the employment group *unable to work or unemployed* and *other commitments* reported less satisfaction with getting an appointment as soon as needed compared to other groups when looking at the proportion who rated their experience a 1 (*poor*). The employment group *other commitment* included women who reported their employment as a full-time homemaker, a full-time student, or a full-time care giver to a child or adult parents.

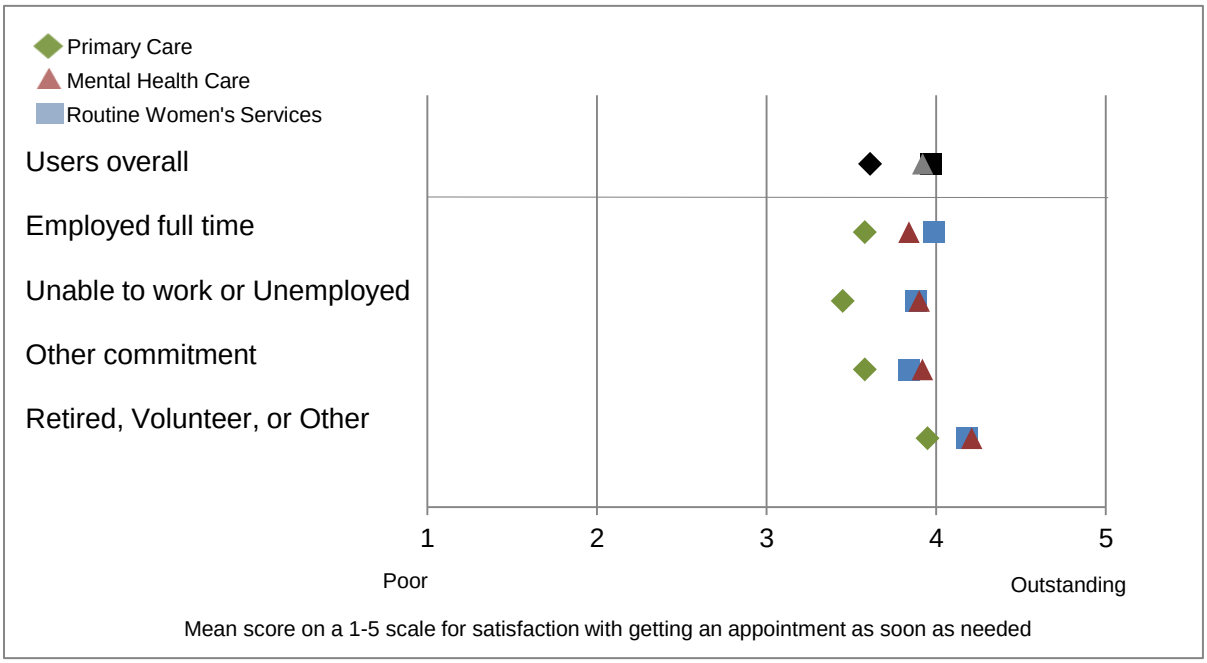
Exhibit 44: Users' experience getting an appointment as soon as needed for Primary Care, Routine women's services, and Mental Health care, overall and by employment type



‡ $p \leq 0.001$ † $p \leq 0.01$

Looking at all scores for satisfaction with *getting an appointment as soon as needed*, Exhibit 45 displays mean scores for the three types of care by employment type. Plotted together, mean scores for satisfaction with getting an appointment at VA fall between 3 and 4 on a 5 point scale, where 5 is *outstanding*; however, mean scores for satisfaction in getting an appointment for Primary Care are lower (closer to 3) than scores for other care types. Users reported almost equal satisfaction with getting an appointment for routine women's health services and mental health care. The group reporting the least satisfaction is women who are *unable to work or unemployed* in their ratings of getting an appointment for Primary Care.

Exhibit 45: Mean score for users' experience getting an appointment as soon as needed for Primary Care, Routine women's services, and Mental Health care, overall and by employment type



Women Veterans' Opinion about Convenient Appointment Times at VA

Users and non-users alike were asked if they thought their VA site of care has appointment times that are convenient for them (yes or no). Based on the last date of VA care reported by women, we know that some non-users have used VA in the past, whether long ago or more recently, while others have never used VA health care. To analyze this question never -users were separated from previous users. Overall, 80% of women indicated that *yes* VA does have appointment times that are convenient, with users reporting slightly more agreement (82%) (Exhibit 46). Current non-users who used VA in the past reported the lowest percent agreement (76%).

Exhibit 46: In general does your VA site of care have appointment times that are convenient, by user status

Respondent characteristic	Unweighted N	Yes (wt%)	Yes (95% CI)
Overall	5,983	80%	(78 - 81)
User type †			
User	3,782	82%	(80 - 83)
Current non-user, previous user	1,121	76%	(73 - 79)
Never user	1,053	80%	(77 - 82)

† $p \leq 0.01$

For users, a linear regression model predicted the amount of VA care used (from "None" to "All" on a five point scale) using *convenience of appointments at the VA* (Yes/No) as a predictor, while also controlling for demographic variables. This model was a good fit, explaining 19% of the variance in frequency of use (Model F= 43.9, r2adj = .19). Convenience of appointments at VA was a strong predictor of frequency of VA usage

(Estimate coefficient= .22, F = 12.8, p = 0.0004). Women reporting agreement that VA has convenient appointment times use VA care more frequently.

Women Veterans' Preferences for Appointment Times

To assist VA with evaluating preferred hours of care and potentially overcoming convenience of appointment times as a barrier, women were asked their opinion on what general times they preferred for appointments: mornings, afternoons, evenings, or weekends. Women Veterans across all user and employment statuses, indicated a preference for morning appointment times (Exhibit 47). More women who are employed full-time indicated a preference for evening or weekend appointments (14% of users and 16% of non-users who are employed full-time versus 1-9% or less for other employment categories by user status).

Exhibit 47: Most convenient appointment times for health care, by user status, employment type, and user status and employment type

Respondent characteristic	Mornings (pop%)	Mornings (95% CI)	Afternoons (pop%)	Afternoons (95% CI)	Evenings (pop%)	Evenings (95% CI)	Weekends (pop%)	Weekends (95% CI)
Overall	54%	(52 - 55)	25%	(24 - 26)	12%	(11 - 13)	10%	(9 - 11)
User type overall ‡								
User	57%	(55 - 59)	28%	(27 - 30)	8%	(7 - 10)	7%	(6 - 8)
Non-user	52%	(51 - 54)	24%	(22 - 25)	13%	(12 - 14)	11%	(10 - 12)
Employment type overall ‡								
Overall, Full time	49%	(48 - 51)	22%	(20 - 23)	16%	(15 - 17)	13%	(12 - 14)
Overall, Unable/Unemployed	54%	(51 - 58)	35%	(32 - 38)	5%	(4 - 7)	5%	(4 - 7)
Overall, Other Commitment	63%	(59 - 67)	23%	(20 - 27)	6%	(4 - 8)	8%	(6 - 11)
Overall, Retired/Volunteer/Other	66%	(63 - 69)	30%	(27 - 34)	2%	(1 - 4)	1% †	(1 - 2)
Employment type for Non-users ‡								
Non-user, full time	49%	(47 - 51)	22%	(20 - 23)	16%	(15 - 18)	14%	(12 - 15)
Non-user, Unable/Unemployed	53%	(48 - 58)	34%	(30 - 39)	6%	(4 - 9)	7%	(4 - 10)
Non-user, Other Commitment	65%	(59 - 70)	21%	(17 - 26)	6%	(4 - 9)	9%	(6 - 13)
Overall, Retired/Volunteer/Other	67%	(62 - 71)	30%	(25 - 34)	3%	(1 - 5)	1%	(1 - 3)
Employment type for Users ‡								
User, full time	53%	(50 - 57)	22%	(20 - 25)	14%	(12 - 16)	10%	(8 - 12)
User, Unable/Unemployed	56%	(52 - 60)	36%	(32 - 40)	4%	(3 - 6)	4%	(3 - 6)
User, Other Commitment	59%	(53 - 65)	30%	(24 - 36)	4%	(2 - 8)	7%	(4 - 10)
Overall, Retired/Volunteer/Other	66%	(61 - 70)	31%	(27 - 35)	2%	(1 - 4)	1%	(0 - 3)

‡ $p \leq 0.001$

5.5.5 Child care

Women often assume the role as primary caretaker of dependent children. This fact, along with the common statistic that women Veterans are more likely to be divorced than non-Veterans[25], means that finding child care to attend a health care appointment could be a significant barrier to care for women Veterans. Per the Public Law the Barriers to Care survey also sought to evaluate this potential barrier.

---Barriers to Care Survey Questions related to this Section---

E20. Do you have dependent children living with you aged 17 or younger?

1. YES
2. NO ---> QE23

E21. The next question asks about finding childcare while you receive medical care. When you have an appointment for your health care would you say that finding childcare is...

1. Very easy,
2. Somewhat easy,
3. Neither easy nor hard,
4. Somewhat hard,
5. Very hard, or
6. I do not need child care? --> QE23

E22. How helpful would on-site childcare be for you? Would you say...

1. Very helpful,
2. Somewhat helpful, or
3. Not helpful?

Stated previously in the demographics section, overall 40% of women indicted having a dependent child in the home. Exhibit 48 displays the proportion of women with dependent children by other demographic data. There are significant differences between user and non-user caretakers by age group and marital status. The majority of users and non-users with children are aged 35-44; however, more non-users in the age group 35-44 have children than users of the same age bracket (48% non-users vs. 41% users) whereas users aged 45+ have more children than non-users of the same age bracket (25% users vs. 21% non-users). Also, among married women, more non-users have children than do users (72% non-users vs. 56% users).

[25] Women Veteran Profile. 2013. National Center for Veterans Analysis and Statistics. http://www.va.gov/vetdata/Veteran_Population.asp

Exhibit 48: Users and Non-users with dependent children, by rurality/urbanity of the Veteran's residence, age group, and marital status

Dependent children by respondent demographics	Overall (wt%)	Overall (95% CI)	Users (wt%)	Users (95% CI)	Non-users (wt%)	Non-users (95% CI)
Age at time of Interview *						
18-34	31%	(29 - 34)	34%	(30 - 38)	31%	(28 - 33)
35-44	47%	(44 - 49)	41%	(37 - 45)	48%	(45 - 51)
45+	22%	(20 - 24)	25%	(22 - 28)	21%	(19 - 23)
Marital Status ‡						
Married or living as married	69%	(67 - 71)	56%	(52 - 60)	72%	(70 - 75)
Not married	31%	(29 - 33)	44%	(40 - 48)	28%	(25 - 30)

‡ $p \leq 0.001$ * $p \leq 0.05$

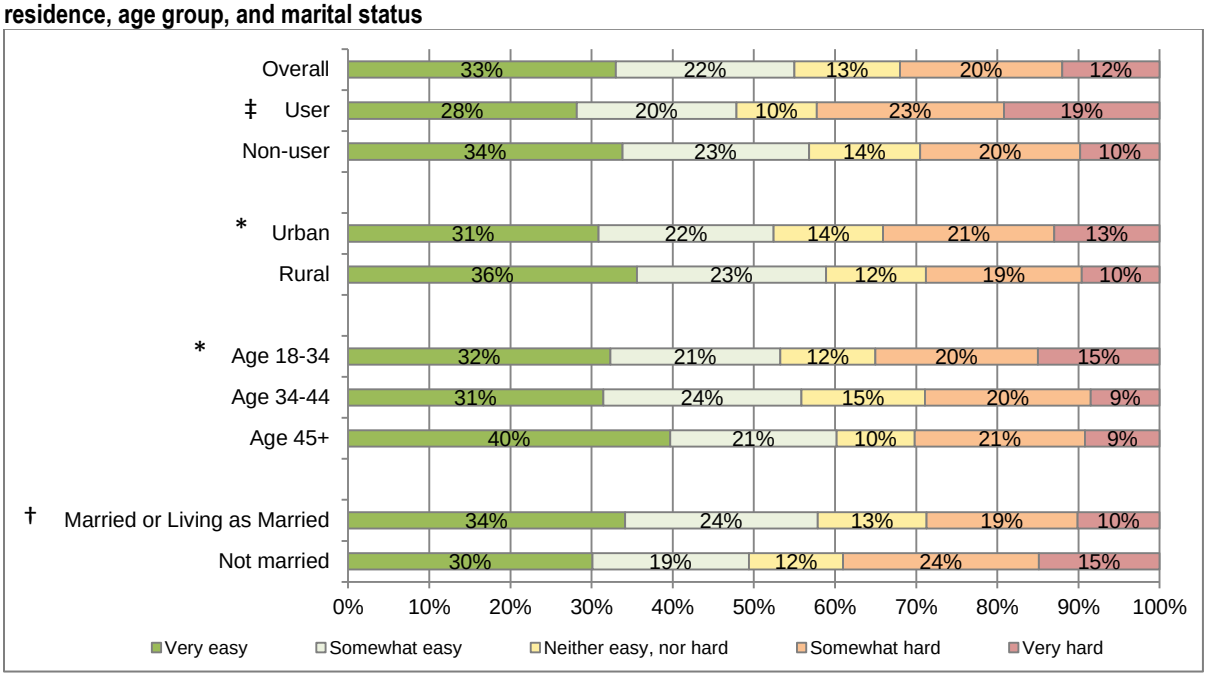
Overall Experience of Child Care as a Barrier

Women who indicated they have a dependent child under the age of 17 at home were asked about the ease of finding child care while attending medical appointments (on a scale from 1 to 5 where 1 is *very easy* and 5 is *very hard*). Exhibit 49 displays the scores for ease of finding child care by several demographics, colored from green (very easy) to red (very hard). Overall, 55% of women reported it was *somewhat* or *very easy* to find childcare for medical appointments. Looking at mean scores (Exhibit 50), on average users and non-users report finding child care is between *somewhat easy* and *neither easy nor hard* (mean scores between 2 and 3), and users report finding child care more difficult than non-users.

Experience of Child Care as a Barrier by Demographics and VISN

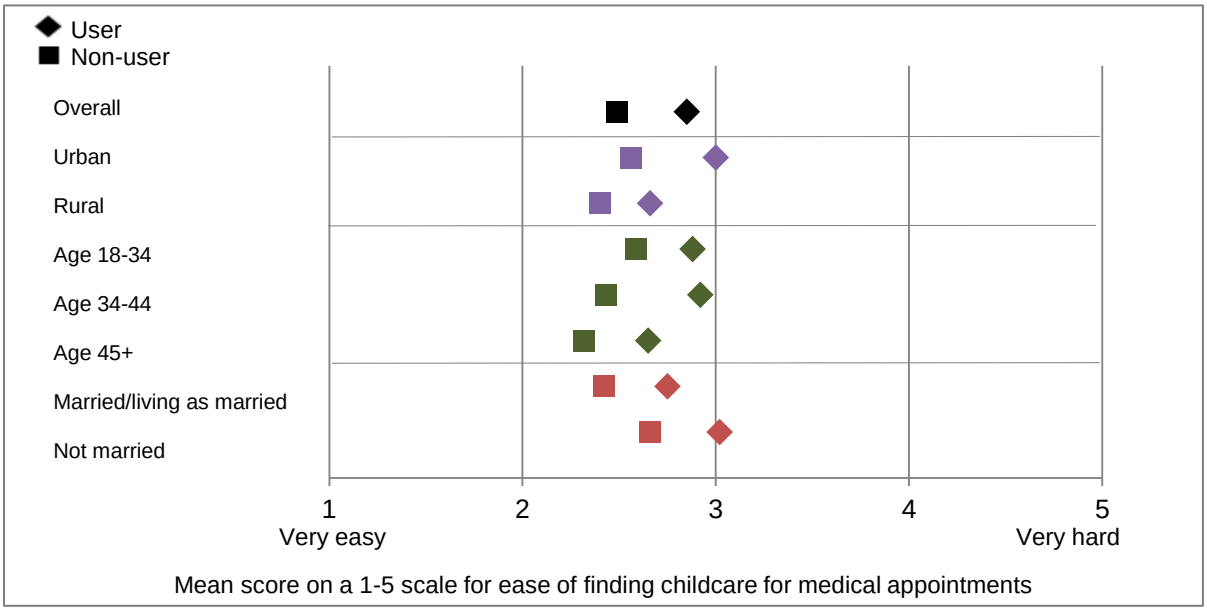
Looking at all scores for finding child care via the mean (Exhibit 51), Veterans having more difficulty finding child care are younger, not married, and living in urban areas.

Exhibit 49: Ease of finding child care for medical appointments, by user status, rurality/urbanity of the Veteran's residence, age group, and marital status



‡ p ≤ 0.001 † p ≤ 0.01 * p ≤ 0.05

Exhibit 50: Mean score for ease of finding child care for medical appointments , by user status, rurality/urbanity of the Veteran's residence, age group, and marital status



There are also significant differences in the means for ease of finding child care across VISNs and within some VISNs by user status and rurality/urbanity of the Veteran's residence (Exhibits 51 and 52).

Exhibit 51: Childcare as a barrier to receiving VA healthcare by user status and VISN

VISN	User mean ‡	Non-user mean
VISN 01	2.74	2.42
VISN 02	2.29	3.10
VISN 03	2.51	2.67
VISN 04	2.43	2.29
VISN 05	2.52	2.16
VISN 06	3.12	2.44
VISN 07	2.73	2.44
VISN 08 ‡	3.98	2.82
VISN 09	2.57	2.17
VISN 10	2.59	2.34
VISN 11	3.14	2.60
VISN 12 *	3.19	2.42
VISN 15 ‡	3.50	2.30
VISN 16	2.17	2.50
VISN 17 *	3.13	2.33
VISN 18	2.85	2.43
VISN 19	2.97	2.73
VISN 20	3.20	2.60
VISN 21	3.34	2.74
VISN 22	2.76	2.72
VISN 23	2.23	2.35

‡ $p \leq 0.001$ * $p \leq 0.05$

Exhibit 52: Childcare as a barrier to receiving VA healthcare by urban/rural and VISN

VISN	Urban mean *	Rural mean
VISN 01	2.27	2.92
VISN 02 ‡	3.55	2.43
VISN 03	2.61	2.96
VISN 04	2.44	2.09
VISN 05	2.16	2.20
VISN 06	2.54	2.63
VISN 07	2.68	2.32
VISN 08	3.07	2.93
VISN 09 *	2.69	1.90
VISN 10	2.58	2.06
VISN 11	2.71	2.60
VISN 12	2.77	2.28
VISN 15	2.23	2.55
VISN 16	2.41	2.42
VISN 17	2.43	2.55
VISN 18	2.38	2.67
VISN 19	3.20	2.43
VISN 20	2.80	2.63

VISN	Urban mean *	Rural mean
VISN 21	3.14	2.60
VISN 22	2.74	2.71
VISN 23 *	2.77	1.99

‡ p ≤ 0.001 * p ≤ 0.05

Women Who Report No Need for Child Care during Medical Appointments

While finding child care could be a barrier to receiving health care, that assumes that women actually need care for their dependent children. Exhibit 53 displays the proportion of women who indicated they do not need child care, by demographic. Here, the only demographic with statistical differences is age group. Within this group, the necessity for child care decreased as age decreased. A possible explanation for this trend is the age of the dependent children. Women aged 45+ likely have older children compared to women aged 18-34, and those older children might either be in school or do not need supervision while the woman is away receiving medical care.

Exhibit 53: I do not need child care

I do not need child care by demographics	pop%	95% CI
Overall	44%	(42 - 46)
User status		
User	44%	(41 - 46)
Non-user	45%	(41 - 49)
Rurality/Urbanicity		
Urban	44%	(41 - 47)
Rural	44%	(40 - 47)
Age group ‡		
Age 18-34	21%	(17 - 24)
Age 34-44	49%	(46 - 53)
Age 45+	67%	(62 - 70)
Marital status		
Married or living as married	43%	(40 - 45)
Not married	47%	(43 - 51)

‡ p ≤ 0.001

A logistic regression model was built to predict VA user status using ease of finding childcare during an appointment as a predictor, while also controlling for demographic variables. Only a proportion of women potentially needed child care (1,440 out of 8,532, or 16.9% of the sample). This model was a poor fit, and childcare needs were not significantly associated with VA user status (Wald = 2.2, p = 0.14, odds ratio = 0.912).

A linear regression model was used to predict the amount of VA care used (ranging from "None" to "All" on a five point scale) using *ease of finding childcare* (from "Very Easy" to "Very Hard" on a five point scale) as a predictor, while also controlling for demographic variables. This model was a good fit, explaining 19% of the variance in frequency of use (Model F=3.8, r^2adj = .19). However, *Ease of finding child care* was not a significant predictor of VA usage (Estimate coefficient= 0.02, F = 0.2, p = 0.66), with ease of finding

childcare having no effect on frequency of VA usage. This lack of effect may be in part because childcare needs can be a barrier to nearly all types of access to healthcare, rather than uniquely for VA care.

Women Veterans' Preference for On-site Child Care

To assist VA in assessing if the barrier of child care could be eased by policy decisions, the survey asked women whether on-site child care would be helpful. Three out of five women (62% overall) indicated that they would find on-site child care *very helpful*. Otherwise, more non-users than users reported that on-site child care would be *somewhat helpful* (22% non-users vs. 16% users) and more users than non-users reported that on-site child care would be *not helpful* (22% users v s. 17% non-users) (Exhibit 54). Based on the outcome of logistic regression analysis, child care as a barrier does not predict user status.

Exhibit 54: Helpfulness of on-site child care at medical appointments, by user status

Helpfulness of onsite child care during medical appointments	Overall (wt%)	Overall (95% CI)	Users (wt%)	Users (95% CI)	Non-users (wt%)	Non-users (95% CI)
Very helpful	62%	(58 - 65)	62%	(56 - 67)	62%	(58 - 65)
Somewhat helpful	21%	(18 - 24)	16%	(13 - 20)	22%	(19 - 25)
Not helpful	18%	(15 - 20)	22%	(17 - 27)	17%	(14 - 19)

* $p \leq 0.05$

Significant differences in the preference for on-site child care across VISNs by user and non-user status are not shown as high coefficients of variation mean that these estimates are not reliable.

5.5.6 Acceptability of integrated care

In recent years, VA has worked hard to ensure that women Veterans have access to women-specific care, such as Pap smears and breast exams, as part of routine primary care at all sites of care. These services delivered together, referred to as Comprehensive Primary Care in VA, are generally provided by Designated Women's Health Primary Care providers who may work in gender neutral care settings (i.e. mixed gender primary care clinics) or in Comprehensive Women's Clinics serving only women. The Public Law outlines the need to evaluate the acceptability of integrated care by women Veterans. The questions used in this study attempted to address concepts related to both gender-integrated care settings and comprehensive care, the extent to which all needed care is integrated into one provider and/or setting. In the Barriers to Care survey women Veterans were asked about their receipt of primary care and women's health care, or comprehensive care. They were also asked several questions about the importance of aspects of care thought to be sensitive or important in the provision of this care. Aspects of care rated include the importance of receiving care in a clinic just for women, the importance of having one provider for all care – primary and women's care, and the importance of having a female provider for women's specific care.

---Barriers to Care Survey Questions related to this Section---

E1. Do you currently have one person or team of providers in one clinic that you consider to be your primary care provider?

1. YES
2. NO

IF QB9 <> YES THEN GO TO QE3

E2. Is your usual source of primary care from the VA or from a non-VA provider?

1. VA ------> QE3
2. NON-VA

E2A. Do you get any of your primary care from a VA site of care?

1. YES
2. NO

.....

*INTRO.*QW

In this section I will use the term "Comprehensive Primary Care" which means having one provider who can provide your general medical care and your routine women's health care such as Pap smears, contraception, and menopause care.

W1. Are you currently getting Comprehensive Primary Care?

1. YES
2. NO ---> QW4

W2. Are you receiving it at a women's only health clinic?

1. YES
2. NO

IF QB9 <> YES THEN GO TO CK.QW4

W3. Are you receiving it at the VA?

1. YES
2. NO

W(6-8). [How important to you.../What about...]

6. "is it to receive all or MOST of your care from a clinic that is just for women?"
7. "having just one provider provide your primary care AND your women's specific care?"
8. "having a female provider for your women's specific health care services?"

   [Would you say.../(Would you say...)]

   1. Very important,

2. Somewhat important,
3. Not very important, or
4. Not at all important?

W9. How strongly do you agree with the following statement: "At VA sites of care, women may see a female provider if they want to?" Would you say you...

1. Strongly agree,
2. Somewhat agree,
3. Neither agree nor disagree,
4. Somewhat disagree, or
5. Strongly disagree?

To evaluate the how well VA is doing in providing women's care in a comprehensive care setting, the Barriers to Care survey first measured where women are receiving their Primary Care and Women's Care, or Comprehensive Primary Care. Exhibit 55 displays data on women Veterans and their receipt of Primary Care. Overall, almost all women Veterans have a primary care provider or team (91%). Of the women who receive care at the VA, 74% report that they usually receive their Primary Care through VA, and women who don't normally receive their primary care through VA do occasionally get some primary care in a VA setting (44% of users who don't normally receive primary care at VA).

In Exhibit 56 data on women Veteran's receipt of Comprehensive Primary Care is shown. Overall 77% of users report receiving Comprehensive primary care. Of those women who report receiving comprehensive primary care, 44% state they receive that care at VA, but not in a women's clinic, and 30% indicate they receive it in a women's clinic at VA.

Exhibit 55: Primary Care details for users of VA health care

Primary Care Details	Est Pop N for "yes"	Users (pop%)	Users (95% CI)
Have a Primary Care Provider or team	319,867	91%	(89 - 92)
(subset) Usual source of primary care is from VA	256,801	74%	(72 - 76)
(second subset) of those whose usual source of primary care is ***not*** from VA, receiving ***some*** primary care at VA	43,404	44%	(40 - 49)

Exhibit 56: Comprehensive Primary Care details for users of VA health care

Comprehensive Primary Care Details	Est Pop N for "yes"	Users (pop%)	Users (95% CI)
Currently receiving Comprehensive Primary Care	270,410	77%	(76 - 79)
(subset) of women receiving Comprehensive Primary Care, ***not*** receiving care in a women's clinic at VA	120,586	44% (of 270,410)	(67 - 73)
(subset) of women receiving Comprehensive Primary Care, ***receiving*** care in a women's clinic at VA	82,449	30% (of 270,410)	(85 - 90)

Overall Experience of Integrated Care as a Barrier

To assess and compare health care delivery in mixed-gender and women's clinic care settings, women were asked three questions about their satisfaction with VA care including the importance of receiving care in a clinic just for women, the importance of having one provider for all care –primary and women's care, and the importance of having a female provider for women's specific care. These elements of care delivery were then measured in regards to the care setting women Veterans reported using (Primary care, but not comprehensive care, Comprehensive care, but not in a women's clinic, and Comprehensive care in a women's clinic). Importance was measured on a 4 point scale from *very important* to *not at all important*.

Exhibits 57 through 60 display data for ratings of importance of different models of care by reported location of care, user status, and history of sexual trauma.[26] Data in these graphs are shaded from purple to orange for level of importance; scores of *very important* and *somewhat important* are shown in shades of purple while scores for *not very important* and *not at all important* are shown in shades of orange.

Importance of Receiving Care from a Clinic Just for Women

For importance of receiving care from a clinic just for women (Exhibit 57), women overall were evenly split between all four response options from *very important* to *not at all important*. When scores are viewed by location type (women's clinic vs. non-women's clinic, inside or outside of VA), type of care received (comprehensive vs. not comprehensive), user status, and history of sexual trauma, all comparison groups show significant differences. The importance of receiving care in a clinic just for women was reported more by users of VA health care than non-users across all care types and location types.

Importance of Receiving Care from a Clinic Just for Women by Current Care Location and Experiences of Sexual Trauma

Receiving care in a clinic just for women was the most important for women already receiving comprehensive care in a clinic just for women (60% of users 47% of non-users) (Exhibit 57). The second group for which care in a women's clinic was more highly rated as *very important* compared to other groups were women not currently receiving comprehensive care (43% of users and 36% of non-users). Additionally, women with an experience of unwanted sexual attention or sexual force also rated care in a women's clinic as *very important* (27% with experience of unwanted sexual attention vs. 25% no experience, and 31% with experience with threat or force of sex vs. 23% no experience).

Importance of Having One Provider for Primary Care and Women's Services

Scores for importance of having one provider for primary care and women's services are shown in Exhibit 58. Overall, 48% of women rated this aspect of care as *very important* and 75% total rated it *very important* or *somewhat important*. Again, more users of VA health

[26] History of sexual trauma obtained from self-reported information gathered through survey questions on unwanted sexual attention and threat or force of sex.

care than non-users rated the measure as *very important* (56% of users, 45% of non-users overall) and that difference spans across all care types except women Veterans not receiving comprehensive care. There were no statistical differences between importance of having one provider by the experience of unwanted sexual attention, and a weak statistical significance between women who did or did not have experience with threat or force of sex (53% with experience of threat or force of sex vs. 46% no experience).

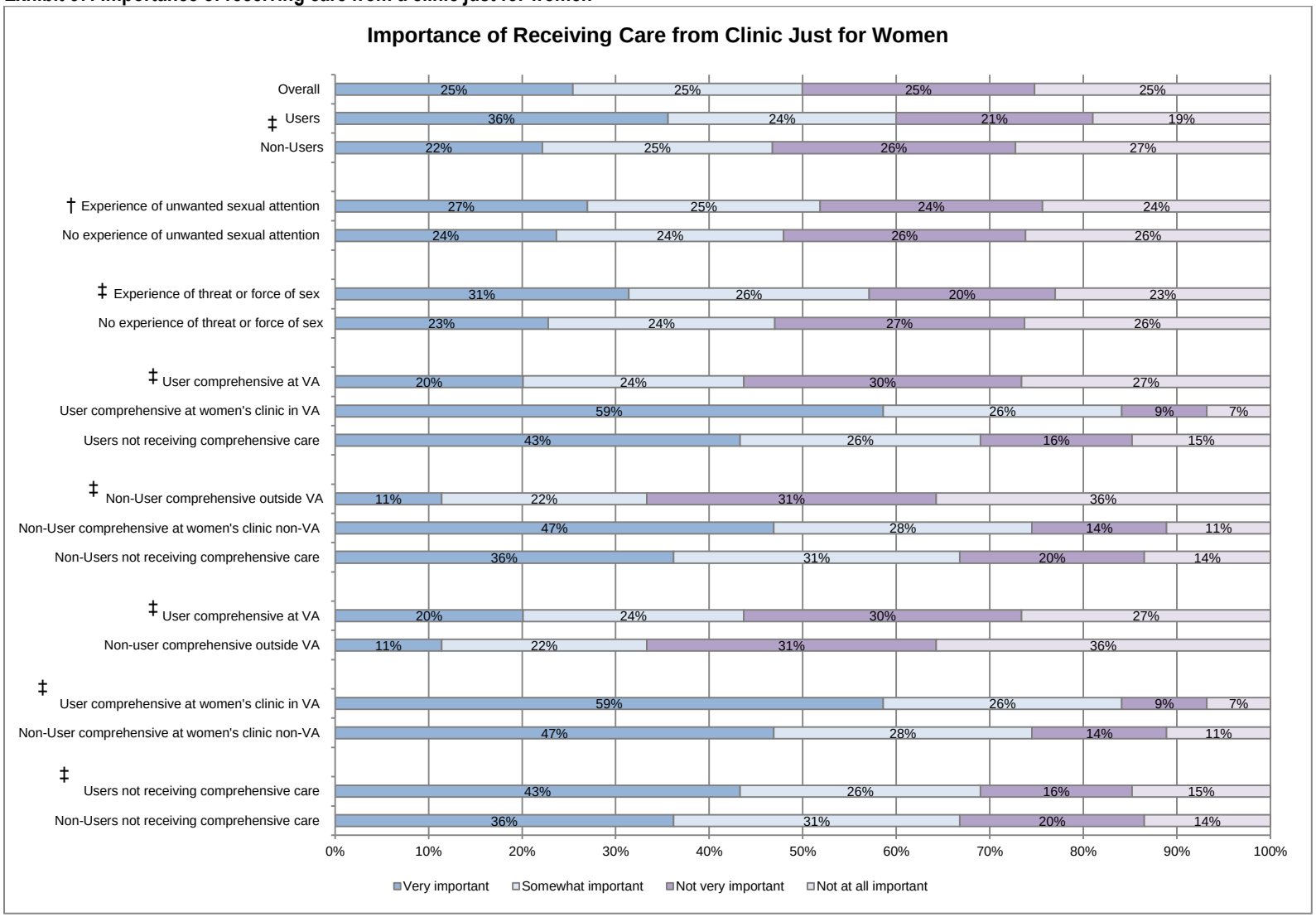
Importance of Having a Female Provider

Overall, the importance of having a female provider for women's services was rated lower than the importance of having one provider for primary care and women's services at 42% overall for *very important* and 65% for *very important* and *somewhat important*. Again, significant differences were seen between users and non-users across care types and location types (50% users overall vs. 39% non-users overall), with users at a comprehensive women's clinic having the highest ratings of *very important* of any comparison group (60% 'very important' and 80% *very important* and *somewhat important*) (Exhibit 59). Interestingly, this group rated importance of having a female provider higher than women with experience of or unwanted sexual attention (45% and 66%) or threat or force of sex (49% and 68%), who may be more commonly thought of as wanting a female provider. Indeed, women with experience of sexual trauma did rank having a female provider more important than women without that experience, but this rating is still eclipsed by women, in general, who receive care in a women's clinic at VA.

A logistic regression model was built to predict VA user status using different aspects of acceptability of integrated care, while also controlling for demographic variables. This model was a good fit, finding that importance of women-only clinics and agreeing that women can see female providers were both associated with a greater likelihood of using the VA (Women-only clinics: Wald = 21.4, $p < 0.001$, odds ratio = 1.18; can see female provider: Wald = 14.7, $p = 0.001$, odds ratio = 1.15). The importance of having one provider ($p = .26$) and the importance of female providers ($p = .38$) were *not* associated with VA user status. Note that these relationships are correlational, rather than causal, and using the VA may shape opinions just as much as opinions may influence VA usage.

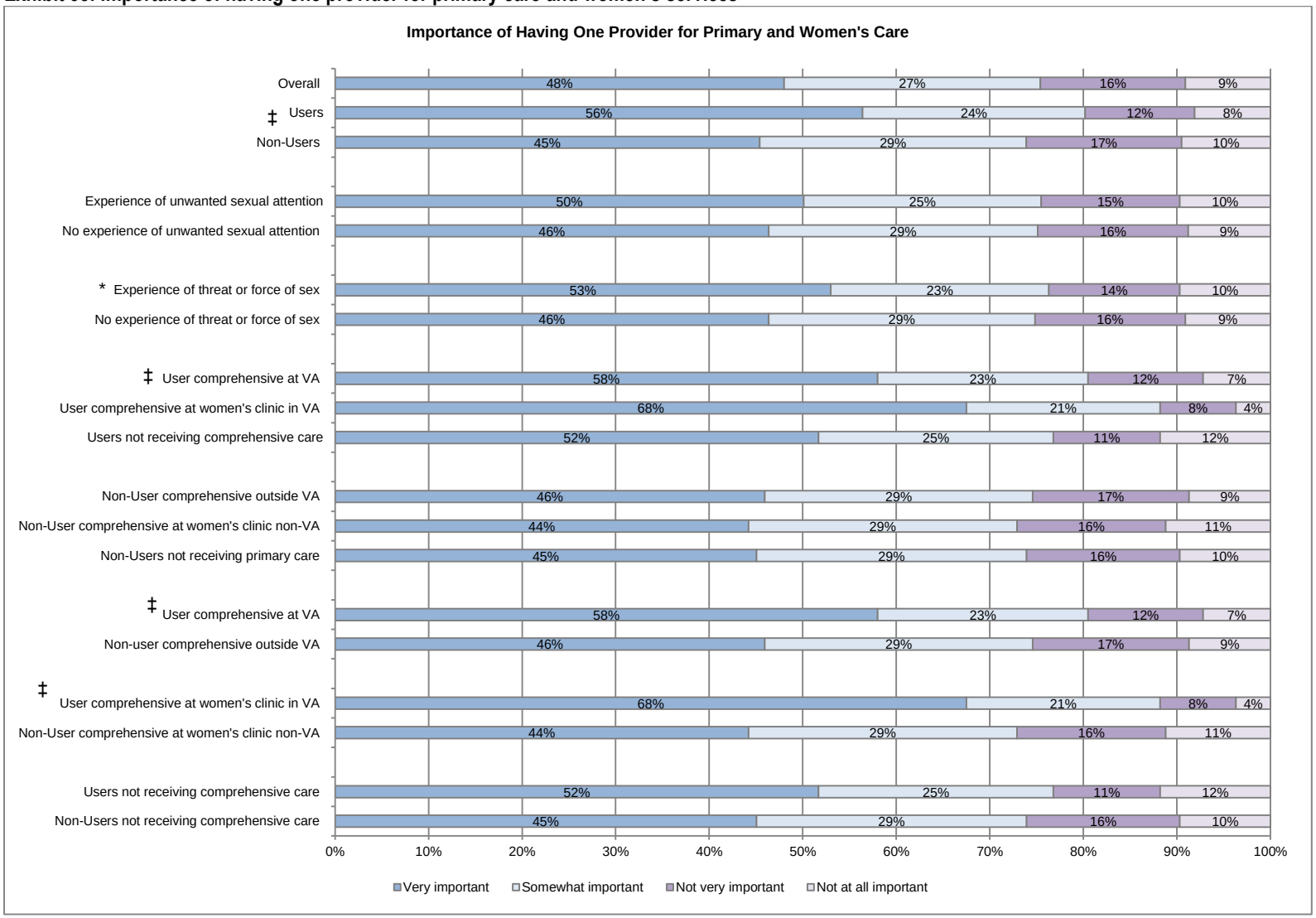
A linear regression model was used to predict the amount of VA care used (ranging from "None" to "All" on a five point scale) using four measures of acceptability of integrated care as predictors, while also controlling for demographic variables. This model was a moderate fit, explaining 22% of the variance in frequency of use (Model F=22.3, r^2adj = .22). Believing in the importance of having one provider was associated with greater VA usage (Estimate coefficient= 0.08, F = 6.8, $p = 0.009$), as was agreeing that women can see female providers (Estimate coefficient= 0.09, F = 15.8, $p < 0.001$). The importance of female providers (Estimate coefficient= 0.04, F = 1.6, $p = 0.20$) and importance of women-only clinics (Estimate coefficient= 0.03, F = 1.0, $p = 0.31$) had no influence on frequency of VA usage. These relationships are correlational, rather than causal, and using the VA may influence opinions just as much as opinions may influence VA usage.

Exhibit 57: Importance of receiving care from a clinic just for women



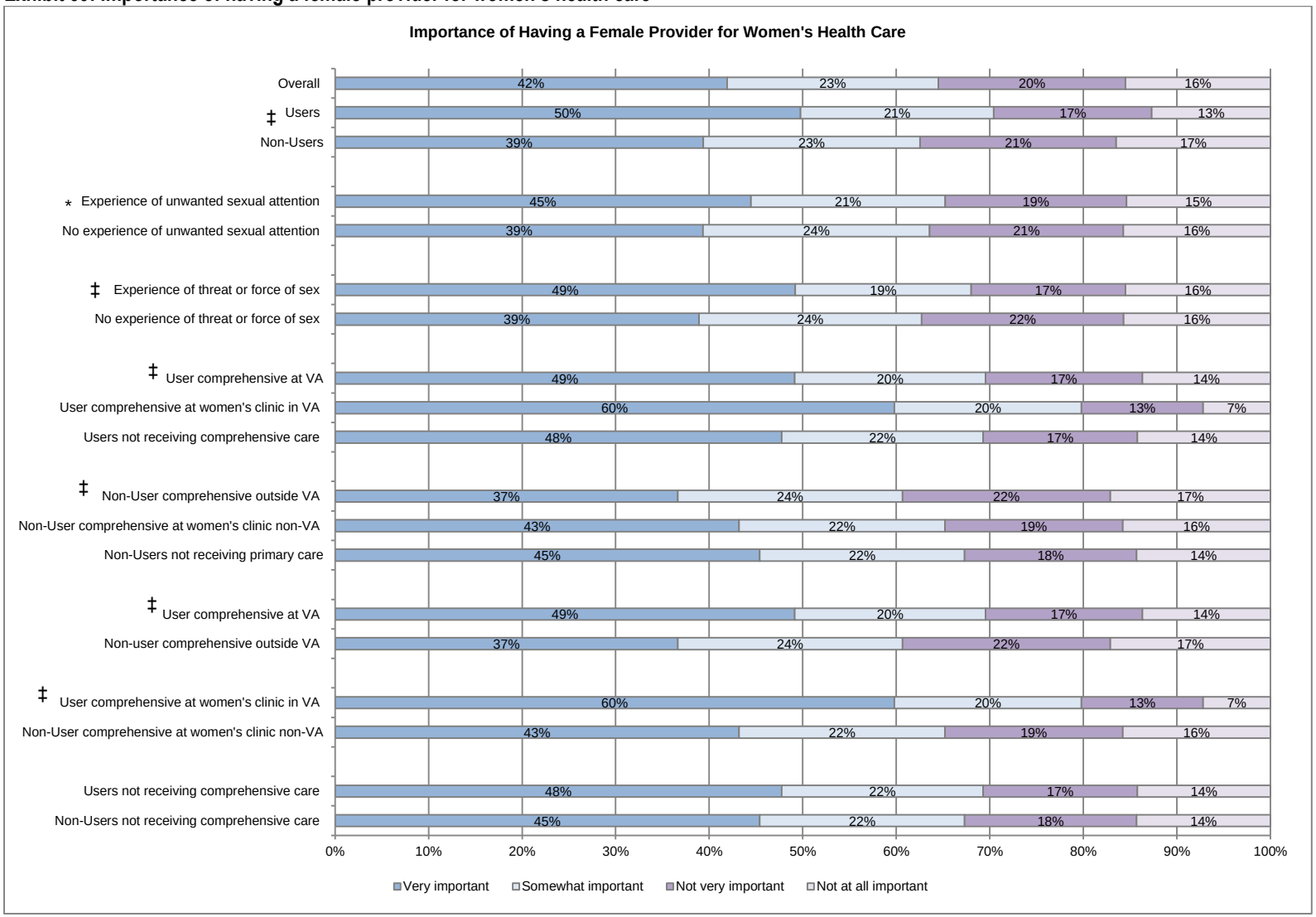
‡ p ≤ 0.001

Exhibit 58: Importance of having one provider for primary care and women's services



‡ p ≤ 0.001 * p ≤ 0.05

Exhibit 59: Importance of having a female provider for women's health care



‡ $p \leq 0.001$ * $p \leq 0.05$

Women Veterans' Beliefs or Experiences in Being Able to Choose a Female Provider

Related to acceptability of integrated services and barriers to care is the anecdote that women Veterans may not seek care at VA because they do not believe they can see a female provider if they wish. The Barriers to Care survey also addressed this potential barrier. The results in Exhibit 60 provide evidence that there is a statistically significant association between self-reported user status and the level of agreement with the statement, "At VA sites of care, women may see a female provider they want to." Specifically, self-reported non-users reported lower rates of agreement (strongly agree, somewhat agree) with the statement (59% of non-users vs. 72% of users). This finding supports the anecdote that perception, or possibly previous experience, is a potential barrier for non-users. With that in mind, overall 28% of users do not agree with that statement indicating that there may be a shortage of female providers at VA sites of care and not every woman Veteran who would like a female provider is assigned to one (or knows they may request one). Across VISNs there are significant differences in the mean level of agreement with the statement among users, but not among non-users. This indicates that some locations may have more or fewer female providers on staff; however, for non-users the perception of the ability to choose a female provider is widespread and not location specific (Exhibit 61).

Exhibit 60: Self-reported agreement/disagreement that women may see a female at VA if they want to

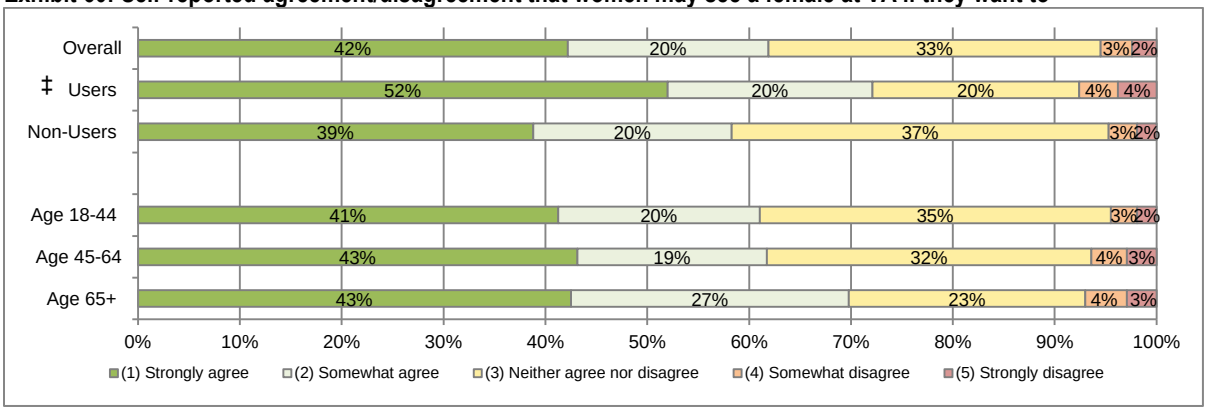


Exhibit 61: Self-reported ability to see female provider at VA by VISN

VISN	User mean †	Non-user mean
VISN 01 †	1.71	2.07
VISN 02 *	1.86	2.19
VISN 03	1.85	2.09
VISN 04 †	1.77	2.16
VISN 05	1.93	2.08
VISN 06 ‡	1.83	2.21
VISN 07	1.98	2.06
VISN 08	2.02	2.17
VISN 09	2.01	2.23

VISN	User mean †	Non-user mean
VISN 10 *	1.77	2.08
VISN 11	2.15	2.01
VISN 12 ‡	1.68	2.08
VISN 15 †	1.68	1.99
VISN 16	2.03	2.11
VISN 17	1.87	2.10
VISN 18	1.91	2.07
VISN 19	2.03	1.98
VISN 20 †	1.71	2.09
VISN 21 †	1.77	2.15
VISN 22 *	1.73	2.00
VISN 23 ‡	1.66	2.04

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

The predictive power of integrated care questions on user status is discussed in section 5.5.9 compared to other barriers to care.

5.5.7 Gender sensitivity

While the proportion of female patients at VA is increasing, the overwhelming majority of current patients at VA facilities are male, and providers are only recently caring for more female patients. VA has strived to provide more women's specific services and improve overall care for women Veterans, including being more respectful and aware of women's specific health needs. As noted in the background section, since 2008 VA has updated the handbook on provision of women's health care and provided women's health education to VA providers. These improvements are still relatively recent and the Public Law outlined a requirement to evaluate gender sensitivity as a potential barrier to care. In the Barriers to Care survey, users were asked a series of questions about satisfaction with providers and level of respect received from providers and staff.

---Barriers to Care Survey Questions related to this Section---

INTRO.QW10

Now thinking only about your primary care experience(s) at your VA site of care in the past 24 MONTHS...

W10(A-E). [How satisfied are you with.../(How about)]

A. "your provider(s)' general medical knowledge?"
B. "your provider(s)' knowledge of women's specific health needs?"
C. "how well your provider(s) understands your needs and concerns as a woman veteran?"
D. "the amount of time your provider(s) spent with you?"
E. "the amount of information you received from your provider(s)?"

[Would you say you are.../(Would you say you are...)]

1. Completely satisfied,
2. Somewhat satisfied,
3. Neither satisfied nor dissatisfied,
4. Somewhat dissatisfied, or
5. Completely dissatisfied?

W(11-13). [Considering all of your health care experiences at your VA site of care in the past 24 MONTHS, please indicate the LEVEL OF RESPECT you were shown by.../What about, the LEVEL OF RESPECT you were shown by...]

11. "your primary care provider."
12. "any other providers you may have seen, such as specialist physicians, nursing staff, or physical therapists."
13. "office staff at your clinic or facility."

(Would you say you were shown...)

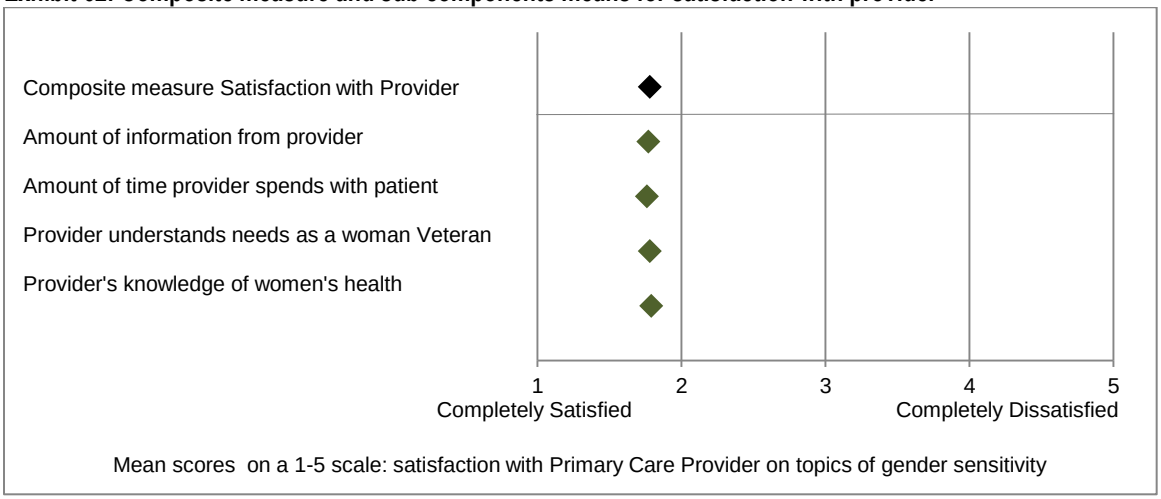
1. A lot,
2. Some,
3. A little,
4. None, or
5. [did you not see a primary care provider/ did you not see any other type of provider/did you not interact with the office staff]?

Creating a Composite Measure for Primary Care Provider Sensitivity

Factor analysis of 4 questions related to satisfaction with primary care provider and 3 questions about respect indicated that they each represent a single concept of satisfaction with care and level of respect from staff. Questions from each section can be combined and analyzed as a composite measure. To build a composite the average scores of the subcomponents are combined.

In Exhibit 62 the means of each subcomponent question in the 'satisfaction with provider' composite measure are shown along with the overall mean score for the composite measure. This Exhibit demonstrates that the subcomponents of the satisfaction with provider composite are all roughly scored the same way by women Veterans; each subcomponent aligns vertically under the composite measure instead of being scattered across the range of means from *completely satisfied* to *completely dissatisfied*. The subcomponents of the satisfaction with provider composite include satisfaction with the amount of information received from provider, the amount of time spent with provider, the provider's understanding of the needs and concerns of women, and the providers' knowledge of women's specific health needs.

Exhibit 62: Composite measure and sub components means for satisfaction with provider



Overall Experience of Primary Care Provider Sensitivity as a Barrier

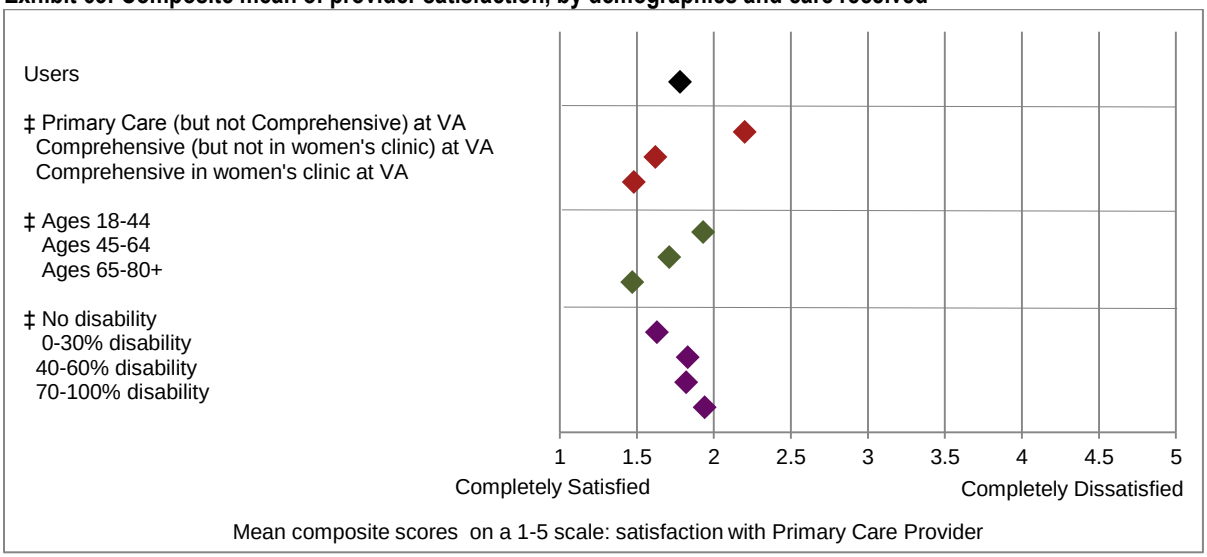
Exhibit 63 displays the mean composite scores for satisfaction with provider by demographics and care type (primary care, comprehensive care in a women's clinic, and comprehensive care delivered outside of a women's clinic). Analyzing the mean allows a more complete and objective review of satisfaction by looking at all scores, not just the top two or bottom two. Comparison groups are differentiated from each other by color coded data points, with the overall score shown in yellow.

On average women reported being *somewhat* or *completely satisfied* with their primary care provider on items related to provider sensitivity (mean score between 1 and 2). Users receiving primary care, but not comprehensive care are less satisfied with their provider, followed by women receiving comprehensive care, but not in a women's clinic. Users who are the most satisfied with their primary care provider, with the lowest mean score, are those who are receiving comprehensive care in a women's clinic at VA.

Experience of Primary Care Provider Sensitivity as a Barrier by Demographics and VISN

In the same exhibit (Exhibit 63) differences by age and disability level are examined. There is an almost linear decrease in satisfaction as age decreases, with women aged 18-44 being the least satisfied and women aged 65-80 being the most satisfied. By disability, there is a similar, almost linear pattern, with satisfaction level decreasing as disability level increases. Women with no disability rating are the most satisfied and women with 70-100% disability rating are the least satisfied.

Exhibit 63: Composite mean of provider satisfaction, by demographics and care received



‡ p ≤ 0.001

Analyses of the composite mean score of satisfaction with provider by VISN and care type yield significant differences within some VISNs by care type and across VISNs overall for users and for those receiving primary care, but not comprehensive care. There were no significant differences across VISNs for women Veterans receiving comprehensive care inside and outside of a women's clinic (Exhibit 64). This indicates that satisfaction with provider for women receiving comprehensive care is consistent across VISNs regardless of whether it is delivered inside or outside of a women's specific clinic; however, within some VISNs satisfaction with provider care type does differ based on type of care and location in which the care is received.

Exhibit 64. Composite mean of provider satisfaction, by care received and VISN

VISN	User Overall ‡	Primary Care but not Comprehensive Care at VA †	Comprehensive Care at VA, but not in a Women's clinic	Comprehensive Care at a women's clinic in VA
VISN 01 †	1.51	1.83	1.58	1.29
VISN 02	1.64	1.63	1.42	1.49
VISN 03	1.71	2.12	1.61	1.42
VISN 04	1.52	1.77	1.35	1.32
VISN 05 *	1.80	2.05	1.38	1.52
VISN 06	1.84	2.02	1.60	1.69
VISN 07 †	1.94	2.40	1.55	1.79
VISN 08	1.63	1.87	1.63	1.41
VISN 09 †	1.82	2.52	1.66	1.56
VISN 10	1.66	1.93	1.40	1.60
VISN 11 ‡	1.71	2.49	1.66	1.32
VISN 12†	1.61	2.07	1.56	1.31
VISN 15 †	1.88	2.79	1.70	1.40

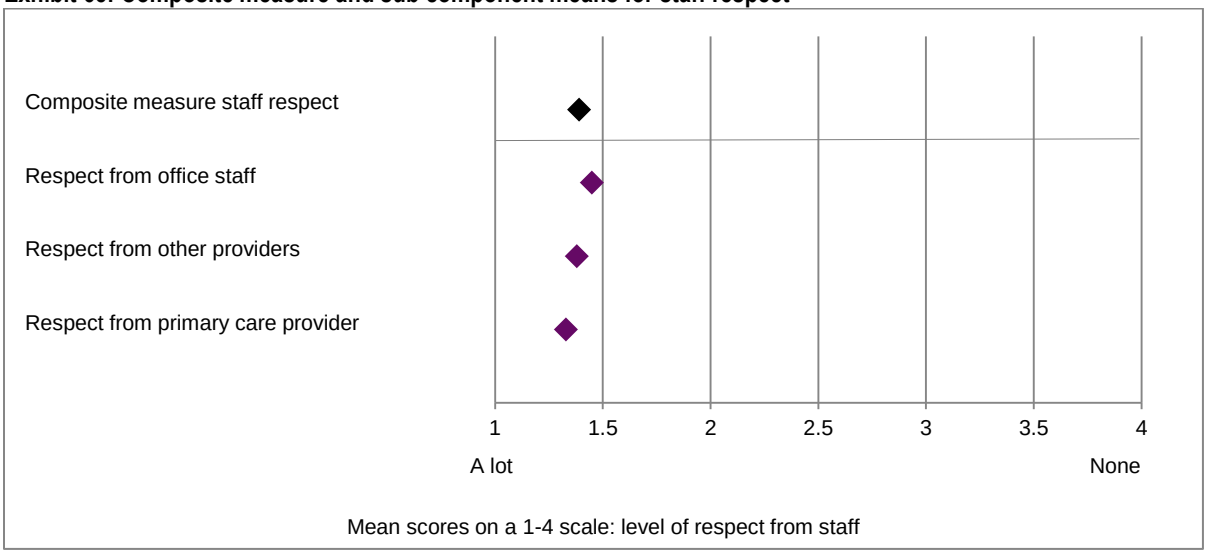
VISN	User Overall ‡	Primary Care but not Comprehensive Care at VA †	Comprehensive Care at VA, but not in a Women's clinic	Comprehensive Care at a women's clinic in VA
VISN 16 †	1.94	2.39	1.88	1.54
VISN 17	1.91	2.51	1.65	1.62
VISN 18 ‡	1.99	2.42	1.90	1.38
VISN 19 ‡	1.88	2.53	1.61	1.67
VISN 20	1.67	2.23	1.56	1.38
VISN 21 ‡	1.70	2.18	1.66	1.24
VISN 22 *	1.67	2.08	1.46	1.35
VISN 23 †	1.68	2.10	1.66	1.30

‡ $p \leq 0.001$ † $p \leq 0.01$ * $p \leq 0.05$

Creating a Composite Measure for Staff Respect

Exhibit 65 displays the subcomponents of the *staff respect* composite measure. While factor analysis did identify that these sub components (respect from office staff, respect from primary care provider, and respect from other providers) together measure one concept of level of respect received from staff, there are some differences by subcomponent. Women reported the highest level of respect from their primary care provider and increasingly less respect by other providers and office staff, with office staff showing the least amount of respect.

Exhibit 65: Composite measure and sub component means for staff respect



Overall Experience of Staff Respect as a Barrier

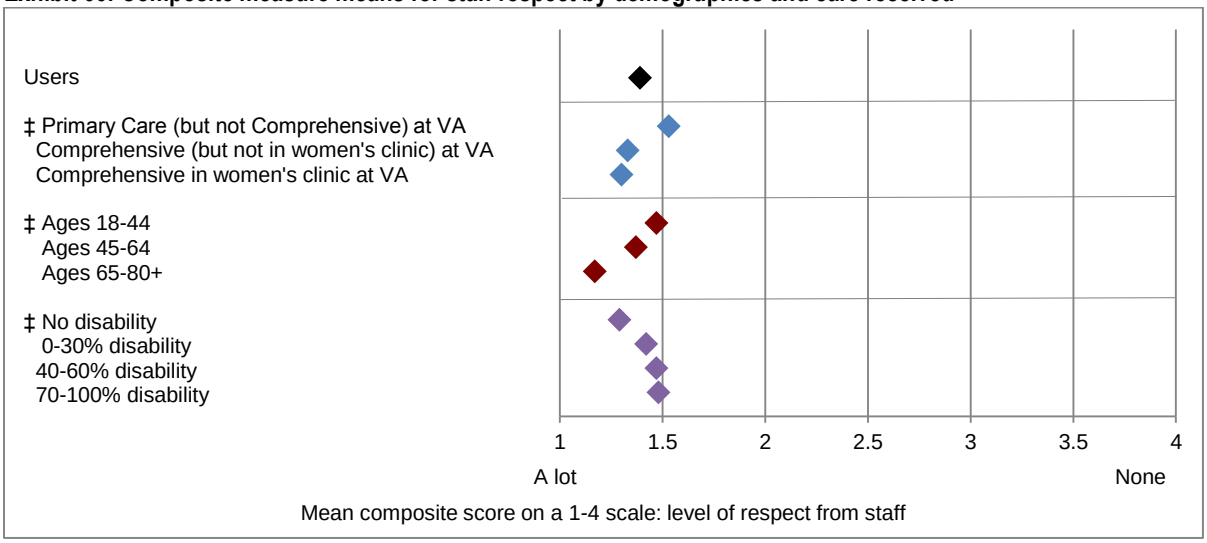
Composite means for staff respect significantly differ for users of VA health care by demographics and type of care received (Exhibit 66). Overall, women reported receiving a lot of respect from VA staff (mean score between 1 (a lot) and 2 (some)). Women receiving comprehensive care in a women's clinic report the highest level of respect from all staff, with

women receiving comprehensive care outside of a women's clinic and receiving primary care, but not comprehensive care reporting increasingly lower levels of respect from VA staff.

Experience of Staff Respect as a Barrier by Demographics and VISN

Also in Exhibit 66, but *by age group*, there is similar to satisfaction with provider. There is an almost linear relationship between level of respect shown by staff and age and disability level. Women aged 65-80 report receiving a lot of respect from all staff, while women aged 18-44 report receiving the least amount of respect from staff. Again, as disability level increases the reported level of respect received from all staff decreases.

Exhibit 66: Composite measure means for staff respect by demographics and care received



‡ p ≤ 0.001

Similar to the satisfaction with provider composite, the staff respect composite has significant differences by VISN overall for users, for women receiving primary care, but not comprehensive care, and additionally differences by VISN and comprehensive care received outside of a women's clinic. Exhibit 67 displays mean composite scores for staff respect by VISN and care type. Within some VISNs there are also significant differences by care type indicating variance in the experiences across settings.

Exhibit 67: Composite mean of staff respect, by care received and VISN

VISN	User Overall *	Primary Care but not Comprehensive Care at VA †	Comprehensive Care at VA, but not in a Women's clinic *	Comprehensive Care at a women's clinic in VA
VISN 01	1.28	1.26	1.30	1.18
VISN 02	1.30	1.24	1.22	1.37
VISN 03 †	1.43	1.68	1.44	1.21
VISN 04	1.31	1.47	1.23	1.26
VISN 05	1.52	1.38	1.42	1.33

VISN	User Overall *	Primary Care but not Comprehensive Care at VA †	Comprehensive Care at VA, but not in a Women's clinic *	Comprehensive Care at a women's clinic in VA
VISN 06	1.40	1.50	1.30	1.31
VISN 07	1.43	1.65	1.27	1.47
VISN 08	1.29	1.32	1.20	1.28
VISN 09 †	1.45	1.75	1.48	1.27
VISN 10 †	1.37	1.64	1.17	1.31
VISN 11 †	1.37	1.74	1.32	1.26
VISN 12	1.35	1.54	1.34	1.25
VISN 15 *	1.41	1.75	1.37	1.22
VISN 16	1.46	1.51	1.40	1.40
VISN 17	1.47	1.73	1.38	1.39
VISN 18 *	1.41	1.57	1.35	1.21
VISN 19	1.48	1.63	1.45	1.33
VISN 20	1.33	1.35	1.28	1.34
VISN 21	1.34	1.37	1.34	1.25
VISN 22	1.38	1.55	1.26	1.22
VISN 23	1.37	1.50	1.41	1.26

† $p \leq 0.01$ * $p \leq 0.05$

Two linear regression models predicted the amount of care received from VA (from “None” to “All” on a five point scale). One model uses a 5-point scale composite of provider-based satisfaction questions (including provider knowledge of women’s health concerns, provider understanding of women’s needs, provider spent enough time with the woman, and provider provided satisfactory information to the woman) as a predictor. The other model uses a 4-point composite of gender sensitivity questions relating respect from staff (respect from primary provider, respect from other providers, and respect from other staff). Both models also control for the demographic variables.

The first model was a good fit, explaining 21% of the variance in frequency of use (Model F=49.1, r2adj = .21). Provider sensitivity was a strong predictor (Estimate coefficient= 0.15, F = 28.8, $p < 0.0001$), with those most satisfied with provider gender sensitivity using the VA more frequently.

The second model was also a good fit, explaining 19% of the variance in frequency of use (Model F=44.5, r2adj = .19). Staff respect was a strong predictor (Estimate coefficient= 0.13, F = 6.6, p = 0.01, with those finding staff more respectful using the VA more frequently.

5.5.8 Mental health stigma

The perceived stigma that is often associated with mental health is believed to be a significant factor in preventing individuals from seeking needed care. Women Veterans who use VA care have a higher incidence of mental health conditions than the corresponding

non-veteran population. This is a very important factor for VA to consider in breaking down barriers to care. In the Barriers to Care survey, all women were asked to share self-reported mental health conditions, hesitancy to seek care for these conditions, and reasons for their hesitancy to seek care.

---Barriers to Care Survey Questions related to this Section---

MH(1-3). [Have you ever been diagnosed with.../How about...]

1. "a traumatic brain injury (TBI)?"
2. "post-traumatic stress disorder (PTSD)?"
3. "depression?"

1. YES
2. NO

MH4. Have you ever felt you needed mental health services related either to your military service or to any other life situation?

1. YES
2. NO

MH5. Have you ever felt hesitant to seek or receive needed mental health care services?

1. YES
2. NO--->QMH7

INTRO.QMH6

Thinking about why you felt hesitant to seek care for mental health care services, please tell me how much you agree or disagree with the following statements: MH6(A-G). [First.../(How about...)]

A. "I would think less of myself."
B. "Others would think less of me."
C. "It could negatively affect my job."
D. "It could affect my relationship with my spouse, children or family."
E. "I am not sure that mental health care will help me."
F. "I am worried about medicines used to treat mental health problems."
G. "I prefer to try spiritual or religious counseling."

(How much do you agree or disagree that this is a reason you felt hesitant to seek care for mental health care services?) [Would you say you.../(Would you say you...)]

1. Strongly agree,
2. Somewhat agree,
3. Neither agree nor disagree,
4. Somewhat disagree, or

5. Strongly disagree?

For each of the self-reported mental health experiences and experiences with sexual trauma shown in Exhibit 68, users have a significantly higher proportion of conditions or experiences than non-users. A self-reported user is 1.85 times more likely (an increased "risk" of 85%) to report depression and 3.63 times more likely to report PTSD than non-users of VA health care. A significant association was also found between Service era and the same self-reported mental health conditions and experiences with sexual trauma (Exhibit 69). Vietnam-OEF/OIF era Veterans overall had the highest proportion of reported mental health conditions and experiences and with the exception of PTSD, which was highest among OEF/OIF -Present era Veterans at 15%, and experience of threat or force of sex while in the military, highest among pre-Vietnam Veterans at 63% (not statistically significant). Additionally, a significantly higher proportion of users compared to non-users reported avoiding VA because of past sexual trauma (19% of users vs. 8% of non-users) (Exhibit 70). Weakly significant differences were seen in avoidance of VA due to past sexual trauma by Service era.

Exhibits 68 and 69 show proportions colored in shades of red with higher proportions of mental health conditions shaded in increasingly darker red.

Exhibit 68: Self-reported mental health conditions and sexual trauma experiences, overall and by user status

Self-reported experiences	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Traumatic Brain Injury (TBI) ‡	2%	(2 - 3)	5%	(4 - 6)	2%	(1 - 2)
Post-Traumatic Stress Syndrome (PTSD) ‡	13%	(12 - 14)	29%	(28 - 31)	8%	(7 - 9)
Depression ‡	34%	(33 - 35)	52%	(50 - 54)	28%	(27 - 30)
Felt you needed mental health services ‡	41%	(39 - 42)	58%	(56 - 60)	35%	(34 - 37)
Unwanted sexual attention ‡	44%	(42 - 45)	51%	(49 - 54)	41%	(39 - 43)
Unwanted sexual attention while in the military ‡	71%	(69 - 72)	80%	(78 - 82)	67%	(64 - 69)
Threat or force of sex ‡	25%	(24 - 26)	35%	(33 - 37)	22%	(21 - 24)
Threat or force of sex while in the military ‡	57%	(54 - 59)	67%	(64 - 70)	52%	(48 - 55)

‡ $p \leq 0.001$

Exhibit 69: Self-reported mental health conditions and sexual trauma experiences by service era

Self-reported experiences	Pre-Vietnam (pop%)	Pre-Vietnam (95% CI)	Vietnam - OEF/OIF (pop%)	Vietnam - OEF/OIF (95% CI)	OEF/OIF - Present (pop%)	OEF/OIF - Present (95% CI)
Traumatic Brain Injury (TBI)	**	**	2%	(2 - 3)	3%	(2 - 4)
Post-Traumatic Stress Syndrome (PTSD) ‡	**	**	12%	(11 - 13)	15%	(14 - 17)
Depression ‡	20%	(14 - 28)	35%	(34 - 37)	33%	(30 - 35)
Felt you needed mental health services ‡	13%	(9 - 18)	40%	(39 - 42)	43%	(41 - 45)
Unwanted sexual attention ‡	21%	(16 - 27)	47%	(46 - 49)	39%	(37 - 42)
Unwanted sexual attention while in the military	54%	(40 - 68)	71%	(69 - 73)	71%	(67 - 74)
Threat or force of sex ‡	14%	(10 - 19)	29%	(27 - 30)	20%	(19 - 22)
Threat or force of sex while in the military	63%	(46 - 77)	58%	(55 - 61)	54%	(49 - 59)

‡ p ≤ 0.001 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 70: Ever avoided VA because of sexual trauma experiences

Avoided the VA because of sexual trauma	pop%	95% CI
Overall	11%	(10 - 12)
User status ‡		
Users	19%	(17 - 21)
Non-users	8%	(6 - 9)
Service Era *		
Pre-Vietnam	**	**
Vietnam - OEF/OIF	11%	(10 - 13)
OEF/OIF - Present	10%	(8 - 12)

‡ p ≤ 0.001 * p ≤ 0.05 ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Overall Experience of Mental Health as a Barrier

All women, users and non-users, were asked if they ever felt the need for mental health care. Overall 52% of women indicated *yes* to a need for mental health care, with the percent reporting *yes* higher amongst users than non-users (56% of users vs. 50% of non-users, p ≤ 0.01). Several questions in the Barriers to Care survey also asked users of VA health care if they received mental health care from VA or from a Vet Center. Of the users of VA health care who indicated a self-reported need for mental health services 49% indicated receipt of mental health care from a Vet Center and 40% reported receiving mental health care from VHA sites of care (questions were not mutually exclusive) (Exhibit 71).

Exhibit 71: Self-reported need for mental health services vs. receipt of services

Self-reported receipt of mental health care/counseling	Users (wt%)	Users (95% CI)	Users who ever felt the need for mental health (wt%)	Users who ever felt the need for mental health (95% CI)
Visited a Vet Center for counseling	49%	(46 - 53)	49%	(46 - 52)
Received mental health care from VA	40%	(38 - 42)	64%	(62 - 67)

To evaluate the potential barrier of mental health stigma, women were asked if they ever felt hesitant to seek mental health services. Overall 24% of women indicated 'yes' they were hesitant to seek care (Exhibit 72), with more users than non-users feeling hesitant (35% of users vs. 21% of non-users). Differences in levels of hesitancy among users and non-users were also found by Service era, those with self-reported traumatic brain injury (TBI), self-reported depression, and unwanted sexual attention or threat or force of sex (50% and 52% of users vs. 35% and 37% of non-users).

Exhibit 72: Ever felt hesitant to seek mental health services, overall and by user status by self-reported experiences

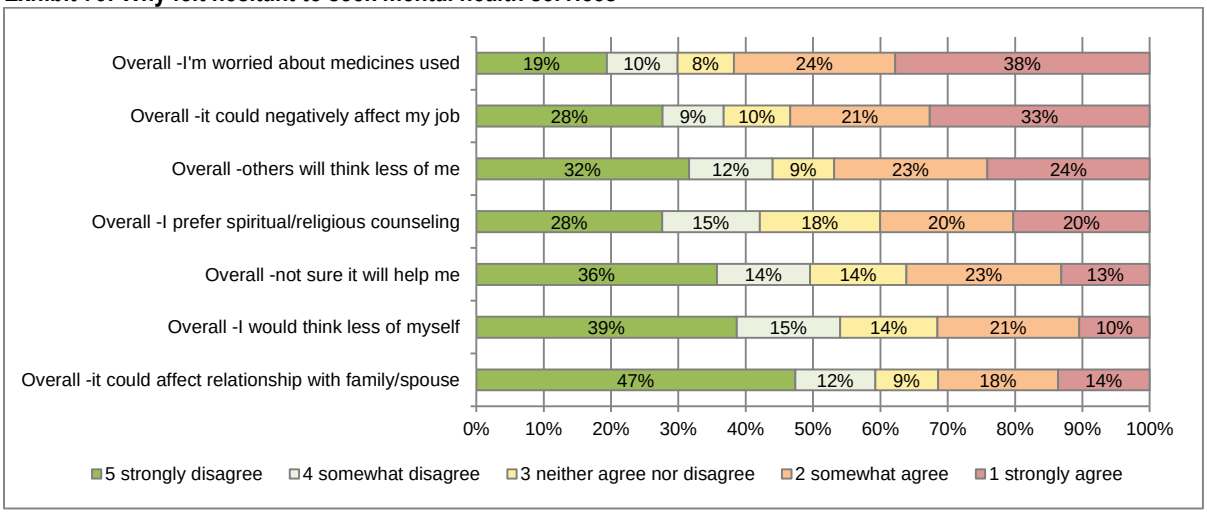
Demographics and experiences	Overall (pop%)	Overall (95% CI)	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
Overall	24%	(23 - 26)	35%	(33 - 37)	21%	(20 - 22)
Service era ‡						
Pre-Viet Nam	3%	(2 - 4)	7%	(4 - 11)	**	**
Viet Nam to OEF/OIF ‡	23%	(22 - 24)	34%	(31 - 36)	20%	(18 - 21)
OEF/OIF to present ‡	29%	(26 - 31)	40%	(37 - 44)	25%	(22 - 27)
Self-reported mental Health condition						
Traumatic Brain Injury (TBI) †	40%	(33 - 47)	51%	(42 - 61)	30%	(21 - 42)
Post-Traumatic Stress Syndrome (PTSD)	57%	(54 - 61)	60%	(57 - 64)	54%	(48 - 60)
Depression ‡	48%	(45 - 50)	53%	(50 - 56)	44%	(41 - 47)
Sexual trauma						
Unwanted sexual attention ‡	40%	(38 - 42)	50%	(47 - 53)	35%	(33 - 38)
Threat or force of sex ‡	42%	(40 - 45)	52%	(49 - 56)	37%	(34 - 41)

‡ $p \leq 0.001$ ** Unreliable estimates. Coefficient of variation is ≥ 0.30.

To better understand reasons for hesitancy to seek mental health care, women were asked to rate their agreement or disagreement with a set of pre-defined reasons supported by the literature. Questions were not mutually exclusive and women could provide a score on any/all reasons for hesitancy. Scores are shown from strongly disagree in green (meaning not the reason for hesitancy to seek care) to strongly agree in red (meaning agreement that the reason stated was a reason for hesitancy to seek care). Overall scores for reasons for hesitancy are shown in Exhibit 73. Reasons for hesitancy (shown in orange and red on the graph), in decreasing order, include *I'm worried about medicines used* (62%), *It could*

negatively affect my job (54%), *Others would think less of me* (47%), *I prefer spiritual/religious counseling* (40%), *I'm not sure it would help me* (36%), *I would think less of myself* (32%), and *It could affect my relationship with family/spouse* (31%).

Exhibit 73: Why felt hesitant to seek mental health services



Experience of Mental Health as a Barrier by Demographics

By Service era, significant differences in mean scores were found for *It could negatively affect my job* (lowest score, highest agreement of a barrier for OEF/OIF-Present era Veterans), and *It could affect my relationship with spouse, children, or family* (lowest score, highest agreement with barrier for Vietnam-OEF/OIF era Veterans) (Exhibit 74).

By user status, significant differences in mean scores were found for *I would think less of myself* (lowest score for users), *It could affect my relationship with my spouse, children or family* (lowest score for users), and *I'm not sure that mental health care will help me* (lowest score for users) (Exhibit 75).

In exhibits 74 and 75 mean scores are shown in shades of red with lower scores (more agreement for reason to hesitate seeking mental health care) shown in darker red.

Exhibit 74: Mean score by Service era, significant categories of why hesitant to seek mental health

Service era	Negatively affect my job ‡	Affect my relationship with my spouse, children or family †
Overall	1.47	1.69
OEF/OIF - Present	1.41	1.73
Vietnam - OEF/OIF	1.51	1.65

‡ $p \leq 0.001$ † $p \leq 0.01$

Exhibit 75: Mean score for users and non-users, significant categories of why hesitant to seek mental health

User status	I would think less of myself ‡	Affect my relationship with my spouse, children or family ‡	Not sure that mental health care will help me †
Overall	1.68	1.69	1.64
User	1.63	1.63	1.60
Non-user	1.72	1.72	1.66

‡ $p \leq 0.001$ † $p \leq 0.01$

A linear regression model was used to predict the amount of VA care used (ranging from "None" to "All" on a five point scale) using hesitancy to seek mental health care ("Yes" or "No") as a predictor, while also controlling for demographic variables. This model was a moderate fit, explaining 19% of the variance in frequency of use (Model F=22.6, r^2adj = .20). Hesitancy to seek mental health care was not a significant predictor (Estimate coefficient= -0.06, F = 1.0, p = 0.31), with hesitancy to seek mental health care having no effect on frequency of VA usage.

A logistic regression model was built to predict VA user status using hesitancy of seeking mental healthcare as a predictor, while also controlling for demographic variables. This model was a good fit, finding that women who were hesitant to seek mental health care were much *more* likely to use the VA than women who were not hesitant (Wald = 58.9, $p < 0.001$, odds ratio = 1.83). This is likely because VA users have a greater need for mental health care than non-users, which is associated with the greater disability status linked to a higher level of VA care. However, as shown in the linear regression, among users, hesitancy to seek mental health had no effect on frequency of receiving VA care.

5.5.9 Safety and comfort

Another known barrier to care is the historically male-dominated environment of VA sites of care based on the volume of male Service members with eligibility for care. Feelings of safety and comfort were another identified barrier identified in the Public Law for this assessment. In the Barriers to Care survey users of VA health care were asked to rate VA facilities on several aspects of safety and comfort from their overall (or general) experiences, inpatient experiences, and inpatient mental health experiences. A total of 3,879 users of VA health care had general experiences to rate, while only 414 users had inpatient experiences to rate and even fewer, 112 users, had inpatient mental health experiences to rate. Ratings were on a 1 to 5 scale where 1 was *strongly agree* and 5 was *strongly disagree*.

---Barriers to Care Survey Questions related to this Section---

Women's experiences when coming to a VA site of care are very important. In this next section, I will ask you about your experiences at VA sites of care.

This set of questions asks about your opinion of the facilities in which care is delivered within the VA. Please indicate how much you agree or disagree with the following statements:

SC1(A-I). [First.../(How about...)]

A. "The physical facility was well-maintained and clean."
B. "The parking areas were accessible."
C. "I could safely get from the parking area to the facility."
D. "The check-in areas had adequate privacy."
E. "The waiting areas were comfortable and welcoming."
F. "I had adequate privacy in the exam room."
G. "The exam room was clean."
H. "The women's restrooms were accessible."
I. "There was a place for my family members or caregivers to wait for me."

[Would you say you.../(Would you say you...)]

1. Strongly agree,
2. Somewhat agree,
3. Neither agree nor disagree,
4. Somewhat disagree, or
5. Strongly disagree?

SC2. In the last 24 months, did you have an INPATIENT STAY OTHER THAN FOR MENTAL HEALTH REASONS at a VA Medical Center where you were admitted to the hospital and stayed overnight?

1. YES
2. NO--->QSC4

INTRO.QSC3

Thinking about your INPATIENT STAY at a VA Medical Center within the last 24 months, please indicate you how much you agree or disagree with the following statements:

SC3(A-G). [First.../(How about...)]

A. "The admission process was easy."
B. "My room was clean and had the equipment I needed."
C. "I felt safe during my inpatient stay."
D. "I had access to a private bathroom during my stay."
E. "I was able to secure my door at night during my stay"
F. "I felt comfortable while showering."
G. "The admission process did not take a long time."

[Would you say you.../(Would you say you...)]

1. Strongly agree,
2. Somewhat agree,
3. Neither agree nor disagree,

4. Somewhat disagree, or
5. Strongly disagree?

SC4. In the last 24 months, did you have a MENTAL HEALTH RELATED INPATIENT STAY at a VA Medical Center or Community Based Outpatient Clinic?

1. YES
2. NO--->INTRO.QMH

INTRO.QSC5

Thinking about your MENTAL HEALTH INPATIENT STAY at a VA Medical Center or Community Based Outpatient Clinic within the last 24 months, Please indicate how much you agree or disagree with the following statements:

SC5(A-G). [First.../(How about...)]

A. "The admission process was easy."
B. "My room was clean and had the equipment I needed."
C. "I felt safe during my inpatient stay."
D. "I had access to a private bathroom during my stay."
E. "I was able to secure my door at night during my stay"
F. "I felt comfortable while showering."
G. "The admission process did not take a long time."

[Would you say you.../(Would you say you...)]

1. Strongly agree,
2. Somewhat agree,
3. Neither agree nor disagree,
4. Somewhat disagree, or
5. Strongly disagree?

Creating a Composite Measure

A factor analysis was done on the multiple aspects of safety and comfort for each care type and all were found to be strongly related to one another, measuring one overall concept of safety and comfort for overall experiences, inpatient experiences, and inpatient mental health experiences. For each of these three care types a composite measure was built, taking the average of each individual aspect of safety and comfort.

5.5.9.1 Overall, general ratings of safety and comfort for VA facilities

Creating a Composite Measure for General Safety and Comfort

For overall (general) experiences with VA facilities, each aspect of the safety and comfort composite was individually statistically significant at $p \leq 0.001$. Therefore, for overall

(general) results of safety and comfort with VA facilities, only the composite measure is displayed in this section.

While each of the nine aspects of safety and comfort for general VA experiences are related and can be reported as a composite, some aspects are rated more similarly than others. Exhibit 76 displays the mean score for the general safety and comfort composite measure as well as the mean scores of the nine subcomponents of the composite. Aspects of safety and comfort that women rate similarly include *adequate privacy in exam room*, *exam room was clean*, *women's rest rooms were accessible*, and *there was a place for family/caregivers to wait*. In contrast women rate 5 aspects of safety and comfort women lower (decreased levels of safety and comfort) than others. These individual items include *facility was well maintained and clean*, *could get safely from parking lot to facility*, *waiting rooms are comfortable and welcoming*, *check-in areas had adequate privacy*, and *parking areas were accessible*. This section will evaluate the experience of safety and comfort as a barrier based on the composite measure, but these differences within the composite are important to note.

Exhibit 76: Composite mean score and individual mean scores for aspects safety and comfort, reported by women Veterans for general, overall experiences with VA facilities

Overall Experience of General Safety and Comfort as a Barrier

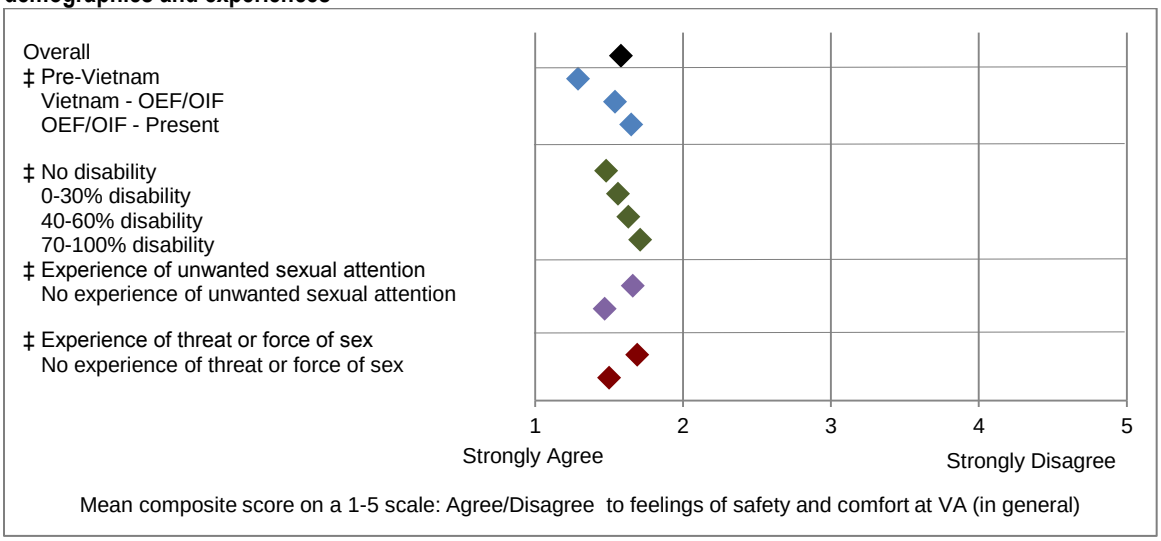
Exhibit 77 displays mean scores for the general experiences safety and comfort composite overall and by demographics. Comparison groups are differentiated by different colored data points. Overall, women report that they feel safe and comfortable in VA sites of care (composite mean score of between 1 (*strongly agree*) and 2 (*somewhat agree*)).

Experience of General Safety and Comfort as a Barrier by Demographics and VISN

Feelings of safety and comfort were significantly different in all comparison groups including Service era, disability level, and experience of unwanted sexual attention and experiences of threat or force of sex. By Service, more recent Veterans from OEF/OIF-Present era felt less safety and comfort overall at VA sites of care. By disability level, feelings of safety and comfort steadily decrease as disability level increases. As may be expected, women

Veterans with experiences of unwanted sexual attention or threat or force of sex have less feeling of safety and comfort in VA sites of care than women Veterans who did not have these experiences.

Exhibit 77: Composite mean score for overall experience of safety and comfort with VA facilities by User demographics and experiences



‡ $p \leq 0.001$

Statistically significant differences in the mean scores for the general services safety and comfort composite were found by VISN and urbanity/rurality of the Veteran's home residence (Exhibit 78).

Exhibit 78: Composite mean score for overall experience with VA facilities by VISN and rurality/urbanity of the Veterans' residence.

VISN	Urban mean score ‡	Rural mean score ‡
VISN 01	1.49	1.57
VISN 02	1.38	1.64
VISN 03	1.59	1.52
VISN 04 *	1.51	1.31
VISN 05	1.81	1.81
VISN 06	1.68	1.59
VISN 07	1.75	1.62
VISN 08	1.55	1.63
VISN 09	1.69	1.53
VISN 10 †	1.53	1.30
VISN 11	1.54	1.58
VISN 12	1.42	1.36
VISN 15 †	1.74	1.43
VISN 16	1.52	1.60
VISN 17	1.75	1.58

VISN	Urban mean score ‡	Rural mean score ‡
VISN 18	1.62	1.54
VISN 19 *	1.79	1.53
VISN 20 *	1.61	1.42
VISN 21	1.56	1.47
VISN 22	1.42	1.49
VISN 23	1.68	1.51

‡ p ≤ 0.001 † p ≤ 0.01 * p ≤ 0.05

A linear regression model predicted VA frequency of use (from "None" to "All" on a five point scale) using a 5-point scale composite of facility safety questions (including facility cleanliness, safe and accessible parking, private check-in, a welcoming waiting area, exam room cleanliness and privacy, accessible restrooms, and a family waiting area) as a predictor, while also controlling for the demographic variables. This model was a good fit, explaining 20% of the variance in frequency of use (Model F=46.8, r^2_{adj} = .20). Facility safety was a moderate strength significant predictor (Estimate coefficient= 0.15, F = 11.7, p = 0.0006), with those finding facilities the safest and most comfortable using the VA more frequently.

5.5.9.2 Inpatient ratings of safety and comfort for VA facilities

For inpatient experiences with VA facilities, each aspect of the safety and comfort composite was not equally statistically significant. Therefore, for inpatient experiences with safety and comfort mean scores for each aspect of safety and comfort, in addition to the composite, are displayed with notations on statistical significance.

Overall Experience of Inpatient Safety and Comfort as a Barrier

Overall, women Veterans *somewhat* or *strongly agree* to feelings of safety and comfort during a VA inpatient stay (mean composite score is 1.73 where 1 is *strongly agree* and 2 is *somewhat agree*). Within the composite, *able to secure my door at night* was the least comfortable aspect of an inpatient stay with a mean score of 2.5 where 2 is *somewhat agree* and 3 is *neither agree nor disagree* (Exhibit 79).

Exhibit 79: Mean score for overall rating of aspects of safety and comfort for an inpatient stay

Aspects of safety and comfort during an inpatient stay	Overall mean score
Inpatient Safety and Comfort composite	1.73
The admission process was easy	1.60
My room was clean and had the equipment I needed	1.45
I felt safe during my inpatient stay	1.35
I had access to a private bathroom during my stay	1.50
I was able to secure my door at night during my stay	2.51
I felt comfortable while showering	1.81
The admission process did not take a long time	1.98

Experience of Inpatient Safety and Comfort as a Barrier by Demographics and VISN

Overall, OEF/OIF-Present era Veterans who experienced an inpatient stay at a VA facility reported feeling significantly less safe and comfortable (highest mean score) compared to women from other Service eras (Exhibit 80). Specifically, OEF/OIF-Present era Veterans felt less safe and comfortable (highest mean score) with the *admissions process*. By disability, those with more severe disabilities (70-100% disability rating) felt significantly less safe and comfortable (highest mean score) related to the *ease and speed admissions process*. Women Veterans with a disability rating of 40-60% reported feeling less safe during the inpatient stay (Exhibit 81). During inpatient stays, women Veterans with previous experiences of unwanted sexual attention or threat or force of sex felt significantly less safe and comfortable than women Veterans without those experiences (for almost all measures) (Exhibit 82). The inpatient measure with which Veterans from all eras felt the least comfortable was *the ability to secure the door to their room at night*.

Exhibit 80: Mean scores of aspects of safety and comfort during an inpatient stay by veteran era

Aspects of safety and comfort during an inpatient stay	Pre-Vietnam mean score	Vietnam - Pre OEF/OIF mean score	OEF/OIF - Present mean score
Inpatient Safety and Comfort composite *	1.42	1.72	1.82
The admission process was easy ‡	1.18	1.60	1.71
My room was clean and had the equipment I needed	1.22	1.46	1.45
I felt safe during my inpatient stay	1.16	1.39	1.28
I had access to a private bathroom during my stay	1.34	1.46	1.63
I was able to secure my door at night during my stay	2.33	2.58	2.39
I felt comfortable while showering	1.42	1.75	2.04
The admission process did not take a long time	1.60	1.88	2.28

‡ $p \leq 0.001$ * $p \leq 0.05$

Exhibit 81: Mean scores of aspects of safety and comfort during an inpatient stay by disability rating

Aspects of safety and comfort during an inpatient stay	No disability mean score	0-30% disability mean score	40-60% disability mean score	70-100% disability mean score
Inpatient Safety and Comfort composite	1.61	1.60	1.77	1.89
The admission process was easy *	1.59	1.31	1.59	1.75
My room was clean and had the equipment I needed	1.34	1.34	1.58	1.55
I felt safe during my inpatient stay *	1.21	1.28	1.53	1.43
I had access to a private bathroom during my stay	1.35	1.33	1.56	1.70
I was able to secure my door at night during my stay	2.26	2.82	2.59	2.61
I felt comfortable while showering	1.57	1.77	2.01	1.99
The admission process did not take a long time ‡	2.01	1.40	1.80	2.26

‡ p ≤ 0.001 * p ≤ 0.05

Exhibit 82: Mean scores of aspects of safety and comfort during an inpatient stay by experience of sexual harassment

Aspects of safety and comfort during an inpatient stay	Experience of unwanted sexual attention	No experience of unwanted sexual attention	Experience of threat or force of sex	No experience of threat or force of sex
Inpatient Safety and Comfort composite † ‡	1.87	1.56	1.90	1.56
The admission process was easy † †	1.75	1.40	1.78	1.41
My room was clean and had the equipment I needed † †	1.58	1.27	1.59	1.30
I felt safe during my inpatient stay ‡ ‡	1.49	1.16	1.50	1.17
I had access to a private bathroom during my stay	1.54	1.48	1.60	1.45
I was able to secure my door at night during my stay ‡ †	2.84	2.19	2.86	2.24
I felt comfortable while showering	1.89	1.71	1.93	1.69
The admission process did not take a long time*	2.13	1.75	2.20	1.71

‡ p ≤ 0.001 † p ≤ 0.01 * p ≤ 0.05

Statistically significant differences were found for the overall composite for inpatient safety and comfort by VISN (Exhibit 83). The number of women who experienced an inpatient stay was too low to review VISN differences by any other demographics or other survey answers.

Exhibit 83: Mean scores for inpatient safety and comfort composite by VISN

VISN	Inpatient mean score *
VISN 01	2.04
VISN 02	1.89
VISN 03	2.06
VISN 04	1.66
VISN 05	1.81
VISN 06	1.64
VISN 07	1.50
VISN 08	1.28
VISN 09	1.66
VISN 10	2.12
VISN 11	1.82
VISN 12	1.66
VISN 15	2.07
VISN 16	1.73
VISN 17	1.62
VISN 18	2.10

VISN	Inpatient mean score *
VISN 19	1.46
VISN 20	1.69
VISN 21	1.78
VISN 22	1.77
VISN 23	1.92

* $p \leq 0.05$

5.5.9.3 Inpatient Mental Health ratings of safety and comfort for VA facilities

Overall Experience of Mental Health Inpatient Safety and Comfort as a Barrier

Similar to the composite measure for inpatient safety and comfort, the subcomponents of the inpatient mental health composite were not equally statistically significant. Therefore, mean scores for all elements of the composite are shown, along with the composite measure.

Overall, women Veterans *somewhat agreed* to feelings of safety and comfort during a mental health inpatient stay at a VA site of care (mean composite score of 2.14 where 2 is *somewhat agree* and 3 is *neither agree nor disagree*). Unlike general safety and comfort and inpatient safety and comfort, where mean scores were generally below 2, scores for sub components of the mental health inpatient safety and comfort composite are well above 2 (Exhibit 84); however, these scores are still well below 5 –*completely disagree* to feelings of safety and comfort.

Exhibit 84: Overall mean scores for mental health inpatient safety and comfort composite and sub components

Aspects of safety and comfort during a mental health inpatient stay	Overall mean score
MH Inpatient Safety and Comfort composite	2.14
The admission process was easy	2.16
My room was clean and had the equipment I needed	1.88
I felt safe during my inpatient stay	1.93
I had access to a private bathroom during my stay	1.57
I was able to secure my door at night during my stay	2.80
I felt comfortable while showering	2.40
The admission process did not take a long time	2.45

Experience of Mental Health Inpatient Safety and Comfort as a Barrier by Demographics

Composite scores for safety and comfort with an inpatient mental health stay were not statistically significant by Service era or disability rating; however, some individual components of the safety and comfort composite were significantly different by demographic. Additionally, the number of pre-Vietnam era women with an inpatient mental health stay was too low to be included in this analysis. By Service era, OEF/OIF-Present era Veterans experienced less comfort (higher mean score) for the *ability to secure the door to*

their room at night and *having access to a private bathroom during their stay* (Exhibit 85). By disability rating, women Veterans with a rating of 40-60% were the least comfortable (highest mean score) with their *comfort while showering* during their stay, and the *speed of the admissions process* (Exhibit 86).

Exhibit 85: Mean scores of aspects of safety and comfort during a mental health inpatient stay by era

Aspects of safety and comfort during a mental health inpatient stay	Vietnam - OEF/OIF mean score	OEF/OIF - Present mean score
Mental Health Inpatient Safety and Comfort composite	2.05	2.45
The admission process was easy	2.07	2.45
My room was clean and had the equipment I needed	1.86	1.92
I felt safe during my inpatient stay	1.85	2.16
I had access to a private bathroom during my stay ‡	1.49	1.81
I was able to secure my door at night during my stay ‡	2.59	3.37
I felt comfortable while showering	2.28	2.75
The admission process did not take a long time	2.38	2.65

‡ $p \leq 0.001$

Exhibit 86: Mean scores of aspects of safety and comfort during a mental health inpatient stay by disability rating

Aspects of safety and comfort during a mental health inpatient stay	**No disability mean score**	**0-30% disability mean score**	**40-60% disability mean score**	**70-100% disability mean score**
Mental Health Inpatient Safety and Comfort composite	2.14	1.60	2.78	2.11
The admission process was easy	2.08	1.60	3.00	2.13
My room was clean and had the equipment I needed	1.86	1.44	2.68	1.75
I felt safe during my inpatient stay	1.77	1.40	2.75	1.97
I had access to a private bathroom during my stay	1.55	1.35	1.73	1.61
I was able to secure my door at night during my stay	2.99	2.67	3.04	2.60
I felt comfortable while showering *	2.55	1.66	3.39	2.20
The admission process did not take a long time ‡	2.49	1.35	3.52	2.47

‡ $p \leq 0.001$ * $p \leq 0.05$

No statistically significant differences in mean ratings for safety and comfort with an inpatient mental health stay were found between women who did, or did not, have experience with sexual trauma or threat or force of sex. Also, the number of women reporting a mental health inpatient stay was too low to assess differences in safety and comfort by VISN.

A linear regression model predicted amount of care received from VA (from “None” to “All” on a five point scale) using a 5-point scale composite of facility safety questions for general VA experiences as a predictor, while also controlling for the demographic variables. The composite included ratings of facility cleanliness, safe and accessible parking, private check-in, a welcoming waiting area, exam room cleanliness and privacy, accessible

restrooms, and a family waiting area. This model was a good fit, explaining 20% of the variance in frequency of use (Model F=22.6, r^2adj = .20). Facility safety was a moderate strength significant predictor (Estimate coefficient= 0.16, F = 13.06, p = 0.0003), with those finding facilities the safest and most comfortable using VA more frequently.

Note: Questions referring specifically to inpatient safety and comfort and mental health inpatient safety and comfort did not have enough responses to allow for independent regression models.

5.5.10 Demographic controls for predicting user status

In the barrier regressions throughout this report, demographic variables were assessed with user status to act as controls. Demographic controls included age, race/ethnicity, employment, education, marital status, and insurance type (VA enrollment was not used as a control, because of its very high association with VA user status). An initial logistic regression model tested demographic variables alone in predicting VA user status. In this model, 56.2% of women were not VA users. This model correctly predicted VA user status for 73.7% of cases. All results are listed in Exhibit 87. In order of predictive strength, the variables that had the biggest effect on user status were insurance type, employment status, marital status, and education. The reference groups for categorical variables were “married” for marital status, “employed” for employment, and “high school” for education. Race and age had little effect on VA user status. The effects of these demographics are controlled for in the analysis of barriers so that demographic effects do not confound barrier effects.

Exhibit 87: Effect of demographic control variables on VA user status

Control Variable	Odds Ratio	Odds Ratio Lower 95%	Odds Ratio Higher 95%	Wald Chi Square (effect size)	p–value (statistical significance)	Interpretation
Age	0.983	0.923	1.048	0.2675	0.605	No effect
MARITAL Reference: Married				43.3553	<.0001	Marital has a significant effect
– Divorced	0.634	0.538	0.746			More likely to use VA than Married
– Domestic Partnership/Civil Union	0.626	0.444	0.884			More likely to use VA than Married
– Don’t Know	1.3	0.591	2.863			No effect
– Never Married	0.662	0.541	0.809			More likely to use VA than Married
– Separated	0.574	0.397	0.829			More likely to use VA than Married
– Widowed	0.787	0.586	1.058			

Control Variable	Odds Ratio	Odds Ratio Lower 95%	Odds Ratio Higher 95%	Wald Chi Square (effect size)	p–value (statistical significance)	Interpretation
EMPLOYMENT Reference: Employed				154.981	<.0001	Employment has a significant effect
– Fulltime Caregiver	0.419	0.213	0.826			More likely to use VA than Employed
– Homemaker	0.795	0.572	1.105			No effect
– Full-time Student	0.426	0.301	0.603			More likely to use VA than Employed
– Volunteer	0.431	0.224	0.83			More likely to use VA than Employed
– Don't Know	0.685	0.332	1.416			No effect
– Other	1.28	0.739	2.218			No effect
– Retired	0.388	0.309	0.487			More likely to use VA than Employed
– Self-employed	0.835	0.613	1.137			No effect
– Unable to Work/Disabled	0.264	0.204	0.341			More likely to use VA than Employed
– Unemployed	0.613	0.463	0.812			More likely to use VA than Employed
EDUCATION Reference: High School				14.0924	0.0286	Education has slightly significant effect
– Bachelor's Degree	0.776	0.594	1.013			No effect
– Don't Know (Education Status)	0.326	0.115	0.926			More likely to use VA than High School graduates
– Graduate Degree	0.763	0.572	1.016			No effect
– Less than a High School Degree or GED	1.571	0.429	5.751			No effect
– Some College/Associate's Degree	0.885	0.683	1.148			No effect
– Trade or Vocational Training	1.148	0.779	1.692			No effect
Insurance – Employer	0.148	0.123	0.178	415.8569	<.0001	Less likely to use VA

Control Variable	Odds Ratio	Odds Ratio Lower 95%	Odds Ratio Higher 95%	Wald Chi Square (effect size)	p–value (statistical significance)	Interpretation
Insurance – No insurance or other coverage at some point in last 24 months	0.688	0.536	0.883	8.65	0.0033	Less likely to use VA
Insurance – Medicare	0.579	0.46	0.73	21.4585	<.0001	Less likely to use VA
Insurance – Medicaid	0.181	0.122	0.269	71.6611	<.0001	Less likely to use VA
Insurance – TRICARE	0.253	0.207	0.309	182.2965	<.0001	Less likely to use VA
Ethnicity	0.922	0.713	1.194	0.3778	0.5388	No effect
Race – Native American	0.967	0.699	1.339	0.0403	0.8409	No effect
Race – Asian	0.69	0.413	1.154	1.9987	0.1574	No effect
Race – Black	1.532	1.017	2.309	4.1577	0.0414	Very slightly more likely to use VA
Race – Islander	1.372	0.737	2.555	0.9977	0.3179	No effect
Race – White	1.117	0.753	1.658	0.3028	0.5822	No effect
Race – Other	1.244	0.755	2.051	0.7352	0.3912	No effect

5.5.11 Other Barriers to Care

While the Barriers to Care survey was designed to respond to the Public Law by measuring women Veterans' experiences with nine previously identified barriers to care, this survey also sought to identify any new barriers to care, not already covered in the Public Law. Thus, a few questions in the survey asked women Veterans to select from a list, or provide in their own words, their reasons for using or not using VA health care.

Users of VA health care were asked, "What was the main reason you chose to use VA health care in the past 24 months?" Women were read a response list and also had the option of giving an other-specify answer. Other-specify answers were recorded as short strings of text by the interviewer and these responses were analyzed by the research team and coded into categories. In descending order of responses, the largest percentage of users self-reported that they used VA health care because they *had no other insurance* (31%), *at VA sites of care they could receive care related to their service-connected disability* (22%), *some other reason not listed* (17%), and that they chose VA because of the *quality of health care provided* (11%) (Exhibit 89). When these results were viewed by age, statistically significant differences were found. Younger Veterans most often indicated *I have no other insurance* (35% for ages 18-44 and 31% for ages 45-64, versus only 15% for ages 65-80), and *they have care specific to my service-connected disability* (23% for ages 18-44

and 23% for ages 45-64, versus only 11% for ages 65-80). The most common reason that women aged 65-80 said they choose VA care is because *they have good quality of care* (23% versus 7% for ages 18-44 and 12% for ages 45-64) and *they have good prescription benefits* (19% versus 3% for ages 18-44 and 5% for ages 45-64) (Exhibit 90). Overall, the most common *other* responses were *it's the cheapest for me* (20%) and *to keep up my VA benefits* (12%) (Exhibit 91). Additional *other* responses were either repetitions of closed-ended response options, descriptions of specific health care, or too numerous and few to be shown individually. By age more women Veterans aged 45-64 indicated *it's the cheapest for me* (22% 45-64 versus 19% 18-44 and 14% 65-80) (Exhibit 92).

Exhibit 88: Main reason users chose VA healthcare in the past 24 months, overall

Main reason for choosing VA healthcare in the past 24 months	Users (pop%)	Users (95% CI)
I have no other insurance	31%	(29 - 33)
It's the most convenient for me	8%	(7 - 9)
They have good quality of care	11%	(10 - 12)
They have good prescription benefits	5%	(5 - 6)
They are sensitive to the needs of Veterans	6%	(5 - 7)
They have care specific to my service-connected disability	22%	(20 - 24)
Other	17%	(15 - 18)

Exhibit 89: Main reason users chose VA healthcare in the past 24 months, by age group

Main reason for choosing VA healthcare in the past 24 months ‡	Users age 18-44 (pop%)	Users age 18-44 (95% CI)	Users age 45-64 (pop%)	Users age 45-64 (95% CI)	Users 65-80+ (pop%)	Users 65-80+ (95% CI)
I have no other insurance	35%	(31 - 38)	31%	(29 - 34)	15%	(12 - 18)
It's the most convenient for me	9%	(7 - 11)	7%	(5 - 8)	10%	(8 - 13)
They have good quality of care	7%	(6 - 9)	12%	(10 - 14)	23%	(19 - 27)
They have good prescription benefits	3%	(2 - 4)	5%	(4 - 6)	19%	(16 - 23)
They are sensitive to the needs of Veterans	6%	(4 - 8)	7%	(5 - 8)	2%	(1 - 4)
They have care specific to my service-connected disability	23%	(21 - 26)	23%	(21 - 25)	11%	(8 - 15)
Other	17%	(14 - 20)	16%	(14 - 19)	19%	(16 - 23)

‡ Rao-Scott chi-square p-value is < 0.001

Exhibit 90: Other-specify responses, why users chose VA healthcare in the past 24 months, overall

Most common other-specify response to: Main reason for choosing VA healthcare in the past 24 months †	Users (% of other)	Users (95% CI)
It's the cheapest for me	20%	(16 - 24)
To keep up my VA benefits	12%	(8 - 17)

Most common other-specify response to: Main reason for choosing VA healthcare in the past 24 months †	Users (% of other)	Users (95% CI)
Description of specific health care service(s) received	11%	(8 - 14)
Repeat of closed-ended response option	21%	(17 - 26)
Other (many different responses)	37%	(31 - 42)

† Rao-Scott chi-square p-value is < 0.01

Exhibit 91

: Other-specify responses, why users chose VA healthcare in the past 24 months, by age group

Most common other-specify response to: Main reason for choosing VA healthcare in the past 24 months †	Users age 18-44 (% of other)	Users age 18-44 (95% CI)	Users age 45-64 (% of other)	Users age 45-64 (95% CI)	Users 65-80+ (% of other)	Users 65-80+ (95% CI)
It's the cheapest for me	19%	(13 - 27)	22%	(16 - 29)	14%	(9 - 23)
To keep up my VA benefits	18%	(11 - 29)	6%	(4 - 10)	13%	(7 - 22)
Description of specific health care service(s) received	7%	(4 - 12)	13%	(8 - 19)	15%	(9 - 24)
Repeat of closed-ended response option	**	**	27%	(21 - 34)	25%	(16 - 37)
Other (many different responses)	42%	(33 - 53)	33%	(26 - 40)	33%	(23 - 44)

† Rao-Scott chi-square p-value is < 0.01

** Unreliable estimates, coefficient of variation ≥ 0.30

Both users and non-users of VA health care were asked what the main reason was they chose to use care outside VA (non-federal care). Respondents were read a response list and also had the option of giving an other-specify answer. Other-specify answers are recorded as short strings of text by the interviewer and these responses were analyzed by the research team and coded into categories. Between users and non-users there were significant differences between their answer choices. Many users and non-users reported unique *other* reasons that could not be grouped together. The most common reason for both users and non-users was *I have insurance outside of the VA*, although more non-users than users chose this answer option (44% of non-users vs. 24% of users) (Exhibit 93). For non-users the second most common response was *I don't know if I'm eligible for VA care* (28% of non-users vs. 4% of users). For users, the most common answer choice was *other* (31% of users vs. 12% of non-users). For users the most common *other* response was *need emergency or urgent care* (22% of users vs. 3% of non-users) and *it's too difficult to get an appointment at VA* (17% of users vs. 6% of non-users) (Exhibit 94). For non-users, the most common *other* answer was *Not eligible for VA care* (28% of non-users vs. 4% of users). This additional information may indicate that some non-users already know they are not eligible for care at this time and some users of VA health care may not be eligible to receive all of their care at VA.

Exhibit 92: Main reason users and non-users chose care outside of VA in the past 24 months, by user status

Main reason for choosing care outside of VA in the past 24 months ‡	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
I don't know if I'm eligible for VA care	4%	(3 - 6)	28%	(26 - 30)
I have insurance outside of the VA	24%	(21 - 26)	44%	(42 - 46)
My Non-VA care location is more convenient	17%	(15 - 19)	8%	(7 - 9)
VA does not have the services I need	10%	(8 - 11)	1%	(1 - 1)
VA does not have a women's clinic	2%	(1 - 2)	**	**
The quality of care outside the VA is better	12%	(10 - 14)	5%	(5 - 6)
I do not feel like I belong at the VA	**	**	3%	(2 - 3)
Other	31%	(29 - 34)	12%	(10 - 13)

‡ Rao-Scott chi-square p-value is < 0.001

** Unreliable estimates, coefficient of variation ≥ 0.30

Exhibit 93: Other-specify responses, why users and non-users chose care outside of VA in the past 24 months, by user status

Most common other-specify response to: Main reason for choosing care outside the VA in the past 24 months ‡	Users (% of other)	Users (95% CI)	Non-users (% of other)	Non-users (95% CI)
Need emergency or urgent care	22%	(19 - 26)	3%	(1 - 5)
Too difficult to get an appointment at VA	17%	(13 - 20)	6%	(4 - 9)
Not eligible for VA care	4%	(3 - 7)	28%	(23 - 33)
Repeat of closed end response	28%	(23 - 32)	34%	(29 - 39)
Other (many different responses)	29%	(25 - 34)	30%	(25 - 35)

‡ Rao-Scott chi-square p-value is < 0.001

The reasons why non-users choose to not use VA is of utmost importance to VA working groups whose mission is to assist more women Veterans in receiving the health care they have earned through their service. Exhibit 95 displays the main reason non-users do not use VA health care by age. Across all age groups the most common 'other' answer was a repeat of *I have insurance outside of the VA*, but said in their own words, with women aged 45-64 reporting this answer more than other age groups (36% 18-44, 44% 45-64 and 40% 65-80). The second most common *other* reason for not using VA health care was a repeat of *I don't know if I'm eligible for VA care*, but said in their own words; younger women reported this answer more than other age groups (28% 18-44 versus 20% 45-64 and 12% 65-80). More women aged 65-80 reported *my non-VA care location is more convenient* than other groups (9% 18-44, 9% 45-64, and 14% 65-80).

Exhibit 94: Main reason Non-users chose care outside of VA in the past 24 months, by age group

Main reason Non-users chose care outside of VA in the past 24 months ‡	Non-users age 18-44 (pop%)	Non-users age 18-44 (95% CI)	Non-users age 45-64 (pop%)	Non-users age 45-64 (95% CI)	Non-users 65-80+ (pop%)	Non-users 65-80+ (95% CI)
I don't know if I'm eligible for VA care	28%	(26 - 31)	20%	(19 - 22)	12%	(9 - 16)
I have insurance outside of the VA	36%	(33 - 38)	44%	(42 - 46)	40%	(36 - 45)
My Non-VA care location is more convenient	9%	(8 - 11)	9%	(8 - 10)	14%	(11 - 18)
VA does not have the services I need	2%	(2 - 3)	3%	(2 - 3)	3%	(2 - 5)
VA does not have a women's clinic	1%	(0 - 1)	1%	(0 - 1)	**	**
The quality of care outside the VA is better	7%	(6 - 8)	6%	(5 - 7)	6%	(4 - 9)
I do not feel like I belong at the VA	2%	(1 - 3)	2%	(2 - 3)	4%	(2 - 6)
Other	15%	(13 - 17)	15%	(13 - 16)	21%	(17 - 25)

‡ Rao-Scott chi-square p-value is < 0.001 ** Unreliable estimates, coefficient of variation ≥ 0.30

The last question in the Barriers to Care survey asked women Veterans to identify what, to them, was a significant barrier that kept them from using VA care now or in the past. The interviewer read a list of response options that described in layman's terms the nine barriers to care. Respondents were allowed to select more than one answer, and if they provided more than one answer they were asked which of those was the most significant. Exhibit 96 reviews the most common pairs of answers for women who provided more than one barrier as a reason they do not or did not use VA care. The most common pairs, listed in decreasing level of overlap (women indicating both), include *I do not understand my benefits* and *I haven't been provided with any information about VA health care*, followed by *I am embarrassed or afraid to seek mental health services* and *other*, *I have no way to get to a VA facility* and *The VA is too far away*, and *VA providers are not sensitive to women's needs* and *There is not enough access to women's services*.

Exhibit 95: Reported barriers to care matrix: most common pairs of responses

Reported Barriers to Care	I don't understand my benefits	I haven't been provided with any information about VA healthcare	I have no way to get to a VA facility	The VA is too far away	The VA's hours are inconvenient	I have no access to child care	VA facilities lack privacy or safety	VA providers are not sensitive to women's needs	There is not enough access to women's services	I am embarrassed or afraid to seek mental health services	Other
I don't understand my benefits	100%	86%	NA	5%	1%	NA	NA	NA	1%	1%	3%
I haven't been provided with any information about VA healthcare	0%	100%	NA	27%	NA	NA	NA	NA	17%	NA	29%
I have no way to get to a VA facility	0%	0%	100%	82%	NA	0%	NA	NA	0%	NA	NA
The VA is too far away	0%	0%	0%	100%	42%	NA	NA	NA	17%	NA	19%
The VA's hours are inconvenient	0%	0%	0%	0%	100%	NA	NA	NA	37%	NA	32%
I have no access to child care	0%	0%	0%	0%	0%	100%	NA	0%	NA	NA	NA
VA facilities lack privacy or safety	0%	0%	0%	0%	0%	0%	100%	NA	NA	NA	NA
VA providers are not sensitive to women's needs	0%	0%	0%	0%	0%	0%	0%	100%	77%	NA	21%
There is not enough access to women's services	0%	0%	0%	0%	0%	0%	0%	0%	100%	NA	85%
I am embarrassed or afraid to seek mental health services	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%

Exhibit 97 reviews the most significant barrier that kept women from using VA now or in the past. Significant differences were found between the answers of users and non-users. Users of VA care more often reported an *other-specify* response (15% users versus 12% non-users), followed by *I don't understand my benefits* (10% users, 29% non-users), and *The VA is too far away* (10% users versus 7% non-users). For non-users, the most common response was *I don't understand my benefits* and *I haven't been provided with any information about VA healthcare* (25% non-users versus 5% users). Looking at other-specify responses (Exhibit 98), users mostly reported *It is too difficult to get an appointment* (25%), and non-users mostly reported *The quality of care at VA is subpar* (16%). It should be noted that of the other-specifies, most were extremely varied and could not be grouped for any meaningful analysis.

Exhibit 96: Most significant barrier that kept women from using VA now or in the past, by user status

Most significant barrier that kept respondent from using VA now or in the past ‡	Users (pop%)	Users (95% CI)	Non-users (pop%)	Non-users (95% CI)
I don't understand my benefits	10%	(9 - 11)	29%	(28 - 31)
I haven't been provided with any information about VA healthcare	5%	(4 - 6)	25%	(24 - 27)
I have no way to get to a VA facility	1%	(1 - 2)	1%	(0 - 1)
The VA is too far away	10%	(9 - 11)	7%	(6 - 8)
The VA's hours are inconvenient	5%	(4 - 6)	2%	(1 - 2)
I have no access to child care	1%	(1 - 2)	**	**
VA facilities lack privacy or safety	1%	(1 - 1)	1%	(0 - 1)
VA providers are not sensitive to women's needs	4%	(3 - 5)	1%	(1 - 2)
There is not enough access to women's services	5%	(4 - 6)	1%	(1 - 2)
I am embarrassed or afraid to seek mental health services	4%	(3 - 5)	1%	(1 - 1)
Other	15%	(13 - 17)	12%	(11 - 13)
None to report	39%	(37 - 41)	20%	(18 - 21)

‡ Rao-Scott chi-square p-value is < 0.001

** Unreliable estimates, coefficient of variation ≥ 0.30

Exhibit 97: Other-specify responses, most significant barrier that kept women from using VA now or in the past, by user status

Most common other-specify response to: Most significant barrier that kept respondent from using VA now or in the past ‡	Users (% of other)	Users (95% CI)	Non-users (% of other)	Non-users (95% CI)
The quality of care the VA is sub-par	13%	(10 - 16)	16%	(13 - 19)
It is too difficult to get an appointment	25%	(21 - 30)	6%	(4 - 8)
I prefer to use other insurance	**	**	11%	(8 - 14)
Repeat of closed-end response	15%	(12 - 19)	16%	(13 - 20)
Other (many different responses)	44%	(39 - 50)	51%	(47 - 56)

‡ Rao-Scott chi-square p-value is < 0.001

** Unreliable estimates, coefficient of variation ≥ 0.30

5.6 Comparison to the National Survey of Women Veterans

Comprehensive comparisons between the NSWV and Barriers to Care surveys are difficult due to differences in both question wording and answer scales. However, some simple comparisons can be performed. Across the studies, VA users agreed in similar proportions about the importance of receiving both women specific care as well as primary care from the same location.

Comprehensive care for users of VA health systems continues to be important, with 80% of users rating this aspect of care *very important* or *somewhat important* across years. Importance of receiving care in a clinic just for women also continues to be rated highly with above 60% of users rating it *very important* or *somewhat important*.

Women Veterans report satisfaction with providers' knowledge of women's health issues. While not directly comparable between surveys, this factor was above 55% in both 2008 and 2012 among VA users for 'top two' satisfaction (*extremely* and *very satisfied* in 2008 versus *completely* and *somewhat satisfied* in 2012).[27] Comparatively, ratings for satisfaction with providers' sensitivity to the concerns of women were over 60% in both 2008 and 2012 for top two satisfaction (*extremely* and *very satisfied* in 2008 versus *completely* and *somewhat satisfied* in 2012). These are viewed as general trends; direct comparison of these statistics is not recommended.

In both studies, the most common self-reported reason to use VA health care was related to *cost of care or lack of other insurance* and *care specific to service-connected disabilities*. The most popular reason for choosing care outside of VA (and at roughly the same magnitude) for both studies was *having insurance outside of the VA*.

A detailed comparison of the two studies can be found in Appendix E.

6.0 Discussion

The respondent population of the Barriers to Care survey generally reflects the demographics of the overall population of women Veterans, is drawn from women across all geographic regions, and includes responses from both users and non-users of VHA services; we can be confident that the data collected in this survey is representative of the experiences of women Veterans as whole.

This discussion will touch upon the highlights of the findings in each of the nine Barriers to Care along with possible implications for these findings. A focus of the study was to identify actionable information for use in informing both policy and practice. Where appropriate, actionable issues are discussed here, but will be addressed in greater detail in the Recommendations section.

[27] 2008 refers to the National Survey of Women Veterans, which was based on a sample population from 2008; 2012 refers to the Barriers to Care survey, fielded in 2013-2014, which was based on a sample population from 2012.

Barrier 1: Comprehension of Eligibility Requirement and Scope of Services

Not surprisingly, a significantly higher percentage of system users reported having received information related to VA services than did non-users. Since this is self-reported and based upon individual recollection, it could very well be that information was received, but the respondent never looked at it, or did not remember looking at it. Women who do not perceive a need for VA services may often just disregard information that they receive. This presumption is manifested in the data in that a significant number of women who reported that they had *not* received VA information also stated that they had did have *sufficient* information. The concern here is that they may be basing their determination on an inadequate or incomplete understanding of what is available and how it might benefit them. This dynamic is consistent across user groups, VISNs and all service areas. Assuming that the woman Veteran received information, but does not report or remember receiving it, an important take-away is **that only 51% of non-users felt that they had enough information on eligibility for VA services**.

As a source of information, **brochures are most preferred by users and non-users alike**. Talking to a VA representative and getting information from family and friends were also popular sources. Reliance on printed sources of information may be counter intuitive in the electronic age, especially given the age and education of the respondents. The survey did not ask for self-reported computer literacy, but given our respondent demographics, it is probable the majority have reasonable levels of literacy with computers and the internet. Access to the internet may be an issue for some, although with the proliferation of data-capable cell phones, an increasing percent of all but the oldest age groups have some type of internet access. The preference for hard-copy resources may be the permanence (one can refer to it repeatedly with minimal effort) and the trustworthiness (reliability of internet sources are sometimes questioned). Person-to-person contact is effective in building trust, facilitating a question/response interaction that allows women to get more information and information that is more specific to their unique situation and interests. **The overall preference for hard copy versus electronic communication is also re-enforced by the fact that respondents indicated a preference for postal mail (46%) by a significant margin and email (26%) for future communications from VA**.

Disability level, however, seems to alter the preferred mode of communication considerably. **As disability level increases, the preference for telephone use increases**. This is important to consider should VA desire to communicate specifically with Veterans awarded disability ratings.

Timing of information delivery seems to support the concept of "early and often". Women would like to receive information both before they separate from service and repeatedly after separation/return from deployment. As discussed earlier, women may not seek or respond to information received if they do not understand the value of it at that

moment. Perceived value or applicability of VA programs often change over time and reaching Veterans when the need becomes apparent is important.

Barrier 2: Effect of Outreach about Women's Health Services

The user/non-user disparity found in assessing receipt of eligibility and service information (above), continues to hold when discussing receipt of information about Women's Health Services. **Most system users (67%) report having received information on Women's Health Services, compared to only 21% of non-users.** The percentage of women who received this information (for both groups) is lower than those having received general VA information. Women from all Service eras reported seeing this information, with pre-Vietnam Veterans reporting the most at 46%, with a declining percentage for each later era.

Across VISNs, there is significant disparity with the percentage reporting having seen information specific to women's care. For users, the range is 56%-83%, and for non-users it is 31%-52%. The lowest VISNs in the user groups do not necessarily correspond to the lowest scoring VISNs in the non-user groups. This may reflect variances within each VISN population, but may also be attributed to VISNs having disparate programs for communicating to women Veterans within their boundaries. It would be useful to explore the methods of those VISNs with high levels of awareness and determine if similar methods would be applicable to other VISNs.

Women who identified friends, family, or other Veterans as primary sources of information were less likely to say they had enough information. Causality cannot be established, however, since a lack of information may be the reason Veterans elect to speak to friends and family about their needs. Receiving a VA brochure or handout was marginally more likely to be associated with having enough information. The other sources were not associated, though this may be in part from a low frequency of occurrence.

Barrier 3: Effect of Driving Distance on Access to Care

The majority of women, whether in urban or rural settings, indicated that finding transportation to VA care was not problematic: overall, only 10% indicated that finding transportation is either *very hard* or *somewhat hard*. However, **there is an additional burden on those Veterans with higher disability ratings**. For women with a 70-100% disability rating, 12% indicate having a *very hard* or *somewhat hard* time finding transportation.

Based upon logistic regression, ease of finding transportation was a moderate strength significant predictor for VA use among current users (Estimate coefficient= 0.06, $F = 7.8$, $p = 0.0052$). **Those for whom finding transportation is easy use VA more frequently.**

Driving themselves was the clearly preferred mode of transportation across all user groups (80%). The second preferred mode was to have family or friends drive them (14%).

There is no significant difference between the transportation preferences of women Veterans living in rural versus urban locations.

The survey asked both users and non-users about their transportation experiences to non-Federal sites of care. Non-users report less difficulty finding transportation; however, this may be because they select their provider based upon proximity to either home or work, which may mitigate transportation problems. The limited number of VA sites of care (compared to available providers outside the federal system) makes this dynamic an inherent structural component of system design.

In general, the survey results do not indicate that transportation is a significant barrier to accessing care through VA for most women, although the population with higher disability rating (70-100% disabled) does bear a slightly higher burden from this perspective.

Barrier 4: Location and Hours

As mentioned in the discussion about transportation, there are clearly some limitations regarding VA locations of care when comparing access with availability of non-VA providers and facilities. VA is not expected to have the market penetration that networks outside the federal system collectively provide. However, there is much to learn about the usage patterns and preferences of those who are eligible for care and within a reasonable distance to a VA facility. Of the users who typically receive their Primary Care at VA sites of care, 10% reported *not* using their *nearest* VA for Primary Care, with no significant differences by VISN.

The most common reasons for bypassing the nearest VA were *the women's services I need are not available* (16%), and *I do not feel the providers are good* (12%). The most common, researcher coded other-specify responses included *I am happy with my outside provider* (22% of other), *the services I need are not available* (21% of other), *the nearest VA is too far away* (11% of other), and *difficulty getting an appointment* (10% of other). There may be some confusion with the *other* response of *the nearest VA is too far away*, as this statement is contradictory to the question being asked, and may relate to the understanding of the term bypass. It could be that these women have access to both VA and non-federal care and choose non-federal care due to proximity (not physically *bypassing* the closest VA facility). The point made by responses to this question is that **perception of quality of providers and availability of needed services are the dominant reasons for selecting one VA facility over another, even if it is further away.**

Assessing the appropriateness of hours is associated with the availability of appointments for the days and hours desired by women Veterans, as well as the urgency of need for the appointment. **The scores are generally very good for women receiving an appointment in the timeframe needed.** Availability of Primary Care appointments (typically needed more urgently than routine or mental health appointments) is scored lowest compared to appointing for other types of health care services. Percent scored as outstanding (a 5 on a

5-point scale) by appointment type is369% for primary care, 47% for routine women's services, and 46% for mental health care. Combined 4 and 5 ratings (top-two on the 5-point scale) are 60%, 71% and 70%, respectively. Non-surprisingly, women in the employment group *retired, volunteer, or other* reported higher levels of satisfaction with appointment times. This group is generally expected to have more flexibility in their schedules and find more of the available appointment times to be satisfactory. Women with the least amount of satisfaction with appointing were in the employment group *unable to work or unemployed* and *other commitments* (other including full-time homemaker, a full-time student, or a full-time care giver to a child or adult parents). Women in these categories may find the least flexibility in adjusting their schedules to accommodate available appointment times.

The logistic regression for Convenience of appointments at VA was a strong predictor of frequency of VA usage (Estimate coefficient= .22, F = 12.8, p = 0.0004). **Women reporting agreement that VA has convenient appointment times use VA care more frequently.**

The open-ended answers provided some very valuable insights into this barrier. Our data indicated that **morning appointments are most preferred across all employment types (including the unemployed)**. This is not surprising, however, some of the reasons for this preference (as gathered from respondent comments) are important to note. The preference is not necessarily because of a personal scheduling convenience, but rather because as the day goes on, appointments may run further and further behind schedule. Respondent comments reflect that appointments scheduled for late morning, or afternoon, may frequently be delayed "all day" because of delays from earlier appointments.

Concerns and recommendations about appointing was one of the top three categories for all the respondent comments (receiving thousands of comments). One theme among the appointing comments was that patients state that they request appointments and are then simply "assigned" an appointment without being consulted as to acceptability of date or time. Some stated that they received a formal letter indicating an appointment time, but they had not been consulted in the scheduling of the appointment. Other women indicated that they even missed scheduled appointments (or had to call to reschedule) because the letter notifying them that an appointment had been made did not arrive in time to comply or the appointment was incompatible with their availability.

The communication about appointing may be a barrier that needs more attention. Even if satisfactory appointment times are available, if the communication and confirmation of appointments is not handled effectively, patients will be highly dissatisfied and this could discourage use of the VA system.

Barrier 5: Childcare

More users than non-users report that finding childcare to attend medical appointments is *somewhat hard* or *very hard* (42% for users, 30% for non-users). Women who are not married also have more difficulty finding childcare (39% find it hard/very hard to find childcare versus 29% for married women). Finding care is easier as women get older, and it

is slightly easier for women in rural settings. For the last three demographics mentioned, this disparity is likely due to support networks available to the women. Married women may be able to rely on their spouse for support. Many in rural communities have stronger local familial networks that may play a role in providing better childcare options. Older women tend to have developed broader (and more stable) networks and may have more financial resources to acquire childcare. Age of the mother is also associated with the age of the child. Older women may have older children that are of an age where they are in school, or can be left alone without needing childcare.

Comparison of means shows significant variation in ease of finding childcare across VISNs. Some of this may be explained by the rural/urban characterization of each VISN. Overall, the logistic regression model was a poor fit. **Ease with which women can find childcare is not associated with user status (Wald = 2.2, *p* = 0.14)**.

When queried about the possibility of on-site childcare, three out of five women (62% overall) indicated that they would find on-site childcare *very helpful*. Otherwise, more non-users than users reported that on-site child care would be *somewhat helpful* (22% non-users vs. 16% users) and more users than non-users reported that on-site child care would be *not helpful* (22% users vs. 17% non-users). **In general, many women would like on-site childcare, but this is not a significant factor in whether they choose to utilize VA care.**

Barrier 6: Acceptability of Integrated care

We assessed the integration of VA health care for women Veterans through the implementation of Comprehensive Care. For this research, Comprehensive Care was defined as having one provider who can provide all general medical care and all routine women's health care such as Pap smears, contraception, and menopause care. Comprehensive Care is becoming more prevalent throughout the healthcare industry and is embraced because it often results in better coordination, better communication, improved outcomes, better control of costs, and higher levels of patient satisfaction.[28] VHA has identified three Women's Health Comprehensive Primary Care Clinic Models which capture the range of settings in which Comprehensive Care is provided for women Veterans.

- Model 1 - General Primary Care Clinics. Comprehensive primary care for the women Veteran is delivered by a DWHP. Women Veterans are seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the Clinic. Referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance.

[28] Patient Protection and Affordable Care Act (P.L. 111-148), Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), Healthy People 2020 (http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services), Grossmeier, J et al. Impact of a Comprehensive Population Health Management Program on Health Care Costs. Journal of Occupational & Environmental Medicine: June 2013, Volume 55, Issue 6. P. 634-643.

- Model 2- Separate but Shared Space. Comprehensive primary care services for women Veterans are offered by DWHP in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.
- Model 3- Women's Health Center (WHC). VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

Overall, almost all women Veterans (91%) have a primary care provider or team. Of the women who receive care at the VA, 74% report that they usually receive their Primary Care through VA and 77% are receiving Comprehensive Primary Care. Of the women receiving Comprehensive Primary Care, 30% are receiving their care at a women's clinic at VA while 44% are receiving their care at VA, but not in a women's clinic.

When asked about the importance of receiving care from a clinic just for women, **users placed a greater importance on having clinics for women only** (60% for users, 47% for non-users). This may be due to the male dominated atmosphere within VA (due to Veteran demographics) as opposed to a typical non-federal care setting, and their satisfaction with the women's clinic setting. While women throughout all demographic categories show a preference for women-only settings, some subsets of the women Veteran population may be particularly sensitive to mixed-gender settings. The study asked about preferred care settings for women who previously experienced *unwanted sexual attention* or *threat or force of sex*. Women who reported previous unwanted sexual attention preferred women-only clinics slightly more than those who did not have that experience (52% to 48%). **Women who experience threat or force of sex felt more strongly, with 57% stating it was *very important* or *somewhat important* to have women-only clinics (versus 47% who did not have that experience).** This is not surprising as women's clinics offer an environment that has minimal male-presence where they may feel more comfortable or less threatened.

Additional comprehensive care features were assessed including *having one provider for primary care and women's services* and *having a female provider for women's specific services*. **With regard to having a single provider for all care, 75% total rated it as *very important* or *somewhat important*.** More VA users than non-users rated the measure as *very important* or *somewhat important* (80% of users, 74% of non-users overall). There are no statistical differences between importance of having one provider by the experience of unwanted sexual attention, and a weak statistical significance between women who did or did not have experience with threat or force of sex (53% with experience of threat or force of sex vs. 46% no experience). Among users, the importance of having one provider for all care may be related to the benefit of ongoing relationships with providers at VA, continuity of care, and scheduling of appointments.

The importance of **having a *female provider for women's services*** may be less important than the other integration of care metrics with 65% of women rating it as *very important* and

somewhat important but, even though the preference is lower, this is still **a strong satisfier for women**. Open-ended comments from respondents noted that women's clinics often had only one female provider and that appointments with that provider frequently backed up. **This would indicate a possible shortage of female providers available to provide women-specific care.**

This segues to the final metric related to integrated care – whether or not women Veterans agree with the statement that *At VA sites of care, women may see a female provider they want to*. Because this question is asked of both user and non-users, the answers may reflect both perception and actual experience. Women who are not using the system reported lower rates of agreement with the statement (59% of non-users vs. 72% of users *somewhat* or *strongly agree*). This finding indicates that perception can be a real barrier for non-users. **Twenty-eight percent of users do not agree with the statement that *they may see a female provider if they want to*.** This may stem from a shortage of female providers at VA sites of care and not every woman Veteran who would like a female provider can access one (or even knows they may request one). Across VISNs there are significant differences in the mean level of agreement with the statement among users, but not among non-users. This indicates that some locations may have more or fewer female providers available. For non-users the perception of the ability to choose a female provider is widespread and not location specific.

Barrier 7: Gender sensitivity (users only)

VA has historically been viewed as having a male dominated culture due to the preponderance of male patients (and providers) resulting from the fact that most Veterans are male. The changing demographic of the VA population makes it imperative that the culture evolve not just to accommodate women Veterans, but to actively embrace their needs and respond accordingly. To evaluate gender sensitivity in VA care settings, the study included questions about satisfaction with the relationships with providers and clinic staff and whether the woman felt respected.

***Satisfaction with provider* for women receiving comprehensive care is good and is fairly consistent across VISNs** regardless of whether it is delivered in a women's specific clinic or in a general primary care clinic. However, within some VISN ratings for *satisfaction with provider* outside of the comprehensive care setting does differ based on type of care and location in which the care is received. This may indicate that **VA is generally performing well in the provision of gender sensitive care, but some VISNs have primary care clinics which are lagging behind other care settings (comprehensive and women only) in this regard.** This may reflect staffing or staff training challenges, and the unique culture of a women's clinic within VA. As may be expected, **regression analysis found that women who report greater satisfaction with their primary care provider use the VA system more frequently.**

The women Veterans using the VA system who are most satisfied with their primary care provider are those who receive comprehensive care in a women's clinic. By age,

there is a near-linear relationship where as age increases, satisfaction increases. Women aged 18-44 are least satisfied and women aged 65-80 are most satisfied. By disability, there is also a near-linear relationship where, as disability rating increases, satisfaction decreases. **Women with 70-100% disability ratings are least satisfied and women with no disability rating are most satisfied.**

Women reported the highest level of respect from their primary care provider and increasingly less respect by other providers and office staff, with office staff showing the least amount of respect. This finding is supported by the open-ended comments. By care type, women receiving comprehensive care in a women's clinic report the highest level of respect from all staff, measured as a composite, with women receiving comprehensive care outside of a women's clinic and women receiving primary care, but not comprehensive care reporting increasingly lower levels of respect from VA staff. Again this may indicate the success of dedicated women's clinics within VA, offering a more women-friendly and respectful environment than that of the greater VA.

The *staff respect* composite shows significant differences by VISN for women receiving primary care, but not comprehensive care, and women receiving comprehensive care received outside of a women's clinic. This indicates that **some VISNs have a greater focus on patient-staff interaction than others, whether or not that is related to respect shown to women Veterans. VISNs that are low performers in staff respect outside of women's clinics may benefit from additional training and/or tools to improve their interaction with women patients.** Similar to the rating on satisfaction with provider discussed in the previous paragraph, there are near-linear relationships between level of respect shown by staff and both age of the woman and disability rating level. Older age groups report being treated with more respect than younger age groups. Those with no disability rating report being treated with more respect than those with higher disability ratings. These findings are supported, appearing as general trends within healthcare literature.

Barrier 8: Mental Health Stigma

Society, in general, and the military culture, in particular, can place many pressures on women in need of mental health services. Yet, data shows that women Veterans have an increased need for these services. **System users are 1.85 times more likely (an increased "risk" of 85%) to report depression and 3.63 times more likely to report PTSD than non-users of VA health care. It is imperative the women Veterans can locate the care they need, and are willing to enter the system to access it.**

More than half of women Veterans (52%) indicate they have needed mental health care. Of the system users who self-reported a need for mental health services, 49% indicated they had received mental health care from a Vet Center, and 64% reported they received mental health care from VHA sites of care (questions were not mutually exclusive).

Overall, 24% of women indicated that they were hesitant to seek care for mental health issues, with more users than non-users feeling hesitant (35% of users vs. 21% of non-users). Differences in levels of hesitancy among users and non-users were also found by Service era, those with self-reported traumatic brain injury (TBI), self-reported depression, and unwanted sexual attention or threat or force of sex. **Reasons for hesitancy to seek care (from any source), in decreasing order, include *I'm worried about medicines used* (62%), *It could negatively affect my job* (54%), *Others would think less of me* (47%), *I prefer spiritual/religious counseling* (40%), *I'm not sure it would help me* (36%), *I would think less of myself* (32%), and *It could affect my relationship with family/spouse* (31%).**

Current social pressures are not the only reason women are hesitant to seek mental health care**. A significantly higher proportion of users, compared to non-users, reported avoiding VA because of past sexual trauma (19% of users vs. 8% of non-users).** Given the enduring male dominated culture and patient base in VA facilities, women who already have misgivings about seeking care, may be even more hesitant when faced with barriers of both mental health stigma and gender sensitivity issues.

Barrier 9: Safety and Comfort (users only)

The simple act of needing healthcare may make some people feel vulnerable. Add to that the complexities of accessing the system and the foreign environment and processes, and it becomes easy to see that helping patients feel comfortable and safe can significantly influence satisfaction.

Of the various safety and comfort factors measured for general VA experiences, the lowest ratings (although still positive) were for *Waiting areas were comfortable and welcoming*, *Check-in areas had adequate privacy*, and *Parking areas were accessible*. However, due to the co-linearity among all the safety and comfort factors, a composite factor was created to facilitate analysis.

The composite scores for all safety and comfort elements, when assessed by various demographic categories, showed similar near-linear relationships as seen on other barrier analyses. **Women from all demographic categories expressed agreement that the safety and comfort factors in VA facilities were adequate.** But women from earlier Service eras had stronger agreement than more recent eras; those with no disability or lower disability ratings showed higher agreement than those with higher disability rating; and those with no experience of unwanted sexual attention/threat or force of sex showed stronger agreement that VA has adequate safety and comfort. Findings by Service era may be more reflective of age than any military experiences, with higher satisfaction among older women Veterans.

By Service era, **more recent Veterans (OEF/OIF-Present era) felt that facilities were less safe and comfortable overall.** By disability rating, **satisfaction with safety and comfort steadily decrease as disability level increases.** As may be expected, **women**

with experiences of unwanted sexual attention or threat or force of sex have feel less safe and comfortable in VA facilities than women who did not have these experiences. These trends may have a basis in that women Veterans are already outnumbered in a mostly older male-dominated environment at VA sites of care, and younger age puts them even more out of place.

Statistically significant differences in the mean scores for the safety and comfort composite were found by VISN and by urbanity/rurality of the respondent's home residence. The logistic regression showed that **facility safety and comfort is a moderate strength, significant predictor of the amount of health care received at VA, with more feelings of comfort related to more frequent use**.

Only 9% of VA healthcare users indicated they had an inpatient experience at VA within the last 24 months. Women from the OEF/OIF-Present era reported significantly less satisfaction with safety and comfort compared to women from other eras. **The least satisfying experience for this group was with the admissions process.** By disability, those with higher disability ratings (70-100%) felt the least safe and comfortable with the ease and speed admissions process. This may be due to limitations with mobility and/or comprehension, resulting in greater dependence on others to help navigate the process.

Women with previous experiences of unwanted sexual attention or threat or force of sex felt significantly less safe and comfortable than women Veterans without those experiences (for almost all measures). **The inpatient measure with which they felt the least comfortable was the ability to secure the door to their room at night.** Statistically significant differences were found for the overall composite for inpatient safety and comfort by VISN.

Additionally, only 3% of women VA healthcare users reported an **inpatient mental health stay** in the previous 24 months**.** The current era respondents were less comfortable with their inability to *secure the door to their room at night* and *having access to a private bathroom* during their stay. By disability rating, women with a rating of 40-60% were the least comfortable during their stay, with their dominant concern being comfort while *showering during their stay* and the *speed of the admissions process*. There are no statistically significant differences in mean ratings for safety and comfort with an inpatient mental health stay for either those having (or not having) previous experience with sexual trauma or threat or force of sex. **The number of women reporting a mental health inpatient stay is too low to assess differences in safety and comfort by VISN, and too low for regression analysis.** Women with 40-60% disability may be less comfortable than women more or less disabled due to the fact that they are disabled enough to be vulnerable, yet likely still able to (and wanting to) take care of themselves compared to Veterans who are more disabled and likely more used to relying on others for assistance.

The preceding discussion highlights the findings in each of the nine identified Barriers to Care. The intent is to provide actionable information to VA to inform development of policies and practice and to guide the use of resources to eliminate or mitigate barriers to care. Recommendations based upon these findings are found in the following section.

7.0 Recommendations for improvement

This assessment of the nine barriers as stated in PL 111-163 provides a solid basis not only for confirming that some of these barriers exist, but for exploring what actions would be most effective in removing or mitigating these barriers. Sometimes the results of the study may be counter intuitive and cast new light on old problems. Additionally, the solicitation of free-form comments allowed respondents to share observations or ideas about barriers that may not have been included in the questionnaire. Evaluating these comments adds breadth to the analysis and will help policy-makers and VA leaders understand a broader spectrum of issues that may need attention.

The barriers explored in the study may be real or perceived. Sometimes the barrier comes in the form of a gap to be filled rather than an obstacle to be removed. Capturing these nuances is critical to interpreting the findings and applying the lessons learned to real-world practice.

One enduring challenge for VA is in the **communication** with and education of the target population (women Veterans). Getting information *to* them is distinct from getting them to read or comprehend what is provided, although both the dissemination of information and the understandability are critical. An interesting finding was that even in the electronic age, the most preferred and trusted sources are hard-copy brochures and person-to-person interaction. This is not to say electronic media presence is not important. Electronic media may be a primary source for many (even if it is not preferred), and those who need to request hardcopy information, or find the phone number for person-to-person, get connected through social media or a website. Because many women will not consume the information until they perceive they need it, it is important to continually seek opportunities to initiate contact with the target population – particularly the current non-users. With respondents' preference for hard copy materials, VA may consider policies to put hard copy materials in the hands of non-users on a periodic basis. Additionally, for electronic forms of information, comments from the open-ended section of the survey indicated that the materials about eligibility and services currently on the VA website are not easily comprehensible. VA may wish to have health literacy experts evaluate the content or display features of their websites to create more functional and understandable resources for prospective and current patients. Special attention should be paid to communications with disabled populations, as they significantly differ from the rest of the population in terms of preferred communication modes.

Dealing specifically with **outreach about Women's Health Services**, the user population is much more informed than the non-users; however, at 67% the user knowledge- base about women's health resources still leaves much to be desired. This may be an area where improvements could have a significant impact on an eligible woman's decision to use VA services. This study demonstrated the importance the women Veteran population places on gender sensitivity and women-specific clinics. VA providers /facilities must be viewed as having equivalent (or better) focus on the unique needs of women, compared to non-federal

providers. While VA has made major improvements in provision of this care in recent years, much of the population is not aware of these resources. Enhancing efforts in this area should help VA improve awareness in the women Veteran population.

VA is not expected to have the market penetration that networks outside the federal system collectively provide. Distance to a VA facility is not a problem that can be solved for everyone in the population. The good news is that most women do not indicate that **driving distance** is the main reason for not seeking care at a VA facility. This fact must be caveated with the fact that the population which has the most difficulty finding transportation to VA is also the population that may be most dependent on VA for care (those with high disability ratings). Therefore, while this population may not be inclined to seek care elsewhere, there is a clear opportunity for enhanced services in the transportation support of the disabled Veteran population. For the rest of the population the vast majority prefer to drive themselves or have friends/family drive them, There does not appear to be demand for VA-sponsored transportation (except possibly for the disabled).

Even when a VA facility may be nearby, some users of the system bypass the nearest VA facility to seek care elsewhere, indicating that **location** itself is not a major factor in the population's willingness to use the VA system. Issues of perceived quality of care/providers and availability of services appear to be more important in selecting a site of care. While excessive distances would certainly be a deterrent to seeking VA care, for those within a reasonable distance there are much more important factors in drawing them into the system. The majority of patients indicted that they were happy with the **availability of appointments** (days and hours) overall, but there is significant room for improvement in this area, especially for Primary Care appointments. The more urgent the need for care, and the more time constrained the individual was (full-time work or caregiving, etc.), the lower the satisfaction with appointment availability. The analysis of open-ended comments provides anecdotal, but very useful, information as to where the system may be improved. Communication and coordination appear to be major issues for appointing – issues that can likely be resolved with improved procedures and staff training. Actually seeing patients at or close to their appointed time is important, and solving this may have implications for both staffing levels and scheduling models. If women believed that an afternoon appointment was as likely to be on time as a morning appointment, demand patterns would change and satisfaction may be positively impacted.

While many women Veterans have children that may require **childcare** when the Veteran has a medical appointment, and 42% of users report having difficulty finding that care, childcare challenges do not appear to significantly influence a woman's decision to receive care at VA. Sixty-two percent of women indicated that they would find on-site childcare helpful, but lack of that care does not currently influence usage behavior. This would be a lower priority for action than other barriers.

Models for delivery of comprehensive care differ by location based on available resources and the population served. Only 3 out of every 10 women Veterans report receiving their Comprehensive Primary Care in a women's only clinic and 36% of all women who are VA

users indicated that having a clinic for women only was *very important* (60% rating it *somewhat* or *very important*). In a regression model, agreement that *women only clinics are important* and agreement that *women can see female providers if they wish* were both associated with a greater likelihood of using the VA, while the importance of *having one provider for all care*, and the importance of h*aving a female provider did not* predict VA use. All three VA models of care for women provide comprehensive care, but women clearly indicate that women-only settings are preferred. VA should look for opportunities to provide more women-only care settings. Improving availability of female providers for women's comprehensive care needs is a clear satisfier, but may not affect more women choosing VA for care. The data also show that women largely do not know that having a female provider is an option at VA facilities. With 28% of current VA users not in agreement with the statement that *women may see a female provider if they wish*, there may be instances where on the clinic operations are not in compliance with policies. Availability of female providers should be promoted in outreach efforts, which means that staffing models must provide adequate availability with these providers.

Gender sensitivity among providers and staff varies by location, but most significantly vary by the setting of care. Those in women-specific settings are viewed as being more sensitive to gender issues and showed more respect to their patients. Respect is critical in all settings and to all patient groups. Given the preconception that VA may not be women-friendly, positive and respectful interpersonal interactions can go a long way toward improving patient satisfaction, especially in places where a women's only clinic cannot be supported. Training and tools will certainly help improve this metric, but ensuring that the culture at VA continues to evolve to be sensitive to women is critical. Women who have a choice in their healthcare system will be deterred if not treated with respect. Younger women and women with higher levels of disability expressed an even greater dissatisfaction with the level of respect. All women Veterans deserve respect when accessing care through VA, and a cultural shift will be necessary to achieve this. This training and cultural shift would go hand-in-hand with overall patient-staff interaction training to ensure VA is treating all of their Veterans with respect and courtesy.

In addition to the mental health resources within the VHA, VA also offers mental health care through Vet Centers located in communities throughout the country. Nevertheless, availability of services may not be the biggest obstacle in reaching women who need this care. Women Veterans are negatively impacted by a perceived cultural stigma around **mental health care**. A quarter of women who needed this care were hesitant to seek it, and for system users 35% were hesitant. The reasons attributed to this reluctance to seek care include concerns about medications used in treatment in addition to personal and professional concerns. First, overcoming the perceived stigma will be essential if VA is to successfully reach and treat women Veterans. Then, once a woman does come to VA for mental health care, it will be doubly important that the environment be welcoming and sensitive to her needs and she feels she can discuss treatment options openly. Women who have experienced past sexual trauma may be even more inclined to avoid VA for their mental health needs, yet this is a population with significant need for these services. VA

must reach out to these women and provide a safe and welcoming environment to encourage them to seek the care they need.

Overall, women Veterans report that VA **facilities are safe and comfortable**. There is always room for improvement, and many of the areas where respondents have concerns should not require major resources to improve. The feel of the waiting areas and privacy at check-in were of highest concern and may be easy to impact. Accessible parking areas were also problematic, but due to established facility infrastructures there may be fewer options to impact this metric. For inpatients, one of the greatest concerns is with the admissions process. This process should be assessed in detail across facilities to identify best practices. Those practices should then be pushed throughout the system. Other concerns for inpatient care revolved around elements of physical safety and privacy. VA should identify where improvements can be made without compromising the ability to provide care.

Open-ended comments indicate that women with negative experiences with the VA consider those experiences as a barrier as well. Some chose to leave the VA system following these experiences while some could not get past the hurdle of the application and claims determination process. VA should explore best practices for positive patient-staff interactions and increase communication surrounding necessary administrative processes, such as appointment scheduling and claims determinations. Having readily available avenues for problem resolution is also essential. Patient advocates are often useful in such cases. The survey did not ask about availability or use of patient advocates, but it would be beneficial for patients trying to navigate the VA health care system. VA should increase awareness of these, or similar, problem resolution resources to better assist patients and ensure that the highest level of satisfaction and care are being achieved.

This study highlights some actionable areas where the VA system can invest effort and resources to improve comprehension, access to care and delivery of services in ways that will influence women Veterans' decisions to seek care through VA. The findings also provide insight into future areas of research. Many of the barriers studied could benefit from additional focused research to dig deeper into the factors and identify more specific actions to improve system usage and patient satisfaction. The variation among VISNs on most barriers indicates significant inconsistency in practices and/or resources. Studies to help identify and evaluate best practices would be worthwhile. VA should then establish mechanisms to implement those best practice system-wide, providing additional guidance and support to facilities that lag in the metrics.

8.0 Resources

Delcher C., Wang Y., Maldonado-Molina M. Trends in financial barriers to medical care for women veterans, 2003-2004 and 2009-2010. Prev Chronic Dis 2013; 10. Available at http://www.cdc.gov/pcd/issues/2013/13_0071.htm

Frayne SM, Phibbs CS, Saechao F, Maisel NC, Friedman SA, Finlay A, Berg E, Balasubramanian V, Dally SK, Ananth L, Romodan Y, Lee J, Iqbal S, Hayes PM, Zephyrin L, Whitehead A, Torgal A, Katon JG, Haskell S. *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 3. Sociodemographics, Utilization, Costs of Care, and Health Profile*. Women's Health Evaluation Initiative, Women's Health Services, Veterans Health Administration, Department of Veterans Affairs, Washington DC. February 2014.

Healthy People 2020 (http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services)

Public Law 111-148. Patient Protection and Affordable Care Act

Public Law 111-152. Health Care and Education Reconciliation Act of 2010

Public Law111-163, Caregivers and Veterans Omnibus Health Services Act of 2010, Section 201.

U.S. Department of Veterans Affairs website, www.va.gov

U.S. Department of Veterans Affairs. VA Women Veterans Task Force*. 2012 report.*

U.S. Department of Veterans Affairs. Center for Women Veterans . Advisory Committee on Women Veterans. Reports. 2012. Available at http://www.va.gov/WOMENVET/docs/Final_Advisory_Committee_on_Women_2012_Report.pdf

U.S. Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1330.01*, May 21, 2010.

U.S. Department of Veterans Affairs. Women's Health Evaluation Initiative (WHEI), VA HSR&D Center for Innovation to Implementation. *Sourcebook: Women Veterans in the Veterans Health Administration, Volume 3: Sociodemographics, Utilization, Cost of Care, and Health Profile,* February 2014

U.S. Department of Veterans Affairs. Center for Women Veterans . Advisory Committee on Women Veterans. Available at http://www.va.gov/womenvet/ACWV.asp

U.S. Department of Veterans Affairs. Women Veterans Health Care. About the Women Veterans Health Care Program. Available at http://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/about.asp

U.S. Department of Veterans Affairs. Center for Women Veterans. Available at http://www.va.gov/womenvet/

U.S. Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Special reports. Available at http://www.va.gov/vetdata/docs/SpecialReports/Women_Veteran_Profile5.pdf

U.S. Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Quick facts. Available at http://www.va.gov/vetdata/docs/QuickFacts/Population_quickfacts.pdf

U.S. Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. Special reports. Available at http://www.va.gov/vetdata/docs/specialreports/final_womens_report_3_2_12_v_7.pdf

U.S. Department of Veterans Affairs. http://www.va.gov/WOMENVET/2011Summit/HayesFINAL.pdf

U.S. Department of Veterans Affairs. Women Veterans Health Care. Women Veterans Call Center. Available at http://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/wvcc.asp

U.S. Department of Veterans Affairs. http://www.va.gov/opa/publications/draft_2012_women-veterans_strategicplan.pdf

U.S. Department of Veterans Affairs. http://www.va.gov/WOMENVET/docs/Final_Advisory_Committee_on_Women_2012_Report.pdf

U.S. Department of Veterans Affairs. Office of Research and Development. The National Survey of Women Veterans by Donna Washington. Available at: http://www.research.va.gov/programs/womens_health/conference2010/washington.cfm

Vogt D, Bergeron A, Salgado D, Daley J, Ouimette P, Wolfe J. Barriers to Veterans Health Administration Care in a Nationally Representative Sample of Women Veterans. J Gen Intern Med. Mar 2006; 21 (Suppl 3): S19-S25. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513162/

Washington DL, Bean-Mayberry B, Riopelle D, Yano EM. Access to care for women veterans: delayed healthcare and unmet need. J Gen Intern Med. 2011 Nov; 26 Suppl 2:655-61. Available at http://www.ncbi.nlm.nih.gov/pubmed/21989618

Washington, Donna L. et al. *Assessment of the Health Care Needs and Barriers to VA Use Experienced by Women Veterans: Findings from the Nation Survey of Women Veterans*. Final Report. November 9, 2009.

Grossmeier, J et al. Impact of a Comprehensive Population Health Management Program on Health Care Costs. Journal of Occupational & Environmental Medicine: June 2013, Volume 55, Issue 6. P. 634-643

Study of Barriers for Women Veterans to VA Health Care

Appendix A

Methodology Report

1.0 Purpose

The Women's Health Services office of the Department of Veterans Affairs (VA) awarded a contract to Alarum Institute to conduct an independent comprehensive study of the barriers of comprehensive health care for women who are Veterans in response to Public Law 111-163, Sec. 201-Women Veterans Health Care Matters.

This study will help VA better understand barriers women Veterans face accessing VA care, the comprehensiveness of care, and improve the understanding of the long-term consequences of military deployment. The data collected will allow the VA to plan and provide better health care for women Veterans and to support reports to Congress about the status of women Veterans health care.

2.0 Background

Today, the proportion of female Service members and Veterans is at its highest point in history, with projections for continued growth. At the outset of this research endeavor, the VA Women Veterans Task Force had just released the draft 2012 report "Strategies for Serving Our Women Veterans" noting that the Active Component of the Armed Forces is now 14 percent female and the Reserve Component is 18 percent female, up from just 2 percent in 1950.[29] As those active and reserve military Service Members transition into Veteran status, women now make up the fastest growing cohort within the Veteran community.[30] One source found that approximately 1.8 million (8 percent) of the 22.2 million Veterans were women in 2011.[31] By 2020, these data indicate that women Veterans will comprise nearly 11 percent of the total Veteran population.

As the number of women Veterans increases, the VA continues to prepare for an increasing demand for women Veterans' health care needs. Over the last decade alone, the number of women Veterans using VA health care has nearly doubled.[32] Currently more than 500,000 women have enrolled in the VA health care system. While the attention and effort to serve the female Veteran population have been in place for decades, there have been renewed efforts to understand the current population dynamics and needs, especially as the war efforts in Iraq and Afghanistan draw down to a close.

On July 15-17, 2011, Secretary of Veteran Affairs, Eric Shinseki hosted the National Training Summit on Women Veterans in Washington, DC, to help identify and address the urgent needs of women Veterans stating, "It's not enough to tell me to just do something—

[29] VA Women Veterans Task Force. 2012 report. "Strategies for Serving Our Women Veterans." Accessed on 3/1/2012. Available at http://nuraiitj.appspot.com/www.va.gov/opa/publications/Draft_2012_Women-Veterans_StrategicPlan.pdf

[30] Ibid.

[31] Department of Veterans Affairs, VetPop07, via the National Center for Veterans Analysis and Statistics (NCVAS)

[32] VA Women Veterans Task Force. 2012 report.

just make things better. Tell me the “what” to attack; what do we need to do? What do we need to go after? What do we need to begin putting in place for the next two generations of women Veterans?” Additionally, during the Summit, Secretary Shinseki called for the formation of a Women Veterans Task Force (WVTF) to lead the development of a comprehensive VA action plan to examine gaps and barriers in how the VA serves women Veterans. This interest and support of the VA’s most senior leadership, combined with the capability and commitment available throughout the VA organization will be critical in the ongoing improvements in serving Women Veterans.

The Study of Barriers for Women Veterans to VA Health Care, overseen by the Women Veterans Health Care team, will help the VA better understand the needs of the growing Women Veterans population by examining health care use, preferences, and the barriers Women Veterans face in access to VA care. The results will aid decision-makers in understanding how women interact with the current VA system and identify actionable opportunities for improvement.

3.0 Public Law 111-163, Section 201

PUBLIC LAW 111–163—MAY 5, 2010 124 STAT. 1145

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS

SEC. 201. STUDY OF BARRIERS FOR WOMEN VETERANS TO HEALTH

CARE FROM THE DEPARTMENT OF VETERANS AFFAIRS.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall conduct a comprehensive study of the barriers to the provision of comprehensive health care by the Department of Veterans Affairs encountered by women who are veterans. In conducting the study, the Secretary shall—

(1) survey women veterans who seek or receive hospital care or medical services provided by the Department of Veterans Affairs as well as women veterans who do not seek or receive such care or services;

(2) administer the survey to a representative sample of women veterans from each Veterans Integrated Service Network; and

(3) ensure that the sample of women veterans surveyed is of sufficient size for the study results to be statistically significant and is a larger sample than that of the study referred to in subsection (b).

(b) USE OF PREVIOUS STUDY.—In conducting the study required by subsection (a), the Secretary shall build on the work of the study of the Department of Veterans Affairs titled ‘‘National Survey of Women Veterans in Fiscal Year 2007–2008’’.

(c) ELEMENTS OF STUDY.—In conducting the study required by subsection (a), the Secretary shall conduct research on the effects of the following on the women veterans surveyed in the study:

(1) The perceived stigma associated with seeking mental health care services.

(2) The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care.

(3) The availability of child care.

(4) The acceptability of integrated primary care, women's health clinics, or both.

(5) The comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services.

(6) The perception of personal safety and comfort in inpatient, outpatient, and behavioral health facilities.

(7) The gender sensitivity of health care providers and staff to issues that particularly affect women.

(8) The effectiveness of outreach for health care services available to women veterans.

(9) The location and operating hours of health care facilities that provide services to women veterans.

(10) Such other significant barriers as the Secretary considers appropriate.

(d) DISCHARGE BY CONTRACT.—The Secretary shall enter into a contract with a qualified independent entity or organization to carry out the study and research required under this section.

(e) MANDATORY REVIEW OF DATA BY CERTAIN DEPARTMENT DIVISIONS.—

(1) IN GENERAL.—The Secretary shall ensure that the head of each division of the Department of Veterans Affairs specified in paragraph (2) reviews the results of the study conducted under this section. The head of each such division shall submit findings with respect to the study to the Under Secretary for Health and to other pertinent program offices within the Department of Veterans Affairs with responsibilities relating to health care services for women veterans.

(2) SPECIFIED DIVISIONS.—The divisions of the Department of Veterans Affairs specified in this paragraph are the following:

(A) The Center for Women Veterans established under section 318 of title 38, United States Code.

(B) The Advisory Committee on Women Veterans established under section 542 of such title.

(f) REPORTS.—

(1) REPORT ON IMPLEMENTATION.—Not later than 6 months after the date on which the Department of Veterans Affairs publishes a final report on the study titled ''National Survey of Women Veterans in Fiscal Year 2007–2008'', the Secretary shall submit to Congress a report on the status of the implementation of this section.

(2) REPORT ON STUDY.—Not later than 30 months after the date on which the Department publishes such final report, the Secretary shall submit to Congress a report on the study required under this section. The report shall include recommendations for such administrative and legislative action as the Secretary considers appropriate. The report shall also include the findings of the head of each division of the Department specified under subsection (e)(2) and of the Under Secretary for Health.

4.0 Scope

Alarum Institute developed a survey in collaboration with a team from the Women's Health Services office that builds on the 2009 National Survey of Women Veterans (NSWV). The goal was to collect at least 400 surveys from each of the 21 Veteran Integrated Service Networks (VISNs) for a minimum of 8400 completed interviews. This telephone survey took about 45 minutes if all questions were applicable to a respondent, and data were collected about barriers to the provision of comprehensive health to women Veterans in compliance with the requirements of Public Law 111-163, sec. 201.

- The perceived stigma associated with seeking mental health care services
- The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care
- The availability of childcare while using VA services
- The acceptability of integrated primary care, women's health clinics or both
- The comprehension of eligibility requirements for, and the scope of services available under hospital care and medical services
- The perception of personal safety and comfort in inpatient, outpatient and behavioral health facilities
- The gender sensitivity of health care providers and staff to issues that particularly affect women
- The effectiveness of outreach for health care services to women Veterans
- The location and operating hours of health care facilities that provides services to women Veterans
- The role and performance of Women Veteran Program Managers at VHA health care systems

5.0 Instrument Development

To meet the analytic goals of the study, the VAWH questionnaire was designed to collect data on the nine barriers to care outlined in Public Law 111-163, as well as in the 2009 NSWV study for comparison. Questions were developed a piori from current literature and in consultation with other VA stakeholders. The survey asks women questions related to each of the nine barriers to care as well as about their current/recent health care including where

they received their care, what type of care they have needed/received, how satisfied they are with that care, and what their preferences for care were. Since non-users are not eligible to answer questions about the VA health system, the survey length was shorter for the non-user population. Additionally, researchers added additional questions to help inform the VHA on closely related women's healthcare issues that were not strictly within the nine pre-defined barriers of care.

Overall, the VAWH survey asks about:

- Utilization of VA health care both in VHA run facilities and care purchased outside the VA system;
- Satisfaction with care received (inpatient and outpatient at VA facilities);
- Reasons for not using VA health care;
- Information on health care access if not using VA health care;
- Barriers to using VA health care (mental and sexual health related questions);
- General questions on status of physical and mental health;
- Demographics.

Filter questions (yes/no response) were developed to guide respondents through each section of the survey. Within each section, respondents were asked a series of closed-ended questions with either a Likert-style response scale or a set of responses developed *a priori* from relevant literature and related surveys. One open-ended question at the end of the survey allowed women Veterans to report, in their own words, anything else upon which they wish to comment. Respondents had the option to skip any question with which they were uncomfortable.

Instrument development occurred over several stages:

- Review of existing surveys in related topics of interest
- Forum discussions with Subject Matter Experts and Stakeholders
- Cognitive interviews with women Veterans
- Test of Final Instrument via 'slow start' of fielding

5.1 Review of Surveys

In preparation for survey development Altarum was tasked to review the National Survey of Women Veterans and other major VA and non-VA surveys to help understand the existing body of work and inform instrument development on the current Barriers to Care study. A summary report was produced which provided an overview of the main surveys reviewed by Altarum researchers.

This review of the professional and academic literature, along with the assessment of existing survey instruments was an essential component of building a relevant and valid research and instrument design for the Barriers to Care study. The health services sector

has a robust and growing basis of evidence to which the current study will contribute. Findings from the existing surveys can direct our efforts to those areas where the greatest probability for collecting new information exists.

The Altarum research team identified an initial group of more than 35 surveys and studies that were potentially relevant to this work. A subset of these was selected for item-by-item review for grouping into our barriers matrix. Ultimately, eleven of these surveys were determined to be the most topically relevant and were discussed in the summary report. An even smaller subset of existing surveys contributed the bulk of the content input to the Barriers to Care survey instrument. These include:

- National Survey of Women Veterans (2009)
- American Legion – Women Veterans Survey (2011)
- Nation Survey of Veterans (2010)
- Survey of Veteran Enrollees' Health and Reliance upon the VA (2011)

The context of these survey instruments, their accompanying reports, methodology and findings are only a portion of the knowledge brought to bear on this important research. The content knowledge and expertise of the project working group is the driving factor toward understanding and interpreting these published studies and findings. The collective knowledge of the group, the sensitivity to the needs of women Veterans, and knowledge of VHA's efforts to improve their care experiences and outcomes makes a true difference in this project. Interaction with these studies and identification of additional studies and published literature was ongoing throughout research design and implementation.

5.2 Subject Matter Expert/Stakeholder Forum

Soliciting input from subject matter experts (SMEs) and stakeholders was an important element in the research design. On May 10, 2012, SMEs/Stakeholders convened in Washington, D.C. for a full day to review the Public Law, the background of the issue, and the goals and approach to the research at hand.

Participants in the Forum included:

Maribel Aponte	Anne Sadler, PhD
Karen Feibus, MD	Amy Smith (Altarum)
Susan Frayne, MD	Barbara Stephens
Sally Haskell, MD	Donna Washington, MD
Patricia Hayes, PhD	Tom Wilkinson (Altarum)
Rachel Kimerling, PhD	Becky Yano, PhD
Karen Metscher, PhD (Altarum)	Laurie Zephyrin, MD
Laura Nelson (Altarum)	

In the morning session, the participants provided extensive input as to the relative importance of various topic areas, the impact topics have in patient care and care delivery systems, and important insights into regional differences and the VA/VHA culture. In the afternoon, we started a review of the draft survey instrument which elicited much discussion. We were not able to complete the instrument review on that day, so telephonic follow-on sessions were scheduled for those participants who wished to continue to provide comments on the balance of the survey. These sessions were completed later in May. Ultimately, major revisions to the instrument were made as a result of receiving input from these SMEs and stakeholders.

5.3 Cognitive Interviewing

As part of the instrument development we also conducted cognitive interviews. Under OMB guidelines we are able to conduct these as long as the number does not exceed nine interviews. We recruited eligible participants via social media, such as Veteran-related group pages on Facebook, and the placement of flyers in a few local VA Women's Health Clinics. In each case, women who saw the solicitation and were interested in participating were asked to contact the project Point of Contact.

Ultimately we were able to complete six cognitive interviews with women who were eligible for VA healthcare. Cognitive interviewing is a technique used to provide insight into learners' perceptions in which individuals are invited to verbalize thoughts and feelings as they examine information. Use of cognitive interview techniques may improve the development of materials. These interviews were conducted in August/September 2012 and included both women who currently utilize the VA healthcare system and those who have never used the VA healthcare system. The feedback from these interviews assisted us in revising wording and response sets to help make the material more understandable and relevant to the respondents.

5.4 Final Instrument Approvals

Production of the final survey instrument (which is included at the end of this document) was a compilation of the components outlined here and the experience and expertise of the participating research staff. The final questionnaire included 92 questions (some of which were multi-part). The Office of Management and Budget (OMB) packet was submitted by the Project Office in October 2012. The packet consisted of the OMB justification document 831, Sections A and B, the adverse event script, the instrument, and all the materials that would be shared with potential respondents (the pre-note letter, the Frequently Asked Questions sheet, the Women's Health Information brochure). Approval of the OMB packet was received in October 2013. The OMB Control number is 2900-0795. Internal Review Board (IRB) approval was received in November 2013.

6.0 Methodology – Sampling and Fielding

6.1 Survey Mode

The VAWH study was conducted via Computer Assisted Telephone Interviewing (CATI). CATI interviewing has several advantages over other modes of survey administration, including respondent retention that yields higher response rates, adherence to skip patterns, immediate data entry, and fewer barriers to respondents such as a need for internet access or levels of reading proficiency. To ensure the highest participation rate possible, a pre-notification letter was sent to each eligible woman Veteran in the sample which explained the purpose of the study. Also included was an informational brochure about the VA's women's health services.

6.2 Data Sources

The Department of Veterans Affairs, Veterans Health Administration, maintains a database of all known U.S. Veterans. This database is known as USVETS. A random sample of 101,100 names of Women Veterans for the VAWH study was extracted from this database and provided to Altarum Institute based on specifications provided by Altarum to comprise the sample frame for the study. While address and contact information were contained within the VA sample frame extraction data, it was imperative to have the most current contact information. Therefore, the sample frame was processed through a third party vendor prior to fielding to update addresses and phone numbers. The third party information, if available, was taken as the most accurate current representation of the VA beneficiaries' contact information. Where there was no person level match with the third party vendor to a given Veteran within the sample frame, the VA supplied data was retained as the most accurate and relevant data for use.

6.3 Sample Frame Construction

To achieve the analytic goals of the study, the sample frame for the VAWH study was stratified by VISN and by those who have used VA health services (heretofore known as 'users') and have not used VA's health services (heretofore known as 'non-users') in the last 24 months, as of the most recent update of the USVETS database, which was end of the fiscal year 2012. The study goal included a minimum of 8,400 completed interviews, targeting 400 cases per VISN equally split between user and non-user populations within each VISN. To begin the sampling process, Altarum reviewed aggregate statistics from the USVETS database. This aggregate demonstrated that there were enough records of women Veterans to complete 200 surveys in each of the 21 VISNs for both users and non-users. However, phone numbers necessary for telephone interviewing were lacking for almost 8 out of 10 (79%) women Veterans in the USVETS database. To meet study requirements given initial response rate assumptions and data limitations found within the USVETS database, Altarum initially requested a total stratified random sample of 73,500 women Veterans with equal representation across VISNs, with disproportionate splits between user

and non-user populations given expected differences in response rates between users and non-users. This resulted in a sample of 3,500 women Veterans per VISN, with 1500 users and 2000 non-users per VISN across the 21 VISNs.

Anticipating an overall 20 percent response rate, with a differential response rate by user/non-user status of 25% and 16.67% respectively, Altarum sub-sampled 42,000 women from the initial larger sample of 73,500 to support initial fielding operations. The 42,000 records comprised 2,000 women veterans from each VISN with 800 representing users and 1,200 representing non-users.

The sample frame was continuously monitored in terms of meeting expected requirements given actual response rates on a weekly basis throughout the fielding process. With each week of fielding, actual strata-specific response rates and sample consumed relative to available sample were reviewed. Strata specific projections were made to allow for adjustment to sampling strategies by strata and to ensure the available sample would meet requirements. After the first few weeks of fielding, projections revealed that, given differential and unexpected response rate levels, additional sample would be required to ensure study requirements would be met. Based on projections and actual experience, strata specific requirements were developed and an additional sample request was made to the VA representing an additional random sample of 27,600 women Veterans. The total resulting sample frame comprised 101,100 female veterans. Exhibit 1 below displays the evolution of the sample frame with strata specific numbers contained in: 1) the initial sample frame; 2) the additional strata specific sample requested; and the resulting total final sample available to support the study.

Exhibit 1 Sample Frame Requirements and Construction

VISN	VA Health Services User Type	Target Completed Cases	Initial VA Sample Size Requested	Additional Sample Count Requested	Final Available Sample Size
VISN 01: VA New England Healthcare System	User	200	1,500	400	1,900
VISN 01: VA New England Healthcare System	Non-user	200	2,000	1,000	3,000
VISN 02: VA Healthcare Network Upstate New York	User	200	1,500	1,000	2,500
VISN 02: VA Healthcare Network Upstate New York	Non-user	200	2,000	1,600	3,600
VISN 03: VA NY/NJ Veterans Healthcare Network	User	200	1,500	400	1,900
VISN 03: VA NY/NJ Veterans Healthcare Network	Non-user	200	2,000	2,000	4,000
VISN 04: VA Stars & Stripes Healthcare Network	User	200	1,500	400	1,900
VISN 04: VA Stars & Stripes Healthcare Network	Non-user	200	2,000	1,400	3,400
VISN 05: VA Capitol Health Care Network	User	200	1,500	800	2,300
VISN 05: VA Capitol Health Care Network	Non-user	200	2,000	1,200	3,200
VISN 06: VA Mid-Atlantic Health Care Network	User	200	1,500	400	1,900
VISN 06: VA Mid-Atlantic Health Care Network	Non-user	200	2,000	400	2,400
VISN 07: The Southeast Network	User	200	1,500	400	1,900
VISN 07: The Southeast Network	Non-user	200	2,000	400	2,400
VISN 08: VA Sunshine Healthcare Network	User	200	1,500	400	1,900
VISN 08: VA Sunshine Healthcare Network	Non-user	200	2,000	400	2,400
VISN 09: VA Mid South Healthcare Network	User	200	1,500	400	1,900
VISN 09: VA Mid South Healthcare Network	Non-user	200	2,000	600	2,600
VISN 10: VA Healthcare System of Ohio	User	200	1,500	400	1,900
VISN 10: VA Healthcare System of Ohio	Non-user	200	2,000	3,000	5,000
VISN 11: Veterans In Partnership	User	200	1,500	400	1,900
VISN 11: Veterans In Partnership	Non-user	200	2,000	400	2,400
VISN 12: VA Great Lakes Health Care System	User	200	1,500	400	1,900
VISN 12: VA Great Lakes Health Care System	Non-user	200	2,000	800	2,800
VISN 15: VA Heartland Network	User	200	1,500	400	1,900
VISN 15: VA Heartland Network	Non-user	200	2,000	400	2,400
VISN 16: South Central VA Health Care Network	User	200	1,500	400	1,900
VISN 16: South Central VA Health Care Network	Non-user	200	2,000	400	2,400
VISN 17: VA Heart of Texas Health Care Network	User	200	1,500	400	1,900

VISN	VA Health Services User Type	Target Completed Cases	Initial VA Sample Size Requested	Additional Sample Count Requested	Final Available Sample Size
VISN 17: VA Heart of Texas Health Care Network	Non-user	200	2,000	400	2,400
VISN 18: VA Southwest Health Care Network	User	200	1,500	400	1,900
VISN 18: VA Southwest Health Care Network	Non-user	200	2,000	800	2,800
VISN 19: Rocky Mountain Network	User	200	1,500	400	1,900
VISN 19: Rocky Mountain Network	Non-user	200	2,000	400	2,400
VISN 20: Northwest Network	User	200	1,500	400	1,900
VISN 20: Northwest Network	Non-user	200	2,000	400	2,400
VISN 21: Sierra Pacific Network	User	200	1,500	400	1,900
VISN 21: Sierra Pacific Network	Non-user	200	2,000	800	2,800
VISN 22: Desert Pacific Healthcare Network	User	200	1,500	400	1,900
VISN 22: Desert Pacific Healthcare Network	Non-user	200	2,000	400	2,400
VISN 23: VA Midwest Health Care Network	User	200	1,500	400	1,900
VISN 23: VA Midwest Health Care Network	Non-user	200	2,000	1,000	3,000
All VISNs	**Users and Non-users**	**8,400**	**73,500**	**27,600**	**101,100**

Prior to fielding, the third party vendor updated the addresses and telephone numbers of the women Veterans contained in the full sample frame. After the vendor update of contact information, the VISN designation of approximately 15 percent of the women in the sample frame indicated a change from their initial VISN to another VISN. In addition, some of the contact information was found to be incorrect or missing. An analysis of the data post vendor update and post data cleaning processes, found the following:

1. Of the 101,100 potential available sample, 91,972 cases contained valid contact and address information. After removing cases for individuals found to be deceased, the final fieldable available sample was comprised of 90,154 cases.
2. The older population is far less likely to have an address change reflecting change in VISN (age 51+ being least likely). The 25 to 33 age group is most likely to have a VISN change having 4.2 times the odds of a change than the elderly population. The age groups 20-24 and 34-41 are in the middle ground for probability of VISN change having 2.7 the odds of the elderly of a VISN change. The age 42-50 group has 1.6 times the odds of a VISN change than the elderly (age 51+). In summary, the probability of VISN change increases with age up to age 41, then decreases with age past age 41, with the age 51+ being the least likely to move across VISNs.
3. Users have increased odds by a factor of 1.37 of having a VISN change relative to non-users, after controlling for other factors.

4. The VISNs with the least change for the initial population are VISNs 1, 10, 12, and 21.
5. The VISNs with the largest change rates for population are VISNs 5, 9, 15, 16, and 17.
6. The distribution of the population in terms of VISN and User/Non-User given VISN change potentially negatively impacts VISN 2 and VISN 3 the most.

6.4 Sample Management

In order to effectively manage the sample in the field and to ensure 400 completions per VISN, with an equal split between users and non-users within VISN, the sample was organized into batches and replicates. Batch sizes consisting of 4,200 cases were created with each batch consisting of 80 user cases and 120 non-user cases for each VISN across the 21 VISNs.

Each batch was organized into replicates of 20 cases each within strata. This allowed for the fielding to be controlled in small batches and additional cases to be released into the field by replicate creating a dynamic process which efficiently conserved resources while effectively supporting target objectives.

Exhibit 2 Fielded Sample Sizes and Completed Cases, by Strata

VISN	VA Health Services User Type	Target Completed Cases	Fielded sample	Completed Cases	% of target
VISN 01: VA New England Healthcare System	User	200	971	**203**	**102%**
VISN 01: VA New England Healthcare System	Non-user	200	2,212	**203**	**102%**
VISN 02: VA Healthcare Network Upstate New York	User	200	1,302	**204**	**102%**
VISN 02: VA Healthcare Network Upstate New York	Non-user	200	2,226	**203**	**102%**
VISN 03: VA NY/NJ Veterans Healthcare Network	User	200	1,395	**203**	**102%**
VISN 03: VA NY/NJ Veterans Healthcare Network	Non-user	200	2,543	**203**	**102%**
VISN 04: VA Stars & Stripes Healthcare Network	User	200	1,251	**203**	**102%**
VISN 04: VA Stars & Stripes Healthcare Network	Non-user	200	2,123	**203**	**102%**
VISN 05: VA Capitol Health Care Network	User	200	1,364	**203**	**102%**
VISN 05: VA Capitol Health Care Network	Non-user	200	1,987	**205**	**103%**
VISN 06: VA Mid-Atlantic Health Care Network	User	200	1,127	**205**	**103%**
VISN 06: VA Mid-Atlantic Health Care Network	Non-user	200	1,726	**203**	**102%**
VISN 07: The Southeast Network	User	200	1,158	**203**	**102%**
VISN 07: The Southeast Network	Non-user	200	1,821	**203**	**102%**
VISN 08: VA Sunshine Healthcare Network	User	200	1,008	**203**	**102%**

VISN	VA Health Services User Type	Target Completed Cases	Fielded sample	Completed Cases	% of target
VISN 08: VA Sunshine Healthcare Network	Non-user	200	1,549	**203**	**102%**
VISN 09: VA Mid South Healthcare Network	User	200	1,140	**204**	**102%**
VISN 09: VA Mid South Healthcare Network	Non-user	200	1,912	**203**	**102%**
VISN 10: VA Healthcare System of Ohio	User	200	1,296	**203**	**102%**
VISN 10: VA Healthcare System of Ohio	Non-user	200	2,359	**203**	**102%**
VISN 11: Veterans In Partnership	User	200	990	**203**	**102%**
VISN 11: Veterans In Partnership	Non-user	200	1,761	**203**	**102%**
VISN 12: VA Great Lakes Health Care System	User	200	983	**203**	**102%**
VISN 12: VA Great Lakes Health Care System	Non-user	200	1,995	**203**	**102%**
VISN 15: VA Heartland Network	User	200	959	**203**	**102%**
VISN 15: VA Heartland Network	Non-user	200	1,734	**203**	**102%**
VISN 16: South Central VA Health Care Network	User	200	1,156	**203**	**102%**
VISN 16: South Central VA Health Care Network	Non-user	200	1,785	**203**	**102%**
VISN 17: VA Heart of Texas Health Care Network	User	200	1,108	**203**	**102%**
VISN 17: VA Heart of Texas Health Care Network	Non-user	200	1,739	**203**	**102%**
VISN 18: VA Southwest Health Care Network	User	200	1,166	**203**	**102%**
VISN 18: VA Southwest Health Care Network	Non-user	200	1,929	**203**	**102%**
VISN 19: Rocky Mountain Network	User	200	1,092	**203**	**102%**
VISN 19: Rocky Mountain Network	Non-user	200	1,836	**203**	**102%**
VISN 20: Northwest Network	User	200	1,137	**203**	**102%**
VISN 20: Northwest Network	Non-user	200	1,657	**203**	**102%**
VISN 21: Sierra Pacific Network	User	200	1,138	**203**	**102%**
VISN 21: Sierra Pacific Network	Non-user	200	1,885	**203**	**102%**
VISN 22: Desert Pacific Healthcare Network	User	200	1,263	**203**	**102%**
VISN 22: Desert Pacific Healthcare Network	Non-user	200	1,884	**203**	**102%**
VISN 23: VA Midwest Health Care Network	User	200	1,068	**203**	**102%**
VISN 23: VA Midwest Health Care Network	Non-user	200	1,774	**203**	**102%**
All VISNs	**Users and Non-users**	**8,400**	**64,509**	**8,532**	**102%**

The field staff worked each batch. Given the dynamic process built into the sampling design, if cases for a specific VISN strata were exhausted in one batch, sample for that VISN or strata was released into the field from the next batch by replicate. This ensured that sample was released in a controlled manner, that field staff were able to work the sample in a dynamic and timely manner consistent with study protocol and design requirements.

This system also allowed fielding staff to monitor the completed case levels by strata relative to targets. At the completion of fielding, target objectives were met or exceeded for every strata. Response rates increased during the latter half of the fielding cycle leading to a reduction in sample size requirements and fielding levels. In total, the study resulted in 8,532 completed cases – exceeding the target objective of 8,400 cases by 132 cases (+1.57% above objective).

Fielded sample comprised 64,509 individuals resulting in an overall response rate of 13.2%, well below the initial assumption at project start of an overall response rate of 20%. Exhibit 2 displays the final fielded sample size, completed case counts, and percent of target objective met for each strata.

6.5 Fielding Protocols

Survey fielding was accomplished through the use of professionally trained interviewers using CATI software. The CATI system allows a computer to perform a number of functions otherwise prone to error when done manually by interviewers, including:

- Providing correct question sequence;
- Automatically executing skip patterns based on prior question answers (which decreases overall burden on respondents);
- Recalling answers to prior questions and displaying the information in the text of later questions;
- Providing random rotation of specified questions or response categories (to avoid bias);
- Ensuring that questions cannot be skipped by the interviewer (i.e., an entry is made to every question, even if the entry is “no response”); and
- Rejecting invalid responses or data entries.

Prior to beginning work on the telephone survey component, all interviewers received extensive training. Interviewer training had two components. First, newly-hired interviewers attended an intensive multi-day training program that covered the technical aspects of computerized interviewing, good interviewing techniques, human subject protection and the ethics of research, and proper recording of call results. Second, prior to working on the VAWH project, all interviewers received additional training specific to this study and the survey questionnaire; this training included the details of the survey protocol and proper interaction with VAWH respondents.

During the field period, interviewing calls were monitored as a primary quality assurance check. Monitoring involved field supervisory staff connecting to ongoing telephone interviews with actual respondents. This connection was unobtrusive and unknown to the interviewer and the respondent. Field supervisors conducted the monitoring and completed a quality control checklist for each monitored interview. After the interview was complete,

field supervisors debriefed the interviewer and discuss any detected deficiencies in technique or the rules of the study protocol.

At least ten contact attempts at various times of the day during different days of the week were attempted with each potential respondent to obtain a completion. Some cases may have received additional follow-up if the field supervisor deemed it to be a possible completion with a little extra effort.

At the conclusion of the fielding period, the collected telephone survey data with final disposition codes was assembled into an encrypted dataset. The original survey sample file was updated with field disposition codes (completed case, invalid phone number, respondent refusal, etc.).

This study utilized the Caller ID function to lend legitimacy to the effort from the perspective of the call recipients. The Caller ID indicated “VA WOMENS STUDY” rather than the name of the organization placing the calls.

An agreement was put in place with The Veterans Crisis Line to allow study interviewers to provide a “warm transfer” for any respondent showing signs of distress and agreeing to be transferred to the Crisis Line. Interviewers could also provide the Crisis Line number to respondents in the event they desired the phone number.

6.6 Fielding Schedule

Following receipt of OMB approval in October 2013, fielding for the survey began on December 10, 2013 with an anticipated nine month fielding period. Calling ended on August 4, 2014, ahead of schedule, having achieved the desired number of completes in all strata. Actual fielding was completed in approximately eight months.

7.0 Methodology – Analysis

7.1 Analysis of the Data

The analysis for the VAWH study included basic descriptive statistics (frequencies and frequency tabulations, measures of central tendency, dispersion, and range of response data) for each of the questions. In addition, bivariate analyses including comparisons between VISNs, users and non-user populations, and similar analyses were conducted using generally accepted statistical methods (e.g., correlation analysis, t-tests, z-tests of proportions, chi-square). Most importantly, the effect of each of the nine known barriers was evaluated using multivariable and multivariate regression methods which control for relevant known factors which may be related to outcome differences (e.g., socio-demographic characteristics). The effect of barriers to care on women is that they prevent women from using health services provided by or paid for by the VA. Through regression analysis we were able to discern the comparative level of effect of each barrier to develop a targeted approach on improving access to care for women Veterans. Additionally, qualitative data from the open-ended question was used in analyses to help support findings and

recommendations. The findings from this VAWH study were compared to the 2009 NSWV study.

7.2 Creating Analysis Variables

Each of the nine barriers to care is assessed through multiple questions in the VAWH survey. Data from each set of questions went through a multi-phased analytical approach which began with an understanding of individual question response levels, transitioned to two-way relationship understanding between pairs of questions, and phased into a multidimensional factor analysis which will be used to ascertain the degree to which the question sets represent a single concept (principal factor) or set of concepts. Factor analysis measures including uniqueness, communality, eigenvalues, and factor loadings will be used to support these assessments. Relationships, or lack thereof, will be reported.

7.3 Weighting the Data

The complex survey design represented within this study required a typical four stage weighting design: 1) base weights; 2) non-response weights; 3) post stratification weights; and 4) final weights equal to the product of the base, non-response, and post stratification weights. Each of these weights was developed as follows:

1. Base weights

Base weights are the initial weights assigned to a given potential respondent in the sample. These weights were calculated as the inverse of the probability of selection for a given individual from within the population. The weight essentially represents the number of people that the person in sample represents within the given population. The base sample design used the 21VISNs by user/non-user status as the basic units of stratification. Since these strata had varying population sizes, there were varying probabilities of selection for individuals within each VISN. The VA included base weights with the 73,500 person extract. The sum of the VA-provided base weights, by strata, for the initial sample of 73,500 female veterans were used to set strata population totals. Once additional sample was supplied, the base weights were adjusted by strata giving each individual in the final data set equal probability (weight). Thus, for a given strata (VISN and User type), base weights sum to VA female veteran national population totals.

2. Non-response weights

Although the base sample weight adjusted for varying probabilities of selection, all studies experience differential non-response across strata. To minimize potential bias in results, this differential response required a post-field non-response weight to be calculated, to bring the final collected sample back to representing the original population. Altarum used the generally accepted statistical practice of logistic regression to estimate non-response rates. A dichotomous dependent variable was created using respondents and non-respondents (1=responded, 0=non-response) and logistic regression was conducted using variable measures known for both respondents and non-respondents to assess which factors

influence differential response rates. These independent variable measures generally consisted of categorical variables representing socio-demographic characteristics. The final regression model led to predicted response probabilities. The inverse of these response probabilities were used as the non-response weights, thus created propensity score adjusted weights. An alternative non-response weight was calculated simply as the inverse of the probability of response by strata. Each type of non-response weight was assessed to determine which should be used for final weight development. Propensity scored weights were determined to best meet requirements and used for final weight development.

3. Post-stratification weights

The application of non-response weights can lead to a misalignment of populations with some potentially excessive weights which skew the respondent population data. To control for this as well as to adjust the weights to ensure they best reflect the populations to which they are to measure, Altarum estimated post stratification weights using Stata statistical software's embedded survey specific procedures. These procedures incorporate a raking scheme (i.e., iterative proportional fitting) to correct the interim weights to come into alignment, as applicable, with the populations they represent.

4. Final weights

Final weights for each respondent were calculated as the product of Base weight * Nonresponse weight * Post-stratification weight. Once final weights were calculated and applied to the data, survey specific analytical techniques and methods were applied to help minimize potential bias, account for within strata correlation, and reduce likelihood of overstating significance of results. Altarum employed survey specific analysis techniques such as those contained within Stata, SUDAAN, and SAS which incorporate the complex survey design and weighting scheme contained within the VAWH survey.

7.4 Variance Estimation

To minimize potential for human error, Altarum employed the built-in survey specific variance estimation algorithms as contained within Stata, SUDAAN, and SAS. These variance estimation methods adjust for within group correlation, adjust for small sample sizes, and correct for issues encountered within survey response data.

Study of Barriers for Women Veterans to VA Health Care

Appendix B

Pre-notification Letter Sent to Study Participants

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

Date: [INSERT CURRENT DATE]

Dear: [INSERT FIRST AND LAST NAME]:

We would like to invite you to participate in a survey about your knowledge of and/or experiences with the Department of Veterans Affairs (VA) health care system. In the next few weeks, an interviewer from Altarum Institute will call you on the phone to ask about your experiences with and views on the general health care, primary care, and/or women's specific services you received from the VA health care system.

Our records indicate that your current phone number is (123) 456-7890.

If this is incorrect or you would prefer to be contacted at another number, please contact us by calling [INSERT NUMBER] or by e-mail at [INSERT EMAIL] to provide us with an updated or preferred phone number.

Following is a little more information about the study we are conducting.

Why are we calling?

- The Department of Veterans Affairs wants to have a better understanding of the health care experiences of women Veterans and their interaction with the VA health care system. VA has asked Altarum Institute to gather this information.
- Altarum will interview about 8,400 women Veterans by phone to hear about their experiences and views.
- You received this invitation because you are a woman Veteran who has used, or may be eligible to use, VA health care benefits. Even if you do not currently use VA health care benefits, we would still like your feedback about our system.

Who is Altarum Institute?

- Altarum is a non-profit independent health research organization, and is not part of VA. The VA hired Altarum to gather information about barriers that may keep women from using the VA's health care system.

How long will the telephone interview take and what will you ask me?

- The interview will take about 45 to 60 minutes.
- We will ask you some questions about your knowledge of, and experience with, the VA health care system. Questions will focus on general health care, primary care, and women's specific services. We will ask about your satisfaction with the care you have received and about your general health.

Do I have to do this?

- This is your chance to share your experiences with the VA health care system, and we believe this is important. However, you do not have to take part if you do not want to. Even if you agree to participate in the survey, you can skip any specific questions you do not want to answer.
- Your decision about taking part in this interview will not affect any services you receive from VA or your eligibility for services in the future.

Is this confidential?

- YES! Your responses are protected.
- No one will connect your name to any information that you provide.
- We will combine your answers with answers from other participating Veterans and show them only as totals and averages, never as individual responses associated with you.

What will Altarum do with this information?

- Your confidential answers will help VA understand women Veterans' experiences.
- VA will use this information to improve the quality of care you and other women Veterans receive.
- VA strongly encourages you to participate in this important study.

Who do I contact for more information?

If you have questions about the survey, please contact **[SURVEY POC/HELPDESK]** by sending an email to **[INSERT EMAIL]**; by calling **[INSERT NUMBER]**; or sending a fax to **[INSERT NUMBER]**.

Thank you very much for helping with this important study. The information you provide will help to improve VA services for all women Veterans.

Sincerely,

Patricia M. Hayes, PhD

Chief Consultant, Women's Health Services

OMB Control Number: 2900-0795
Expiration: 10/31/2016
Public Reporting Burden Statement
VA may not conduct, sponsor, or require the respondent to respond to this collection of information unless it displays a valid OMB Control Number. All responses to this collection are voluntary. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time necessary for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Failure to furnish the requested information will have no adverse effect on any VA benefits to which you may be entitled.
The information you supply will be confidential and protected by the Privacy Act of 1974 (5 U.S.C. 522a) and the VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b). Disclosure of information involves releases of statistical data and other non-identifying data for the improvement of services with the VA benefits processing system and for associated administrative purposes. If you have comments regarding this burden estimate or any aspects of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

Study of Barriers for Women Veterans to VA Health Care

Appendix C

Sample informational Brochure Sent to Study Participants

The following exhibits are examples of a brochure that were sent to women Veterans sampled to participate in the Barriers to Care survey, along with the cover letter explaining they would be contacted. These images feature the front and back sides of an insert that discussed frequently asked quesitons (FAQs) about women Veteran's Health Care at VA.

WOMEN VETERANS HEALTH CARE

Frequently Asked Questions

1. **What health care services are available to women Veterans?**

   A full continuum of health care, including comprehensive primary care (care for acute and chronic illness and gender-specific care), specialty care, mental health care, disease prevention and screening, emergency care, and women's health specialty care (e.g., advanced breast and gynecological care, maternity care, and some infertility treatments). In addition, VA offers services such as inpatient medical/surgical/mental health care, physical rehabilitation, substance abuse treatment, long-term care, and pharmacy benefits. For more information on VA services provided to women Veterans, call 1-855-VA-WOMEN (1-855-829-6636).

2. **How can I learn about eligibility and enroll for VA health care?**

   Veterans can apply for VA health care enrollment and other Veterans benefits by completing VA Form 10-10EZ. Apply online at www.1010ez.med.va.gov or visit, call, or write to any VA health care facility or Veterans' benefits office. You can also call the VA Health Benefits Call Center toll free at 877-222-VETS (8387), or get more information online about VA benefits (www.vba.va.gov) and eligibility (http://www.va.gov/healtheligibility/).

3. **How do I get started with getting my health care in VA?**

   After you have enrolled for benefits (see #2 above), contact your local VA health care facility (found online at www.va.gov/directory) to arrange a primary care appointment.

4. **How do I get a clinic appointment? What if there is a waiting list for an initial appointment?**

   It is the Veterans Health Administration (VHA) goal that every new patient be scheduled for a non-urgent appointment within 14 days. If you have an urgent or emergent medical condition, contact your local VA health care facility (found online at www.va.gov/directory) or visit their walk-in (urgent care) clinic or emergency room.

5. **Does VA provide gynecologic care for menstrual problems and services such as Pap smears and birth control? What about breast care such as mammograms and breast cancer treatments?**

   VA provides women Veterans with a full range of reproductive health services necessary for optimal health throughout their lives, including the services above and more. Gynecology and maternity care are available either at your VA facility or through referrals to appropriate providers in the community. This referred care is covered by VA.

6. **Does VA provide pregnancy care?**

   VA covers pregnancy care typically through arrangements with community providers. VA will pay for prenatal care, delivery, and postnatal care for eligible women Veterans.

7. **If VA covers pregnancy care, why aren't babies delivered in VA hospitals?**

   VA covers pregnancy care through arrangements with community providers. VA will pay for prenatal care, delivery, and postnatal care for eligible women Veterans, as well as care to newborns for the first seven days after birth for all eligible women Veterans. Many details are involved with pregnancy care. Contact a Women Veterans Program Manager as early in pregnancy as possible to discuss local processes regarding prenatal care and to explore your options. If a pregnant Veteran has a permanent, total disability resulting from a service-connected injury, and the child is not otherwise eligible for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), then the child could receive care under VA's Civilian Health and Medical Program (CHAMPVA), which is different from VA's routine, seven-day newborn coverage.

8. **Does VA cover newborn care?**

   Yes, VA covers care to newborns for the first seven days after birth, for eligible women Veterans who are receiving VA maternity care.

9. **Does VA provide health care for my children?**

   The provision of health care to children who are not Veterans is limited to those instances where specific authority is given to VA by law. Contact your nearest VA health care facility (found online at www.va.gov/directory) and ask to speak with the Women Veterans Program Manager. Also, to find out if your child qualifies for health care through Medicaid and the Children's Health Insurance Program (CHIP) in your state, see http://www.insurekidsnow.gov/state/index.html or call 1-877-543-7669.

10. **Where can I get inpatient psychiatric care as a woman Veteran?**

    Most VA Medical Centers have inpatient mental health programs. Contact your VA Primary Care Provider, Women Veterans Program Manager, or the local Mental Health Program Office for assistance. If you already have a therapist and need inpatient care, please discuss your concerns with your therapist. If you have urgent or emergent needs, you can contact your local VA health care facility (found online at www.va.gov/directory),emergency center, or call the Veterans Crisis Line at 1-800-273-8255 and press "1" to receive confidential support 24 hours a day, 7 days a week.

11. **Where can I get inpatient medical/surgical care as a woman Veteran?**

    Most VA Medical Centers have inpatient medical units and surgery departments. Contact your VA Primary Care Provider or Women Veterans Program Manager for more information. If you have urgent or emergent needs, you can contact your local VA health care facility (found online at www.va.gov/directory) or emergency center.

12. **How do I get evaluated for nursing home care?**

    Under the Millennium Health Care Act of 1999, VA must provide or pay for nursing home care for Veterans who require it and who meet the following criteria:

    - Have a service-connected disability rating of 70 percent or more
    - Need nursing home care for a service-connected disability
    - Are rated 60 percent service-connected and are either unemployable or have an official rating of "permanently and totally disabled"

    Veterans enrolled in the VA healthcare system who require nursing home care for any other reason must meet income and asset criteria to be eligible. Placement is made based on nursing home availability and the Veteran may be assessed a co-payment for such services. Specific eligibility and admission criteria are unique to each nursing home. Learn more about long term care eligibility at http://www.va.gov/GERIATRICS/Guide/LongTermCare/Eligibility.asp. If you have never been seen at a VA health care facility, you must first enroll for benefits (see #2 above). Then you must enroll in a primary care clinic (see #3 above) and ask to be evaluated for nursing home care. The evaluation will be done either by the primary care provider or a geriatric care team.

13. **How can I get help if I am in crisis or to help another Veteran who is?**

    The Veterans Crisis Line is available 24/7. Call 1-800-273-8255 and press "1" to talk with someone immediately. Or text "838255" for a confidential chat.

14. **How can I get help related to sexual trauma?**

    VA provides free services to help Veterans who have experienced sexual trauma. Call the Veterans Crisis Line at 1-800-273-8255 and press "1" to receive confidential support 24 hours a day, 7 days a week.

15. **How can I get help if I am homeless or at risk of becoming homeless, or know another Veteran who is?**

    VA's 24/7 National Call Center for Homeless Veterans is staffed by VA counselors trained to help homeless Veterans or Veterans at risk for homelessness. The call center can be reached by calling 877-4AID-VET (877-424-3838). You can also contact your nearest VA health care facility (found online at www.va.gov/directory) and ask for the VA Homeless Coordinator or the Women Veterans Program Manager.

16. **What if I have a complaint about my care?**

    Contact the Women Veterans Program Manager or Patient Advocate at your nearest VA facility (found online at www.va.gov/directory). During normal business hours, you can contact the Veterans Health Administration (VHA) Women's Health Services at 202-461-0373 or VA Center for Women Veterans at 202-461-6193.

17. **How and where do I find historical information on women Veterans?**

    Read a VA report on the History of Military Women and their use of VA Benefits and Services at http://www.va.gov/VETDATA/docs/SpecialReports/Final_Womens_Report_3_2_12_v_7.pdf or go to the Women in Military Service for America Memorial website at www.womensmemorial.org.

18. **Who can I call for more help?**

    Women Veterans, caregivers and family members can call the Women Veterans Call Center at 1-855-VA-WOMEN (1-855-829-6636) for assistance. Caregivers can also reach out to the Caregiver Support Line at 1-855-260-3274.

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

WOMEN VETERANS HEALTH CARE

Women's Health Services, Department of Veterans Affairs, Veterans Health Administration, Washington, DC 20420
P96613 IB 10-561
07/13

Study of Barriers for Women Veterans to VA Health Care

Appendix D

Annotated Questionnaire

1.0 Introduction

The instrument for the Barriers to Care study is provided in the form of the Computer Assisted Telephone Interviewing (CATI) script that was read to each respondent. The script includes the specific language used by the interviewers as well as the skip patterns that were applied. Note that the automated CATI system applied the skip patterns based upon the recorded responses entered by the interviewers. Also note that interviewers were required to provide only the information within the script and could not add additional commentary. The interviewers were provided with additional scripts that provided more information on many of the questions, and they could read those to the respondents if the respondent asked for clarification or stated that they didn't understand what was being asked. Interviewers read all response options with each question. All interviewers were female due to the sensitive nature of some of the survey questions.

2.0 Annotation

Here we provide an annotated version of the CATI instrument. The annotation includes the provision of basic response results (i.e. the percent that women Veterans chose each response option). Additionally, for dataset users, the questionnaire has been annotated with additional information. The format of this annotated questionnaire is:

- Question number
- Variable name
- Question read to respondent
- Directions for help text or response criteria (i.e. select one or select all that apply)
- List of response options showing the percent of women Veterans who chose the first response option, followed by the value of this response option in the dataset, followed by the response option itself that was read aloud to the respondent
- Skip pattern logic

This type of annotation allows for a quick reference for tying questions to responses. Percentages of each response option are weighted to population totals. Some questions that allowed multiple responses will have total percentages over 100%. Respondents had the option to skip or refuse to answer any survey question they did not wish to provide an answer to.

"Hello, this is [Interviewer name] calling on behalf of the Department of Veterans Affairs. May I speak with [MS.] [First Name] [Last Name] to conduct an official survey?"

"I am calling from Altarum Institute, a non-profit health research organization. The Department of Veterans Affairs has requested we conduct a survey about your knowledge of, and interaction with, the health system and services offered by the VA. You may have already received an information packet in the mail about this survey. It is very important that we gather valuable feedback from all women veterans and we appreciate your participation. Portions of this call may be recorded for quality assurance purposes. The length of the survey varies based upon how many questions apply to you, but will not exceed 45 minutes."

Question number: S2
Variable name: WOMAN
Question: ***"Are you a woman who has ever served in the active U.S. Armed Forces?"***

1 *Yes*
2 *No*
3 No, not a woman (not read aloud, volunteered by respondent)

Skip logic: if yes, then go to question S4
Skip logic: If No, not a woman then terminate interview

Question number: S3
Variable name: ACTIVE_DUTY
Question: ***"Are you, or were you ever, a Reservist or National Guard member and called to active duty by a Federal Order for reasons other than training purposes and completed your full call-up period?"***

1 *Yes*
2 *No*

Skip logic: If QS2 not equal to Yes and QS3 is not equal to Yes, then terminate interview

Question number: S4
Variable name: EMPLOYED_BY_VA
Question: ***"Are you currently employed by the Department of Veterans Affairs?"***

1 *Yes*
2 *No*

Skip logic: if yes, then terminate interview

Skip logic: if don't know, then terminate interview

Skip logic: if refused to answer, then terminate interview

"Before we begin, I want to assure you that providing information in this survey is voluntary. There is no penalty and your VA benefits will not be affected in any way if you choose not to respond. The information you provide will be treated as confidential, and your name will not be linked with your answers. No identifying information about you is provided to the VA. Some questions in this survey deal with health issues and your military experience, and these questions may be upsetting to some people. If you are uncomfortable with any question, just tell me and we will skip it. May I have your consent to start the interview? Let's get started."

Question number: B1
Variable name: START_SERVICE
Question: ***In what year did you begin your initial active military service?***

99% Numeric response

Question number: B2
Variable name: END_SERVICE
Question: ***In what year did you last separate from active service?***

99% Numeric response

Skip logic: IF question B2 is not equal to 0000 then go to question B3

Question number: B3
Variable name: SERVICE_BRANCH
Question: ***In which branch(s) of the military did you serve?***

(Select all that apply)

48.7% 1 *Army or affiliated corps*
5.9% 2 *Marine Corps*
20.4% 3 *Navy or Affiliated Corps*
24.8% 4 *Air Force or affiliated corps*
1.8% 5 *Coast Guard or affiliated corps*

Question number: B4
Variable name: GRADE
Question: ***What grade did you hold at the time of your last separation from service or that you currently hold if you are still in the military?***

96% Numeric/Character response

Question number: B5
Variable name: COMBAT
Question: ***Did you ever serve in a combat or war zone as a member of the military?***

Help text (read if necessary): "This can be as active duty or mobilized reserve or national guard"

23.0% 1 *Yes*
76.0% 2 *No*

Question number: B6
Variable name: APPLIED_BENEFITS
Question: ***Have you ever applied for ANY benefits through the Department of Veterans Affairs (VA)? (health care, claim for disability. home loans, insurance, education, etc.)***

Help text (read if necessary): "Benefits could include health care, claim for disability, home loans, insurance, education, etc."

58.6% 1 *Yes*
40.5% 2 *No*

Question number: B7
Variable name: DISABILITY
Question: ***Do you have a VA service-connected disability rating?***

27.8% 1 *Yes*
70.2% 2 *No*

Skip logic: if No then go to question number B8

Question number: B7A
Variable name: DISABILITY_RATING
Question: ***What is your VA service-connected disability rating?***

(Any numeric response from zero to 100%)

26% Numeric response

Question number: B8
Variable name: ENROLLED
Question: ***Are you currently enrolled with the Veterans Health Administration?***

32.6% 1 *Yes*
61.3% 2 *No*

"During this interview, we are going to talk about three general ways that women Veterans can receive healthcare. The first is directly at a VA site of care, such as a VA medical center, a VA hospital, or a VA outpatient clinic. The second way is when the VA pays for care received by a woman Veteran outside of a VA site-of-care; this is sometimes called "contract care" or "fee-basis" care. And the third way is when a woman just receives care completely outside the VA system, from regular civilian providers who are not associated with the VA. This next section includes questions about these different categories of care."

Question number: B9
Variable name: VA_CARE
Question: ***In the past 24 months, have you received any care in a VA site of care?***

24.3% 1 *Yes*
75.5% 2 *No*
0.2% Don't know (volunteered, do not read)

Question number: B10
Variable name: CONTRACT_CARE
Question: ***In some cases, VA pays for a woman to receive care from a non-VA clinic or hospital. This is called "fee basis" or "contract care" care. In the past 24 months, have you received any care through the VA fee basis or contract care system?***

10.3% 1 *Yes*
88.7% 2 *No*
1.0% Don't know (volunteered, do not read)

Question number: B11
Variable name: PRIVATE_CARE
Question: ***Some women receive other health care outside the VA that they pay for through private insurance, through Medicare or Medicaid, or out of pocket. In the past 24 months, have you received any care in a non-VA setting?***

72.8% 1 *Yes*
26.8% 2 *No*
0.4% Don't know (volunteered, do not read)

"Please remember the three care settings I described earlier: Care received through a VA site of care, Care received through the VA "fee basis" system, and Care received completely outside the VA system. Throughout this survey you will be asked questions separately about each of these three care settings."

Question number: B12
Variable name: RECENT_VISIT
Question: ***When was your MOST RECENT visit to a VA health care site of care?***

(Year or Years ago)

48% Numeric response

Question number: B13
Variable name: HOME_CARE_SITE
Question: ***If you can, please identify the VA site of care nearest to your HOME?***

(Name of facility or city and state of facility)

100% Character response

Skip logic: IF QB9 is not equal to yes, then go to the introduction to the C-series questions.

Question number: B14
Variable name: MOST_CARE_SITE
Question: ***At which VA site of care do you receive most of your healthcare?***

(Name of facility or city and state of facility)

24% Character response

Question number: B15
Variable name: HOW_MUCH_CARE
Question: ***About how much of your health care did you receive from a VA site of care in the last 24 months?***

35.7% 1 *All*
29.3% 2 *Most*
16.7% 3 *Some*
14.8% 4 *Little*
2.5% 5 *None*
1.1% Don't know (volunteered, do not read)
0.02% Refused (volunteered, do not read)

"The VA offers a range of benefits to Veterans. Telling Veterans about these benefits is an ongoing effort. The next set of questions is about getting information from the VA."

Question number: C1A
Variable name: INFO_ELIG
Question: ***Do you recall receiving information about the eligibility requirements for VA health care services?***

44.7% 1 *Yes*
52.0% 2 *No*
3.3% Don't know (volunteered, do not read)

Skip logic: if no then go to question C4A through D
Skip logic if don't know then go to question C4 through D

Question number: C2A
Variable name: INFO_ELIG_SRC
Question: ***Did you get this information from…***

(Select all that apply)

8.3% 1 *Health provider*
3.1% 2 *Newspaper, magazine, or on television*
15.2% 3 *Friends, family, or another veteran*
10.4% 4 *Website or blog*
25.2% 5 *Talking to a VA representative*
51.5% 6 *Brochure or other handout from the VA*
9.4% 9 *None of the above*

Skip logic: if only one response option is selected then go to question C4A through D
Only options selected in question C2 will be presented in Question C3

Question number: C3A
Variable name: INFO_ELIG_HELP
Question: ***Which of these sources of information was the MOST helpful to you in understanding your VA benefits?***

8.2% 1 *Health provider*
0.6% 2 *Newspaper, magazine, or on television*
16.7% 3 *Friends, family, or another veteran*
13.7% 4 *Website or blog*
31.3% 5 *Talking to a VA representative*
24.1% 6 *Brochure or other handout from the VA*

Question number: C4A
Variable name: INFO_ELIG_LIKE
Question: ***Do you have as much information as you would like about the eligibility requirements for VA health care services?***

(If respondent says "NO", PROBE: "Would you say you need A LITTLE MORE or A LOT MORE information?)

55.1% 1 *Yes, I have enough*
10.4% 2 *No, I Need A Little More*
30.3% 3 No, I need a lot more
4.2% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: C1B
Variable name: INFO_AVAIL
Question: ***Do you recall receiving information about the health services at the VA that are available to you?***

42.1% 1 *Yes*
55.9% 2 *No*
2.0% Don't know (volunteered, do not read)

Skip logic: if no then go to question C4A through D
Skip logic if don't know then go to question C4A through D

Question number: C2B
Variable name: INFO_AVAIL_SRC
Question: ***Did you get this information from…***

(Select all that apply)

13.5% 1 *Health provider*
1.6% 2 *Newspaper, magazine, or on television*
12.3% 3 *Friends, family, or another veteran*
9.1% 4 *Website or blog*
27.6% 5 *Talking to a VA representative*
51.9% 6 *Brochure or other handout from the VA*
5.9% 9 *None of the above*

Skip logic: if only one option is selected then go to question C4A through D
Only options selected in question C2 will be presented in question C3

Question number: C3B
Variable name: INFO_AVAIL_HELP
Question: ***Which of these sources of information was the MOST helpful to you in understanding your VA benefits?***

13.0% 1 *Health provider*
0.5% 2 *Newspaper, magazine, or on television*
11.7% 3 *Friends, family, or another veteran*
10.3% 4 *Website or blog*
36.2% 5 *Talking to a VA representative*
24.9% 6 *Brochure or other handout from the VA*
3.5% Don't know (volunteered, do not read)
0.0% 9 None of the above

Question number: C4B
Variable name: INFO_AVAIL_LIKE
Question: ***Do you have as much information as you would like about the health services at the VA that are available to you?***

(If respondent says "NO", PROBE: "Would you say you need A LITTLE MORE or A LOT MORE information?)

53.9% 1 *Yes, I have enough*
10.9% 2 *No, I Need A Little More*
33.1% 3 *No, I need a lot more*
1.9% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: C1C
Variable name: INFO_WOMEN
Question: ***Do you recall receiving information about the health services at the VA that are available to women veterans specifically?***

32.0% 1 *Yes*
66.6% 2 *No*
1.4% Don't know (volunteered, do not read)

Skip logic: if no then go to question C4A through D
Skip logic: if don't know then go to question C4A through D

Question number: C2C
Variable name: INFO_WOMEN_SRC
Question: ***Did you get this information from…***

(Select all that apply)

18.5% 1 *Health provider*
2.0% 2 *Newspaper, magazine, or on television*
7.9% 3 *Friends, family, or another veteran*
7.0% 4 Website or blog
21.1% 5 *Talking to a VA representative*
54.5% 6 *Brochure or other handout from the VA*
6.1% 9 *None of the above*

Skip logic: if only 1 option is selected then go to question C4A through D
Only options selected in question C2 will be presented in question C3

Question number: C3C
Variable name: INFO_WOMEN_HELP
Question: ***Which of these sources of information was the MOST helpful to you in understanding your VA benefits?***

20.2% 1 *Health provider*
0.1% 2 *Newspaper, magazine, or on television*
10.4% 3 *Friends, family, or another veteran*
9.7% 4 *Website or blog*
28.6% 5 *Talking to a VA representative*
26.5% 6 *Brochure or other handout from the VA*
4.5% Don't know (volunteered, do not read)

Question number: C4C
Variable name: INFO_WOMEN_LIKE
Question: ***Do you have as much information as you would like about the health services at the VA that are available to women veterans specifically?***

(If respondent says "NO", PROBE: "Would you say you need A LITTLE MORE or A LOT MORE information?)

47.7% 1 Yes, I have enough
11.9% 2 No, I Need A Little More
38.7% 3 No, I need a lot more
1.7% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: C1D
Variable name: INFO_HOW
Question: ***Do you recall receiving information about how to get health care services at the VA?***

40.0% 1 *Yes*
58.1% 2 *No*
1.9% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: if no then go to question C4A through D
Skip logic: if don't know then go to question C4A through D
Skip logic: if refused then go to question C4A through D

Question number: C2D
Variable name: INFO_HOW_SRC
Question: ***Did you get this information from…***

(Select all that apply)

12.6% 1 *Health provider*
1.6% 2 *Newspaper, magazine, or on television*
13.6% 3 *Friends, family, or another veteran*
10.9% 4 *Website or blog*
32.2% 5 *Talking to a VA representative*
46.3% 6 *Brochure or other handout from the VA*
4.7% 9 *None of the above*

Skip logic: if only 1 option selected then go to question C4A through D
Only options selected in question C2 will be presented in question C3

Question number: C3D
Variable name: INFO_HOW_HELP
Question: ***Which of these sources of information was the MOST helpful to you in understanding your VA benefits?***

9.3% 1 *Health provider*
0.7% 2 *Newspaper, magazine, or on television*
14.0% 3 *Friends, family, or another veteran*
11.2% 4 *Website or blog*
39.6% 5 *Talking to a VA representative*
22.5% 6 *Brochure or other handout from the VA*
2.7% Don't know (volunteered, do not read)

Question number: C4D
Variable name: INFO_HOW_LIKE
Question: ***Do you have as much information as you would like about how to get health care services at the VA?***

(If respondent says "NO", PROBE: "Would you say you need A LITTLE MORE or A LOT MORE information?)

52.2% 1 *Yes, I have enough*
11.3% 2 *No, I Need A Little More*
35.1% 3 *No, I need a lot more*
1.3% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: C5
Variable name: REACH_BY
Question: ***If the VA were trying to reach you to provide information about eligibility for VA health care, what would be the BEST way?***

20.8% 1 *By telephone*
46.5% 2 *By mail*
25.8% 3 *By e-mail*
3.2% 4 *Through a website or blog*
1.3% 5 *Newspapers, magazines, or on television*
1.6% 6 *Through social media*
0.7% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: If the response to B2 is not within the past 10 years then go to the introduction of the E series questions.

Question number: C6
Variable name: REACH_WHEN
Question: ***If the VA were trying to reach you to provide information about eligibility and benefits for VA health care, when would you have liked to receive this information?***

39.9% 1 *Prior to separation from the military*
13.1% 2 *Shortly after separation or post deployment (less than a year)*
2.5% 3 *One year after separation or post deployment*
42.1% 4 *Repeatedly on an annual basis after separation or post deployment*
2.4% Don't Know (volunteered, do not read)

The VA is interested in understanding where veterans get their health care and some basic information about how that care is received. In the next section, I will ask you questions about how you access care, and any issues you faced in getting that care. Some of these questions ask specifically about Primary Health Care. Primary Health Care is defined as general medical care and health prevention services.

Question number: E1
Variable name: HAVE_PROVIDER
Question: ***Do you currently have one person or team of providers in one clinic that you consider to be your primary care provider?***

86.4% 1 *Yes*
12.7% 2 *No*

Skip logic: IF QB9 is not equal to yes then go to question E3

Question number: E2
Variable name: VA_PROVIDER
Question: ***Is your usual source of primary care from the VA or from a non-VA provider?***

72.2% 1 *VA*
25.1% 2 *Non-VA*
1.8% Don't Know (volunteered, do not read)

Skip logic: if VA then go to question E3

Question number: E2A
Variable name: ANY_CARE_VA
Question: ***Do you get any of your primary care from a VA site of care?***

43.9% 1 *Yes*
54.8% 2 *No*
1.2% Don't Know (volunteered, do not read)

Question number: E3
Variable name: TIME_TO_CARE
Question: ***Thinking about where you usually go for primary care, how long does it typically take you to get there?***

38.9% 1 *Less than 15 minutes*
34.7% 2 *15-29 minutes*
13.6% 3 *30-44 minutes*
6.9% 4 *45-60 minutes*
2.9% 5 *More than one hour*

Skip logic: If QB9 is not equal to yes then go to question E7

Question number: E4
Variable name: NEAR_VA_CARE
Question: ***Is the VA site of care nearest you where you normally get your primary care?***

74.7% 1 *Yes*
23.5% 2 *No*
1.8% Don't Know (volunteered, do not read)

Skip logic: if yes then go to question E6
Skip logic: if don't know then go to question E6
Skip logic: if refused then go to question E7

Question number: E5
Variable name: WHY_NOT_NEAR
Question: ***We are interested in why you do not receive primary care services at your nearest VA site of care. Please select the answer that BEST describes why you do not get VA care at the VA site of care nearest you.***

6.9% 1 *The women's services I need are not available*
4.1% 2 *The hours I want are not available*
9.8% 3 *I do not feel the providers are good*
1.7% 4 *I am unable to choose whether my provider is a man or woman*
74.5% 5 *Some other reason?* (Specify) (interviewer listens to answer and types as text)
2.9% Don't Know (volunteered, do not read)

Question number: E6
Variable name: FINDING_TRANS_VA
Question: ***This question asks about transportation for you to get to your VA SITE OF CARE. Would you say that finding transportation to your medical care is...***

63.3% 1 *Very easy*
15.9% 2 *Somewhat easy*
7.9% 3 *Neither easy, nor hard*
5.5% 4 *Somewhat hard*
3.4% 5 *Very hard*
4.0% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E7
Variable name: FINDING_TRANS_NONVA
Question: ***This question asks about transportation for your medical care to a NON-VA health care site of care. Would you say that finding transportation to your medical care is...***

74.0% 1 *Very easy*
11.9% 2 *Somewhat easy*
6.2% 3 *Neither easy, nor hard*
2.5% 4 *Somewhat hard*
2.0% 5 *Very hard*
1.4% 6 *Not applicable*
2.0% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: If QB9 is not equal to yes then go to the introduction to question E9

Question number: E8
Variable name: TRANS_MODE
Question: ***Please indicate the mode of transportation you prefer to use when you have an appointment for your health care at a VA site of care. Would you prefer to...***

79.6% 1 *Drive yourself*
13.9% 2 *Have a family member, friend, or significant other drive you*
2.3% 3 *Take public transportation*
2.0% 4 *Use shuttle services*
1.2% 5 *Use some other mode of transportation?* (specify) (interviewer listens and types as text)
1.0% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: IF QB9 is not equal to YES and QB10 is not equal to YES then go to question E18

In the next set of questions, I will ask you about the types of health care you may have received in the past 24 MONTHS, such as women's specific health care. Please note that women's specific health care refers to care such as pap smears, mammograms, birth control, prenatal care, HPV vaccination, or menopausal support. I will also ask about Mental Health Services you may have received.

Skip logic: IF QB9 is not equal to YES then go to next skip logic for question E10

Question number: E9A
Variable name: VACARE_PRIMARY
Question: ***What types of health care services have you received at ANY VA SITE OF CARE in the past 24 MONTHS? Did you receive PRIMARY CARE (GENERAL MEDICAL CARE)?***

85.4% 1 *Yes*
13.8% 2 *No*
0.8% Don't Know (volunteered, do not read)

Question number: E9B
Variable name: VACARE_ROUTINE
Question: ***any ROUTINE WOMEN'S HEALTH SERVICES (SUCH AS PAP SMEARS, CONTRACEPTION, BREAST EXAMS)?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

64.2% 1 *Yes*
34.9% 2 *No*
0.9% Don't Know (volunteered, do not read)

Question number; E9C
Variable name: VACARE_GYN
Question: ***any GYNECOLOGY REFERRAL SERVICES (SUCH AS ABNORMAL PAP, ABNORMAL BLEEDING, GYN SURGERY)?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

27.4% 1 *Yes*
71.8% 2 *No*
0.9% Don't Know (volunteered, do not read)

Question number: E9D
Variable name: VACARE_MATERNITY
Question: ***MATERNITY CARE (PREGNANCY CARE)?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

2.3% 1 *Yes*
97.1% 2 *No*
0.6% Don't Know (volunteered, do not read)

Question number: E9E
Variable name: VACARE_INPATIENT
Question: ***INPATIENT CARE?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

15.1% 1 *Yes*
83.6% 2 *No*
1.3% Don't Know (volunteered, do not read)

Question number: E9F
Variable name: VACARE_ER
Question: ***EMERGENCY DEPARTMENT CARE?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

30.2% 1 *Yes*
69.1% 2 *No*
0.6% Don't Know (volunteered, do not read)

Question number: E9G
Variable name: VACARE_MH
Question: ***MENTAL HEALTH SERVICES?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

39.8% 1 *Yes*
59.2% 2 *No*
1.0% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E9H
Variable name: VACARE_SPECIALTY
Question: ***SPECIALTY CARE?***

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

45.3% 1 Yes
52.0% 2 No
2.7% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E9I
Variable name: VACARE_OTH
Question: ***some OTHER type of care*** (SPECIFY) (interviewer listens and types as text)

(If necessary probe: "Did you receive this type of health care service at ANY VA SITE OF CARE in the past 24 months"?)

23.6% 1 *Yes*
73.3% 2 *No*
3.1% Don't Know (volunteered, do not read)

Skip logic: only ask question E9J if all answers for questions E9A through I were no

Question number: E9J
Variable name: VACARE_NONE
Question: ***So, you have received NO CARE AT ALL from a VA site of care in the past 24 months - is that correct?***

57.7% 1 *Yes*
33.3% 2 *No*
8.3% Don't Know (volunteered, do not read)
0.8% Refused (volunteered, do not read)

Skip logic before E10: IF question B10 is not equal to yes then go to skip pattern logic check for question E11

Question number: E10A
Variable name: FEECARE_PRIMARY
Question: ***What types of health care services have you received as FEE BASIS care in the past 24 MONTHS? Did you receive PRIMARY CARE (GENERAL MEDICAL CARE)?***

38.5% 1 *Yes*
59.7% 2 *No*
1.8% Don't Know (volunteered, do not read)

Question number: E10B
Variable name: FEECARE_ROUTINE
Question: ***any ROUTINE WOMEN'S HEALTH SERVICES (SUCH AS PAP SMEARS, CONTRACEPTION, BREAST EXAMS)?***

51.7% 1 *Yes*
46.9% 2 *No*
1.4% Don't Know (volunteered, do not read)

Question number: E10C
Variable name: FEECARE_GYN
Question: ***any GYNECOLOGY REFERRAL SERVICES (SUCH AS ABNORMAL PAP, ABNORMAL BLEEDING, GYN SURGERY)?***

17.7% 1 *Yes*
81.7% 2 *No*
0.5% Don't Know (volunteered, do not read)

Question number: E10D
Variable name: FEECARE_MATERNITY
Question: ***MATERNITY CARE (PREGNANCY CARE)?***

6.7% 1 *Yes*
92.8% 2 *No*
0.6% Don't Know (volunteered, do not read)

Question number: E10E
Variable name: FEECARE_INPATIENT
Question: ***INPATIENT CARE?***

14.0% 1 *Yes*
85.0% 2 *No*
1.1% Don't Know (volunteered, do not read)

Question number: E10F
Variable name: FEECARE_ER
Question: ***EMERGENCY DEPARTMENT CARE?***

22.1% 1 *Yes*
77.4% 2 *No*
0.5% Don't Know (volunteered, do not read)

Question number: E10G
Variable name: FEECARE_MH
Question: ***MENTAL HEALTH SERVICES?***

13.2% 1 *Yes*
86.0% 2 *No*
0.7% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E10H
Variable name: FEECARE_SPECIALTY
Question: ***SPECIALTY CARE?***

36.5% 1 *Yes*
61.7% 2 *No*
1.8% Don't Know (volunteered, do not read)

Question number: E10I
Variable name: FEECARE_OTH
Question: ***some OTHER type of care?*** (SPECIFY) (Interviewer listens and types as text)

14.1% 1 *Yes*
83.8% 2 *No*
2.1% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: only ask question E10J if questions E10A through J are no

Question number: E10J
Variable name: FEECARE_NONE
Question: ***So, you have received NO CARE AT ALL as FEE BASIS care in the past 24 months - is that correct?***

68.3% 1 *Yes*
27.7% 2 *No*
4.0% Don't Know (volunteered, do not read)

Skip logic: If QE9(A-D) do not equal YES AND QE10(A-D) do not equal YES then go to QE12
Ask only the items answered yes to in questions E9 and/or questions E10

Question number: E11A
Variable name: COORDINATE_PRIMARY
Question: ***How helpful was THE VA in coordinating your PRIMARY CARE (GENERAL MEDICAL CARE)?***

33.4% 1 *Extremely helpful*
33.3% 2 *Very helpful*
22.7% 3 *Somewhat helpful*
8.2% 4 *Not at all helpful*
2.3% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E11B
Variable name: COORDINATE_ROUTINE
Question: ***How helpful was THE VA in coordinating your ROUTINE WOMEN'S HEALTH SERVICES (SUCH AS PAP SMEARS,CONTRACEPTION, BREAST EXAMS)?***

40.8% 1 *Extremely helpful*
33.5% 2 *Very helpful*
18.2% 3 *Somewhat helpful*
5.5% 4 *Not at all helpful*
2.0% Don't Know (volunteered, do not read)

Question number: E11C
Variable name: COORDINATE_GYN
Question: ***How helpful was THE VA in coordinating your GYNECOLOGY REFERRAL SERVICES (SUCH AS ABNORMAL PAP, ABNORMAL BLEEDING, GYN SURGERY)?***

38.7% 1 *Extremely helpful*
33.4% 2 *Very helpful*
14.8% 3 *Somewhat helpful*
8.3% 4 *Not at all helpful*
4.7% Don't Know (volunteered, do not read)

Question number: E11D
Variable name: COORDINATE_MATERNITY
Question: ***How helpful was THE VA in coordinating your MATERNITY CARE (PREGNANCY CARE)?***

30.4% 1 *Extremely helpful*
25.2% 2 *Very helpful*
20.6% 3 *Somewhat helpful*
17.6% 4 *Not at all helpful*
6.2% Don't Know (volunteered, do not read)

Skip logic: IF QE9D is not equal to YES AND QE10D is not equal to YES then go to skip logic check for QE13

Question number: E12
Variable name: VACARE_AFTER_PREGNANCY
Question: ***Since your pregnancy, have you received any care from the VA?***

52.0% 1 *Yes*
42.5% 2 *No*
1.9% 3 Still pregnant (volunteered)
3.6% Don't Know (volunteered, do not read)

Skip logic: IF QE9G is not equal to YES AND QE10G is not equal to YES then go to skip logic check for QE14

Question number: E13
Variable name: VETCENTER_MH
Question: ***The VA has separate facilities, called Vet Centers, which provide counseling and mental health services. Regarding the Mental Health Services you accessed, did you receive these services from a Vet Center?***

47.5% 1 Yes
48.6% 2 *No*
4.0% Don't Know (volunteered, do not read)

Skip logic: IF QE9A is not equal to YES AND QE9B is not equal to YES AND QE9D is not equal to YES AND QE9G is not equal to YES then go to QE18.

This next set of questions will ask about your experiences getting or attempting to get appointments for the [primary care/women-specific health care/maternity care/mental health care] that you received at a VA site of care.

Skip logic: ask only the items answered yes to in QE9

Question number: E14
Variable name: ACCESS_PRIMARY
Question: ***First, how would you rate your experience in the past 24 MONTHS getting an appointment as soon as you thought you needed it for PRIMARY CARE on a scale from 1 to 5 where 1 is poor and 5 is outstanding?***

12.2% 1 Poor
10.0% 2
17.2% 3
23.9% 4
35.6% 5 Outstanding
1.1% Don't Know (volunteered, do not read)

Question number: E15
Variable name: ACCESS_ROUTINE
Question: ***How about ROUTINE WOMEN'S SERVICES?***

(read if necessary: how would you rate your experience getting an appointment in the past 24 months as soon as you thought you need it for ROUTINE WOMEN'S SERVICES?)
(read if necessary: on a scale from 1 to 5 where 1 is poor and 5 is outstanding)

7.3% 1 Poor
6.7% 2
14.0% 3
23.6% 4
46.3% 5 Outstanding
2.0% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E16
Variable name: ACCESS_MATERNITY
Question: ***How about MATERNITY CARE?***

(read if necessary: how would you rate your experience getting an appointment in the past 24 months as soon as you thought you need it for MATERNITY CARE?)
(read if necessary: on a scale from 1 to 5 where 1 is poor and 5 is outstanding)

5.3% 1 Poor
4.1% 2
7.8% 3
19.2% 4
44.7% 5 Outstanding
19.0% Don't Know (volunteered, do not read)

Question number: E17
Variable name: ACCESS_MH
Question: ***How about MENTAL HEALTH CARE?***

(read if necessary: how would you rate your experience getting an appointment in the past 24 months as soon as you thought you need it for MENTAL HEALTH CARE?)
(read if necessary: on a scale from 1 to 5 where 1 is poor and 5 is outstanding)

8.0% 1 Poor
7.6% 2
14.1% 3
23.1% 4
45.5% 5 Outstanding
1.6% Don't Know (volunteered, do not read)

Question number: E18
Variable name: CONV_APPT_TIMES
Question: ***In GENERAL, does your VA site of care have appointment times that are convenient for you to get care?***

46.0% 1 *Yes*
11.9% 2 *No*
42.1% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E19
Variable name: PREFER_APPT_TIME
Question: ***We are interested in what appointment times are MOST convenient for you to receive health care. In GENERAL, which of the following appointment times do you prefer?***

52.7% 1 *Mornings*
24.3% 2 *Afternoons*
11.5% 3 *Evenings*
9.9% 4 *Weekends*
1.5% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: E20
Variable name: DEPENDENTS
Question: ***Do you have dependent children living with you aged 17 or younger?***

40.3% 1 *Yes*
59.5% 2 *No*
0.1% Don't Know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Skip logic: if no then go to question E23

Question number: E21
Variable name: FIND_CHILDCARE
Question: ***The next question asks about finding childcare while you receive medical care. When you have an appointment for your health care would you say that finding childcare is...***

18.3% 1 *Very easy*
12.4% 2 *Somewhat easy*
7.2% 3 *Neither easy nor hard*
11.3% 4 *Somewhat hard*
6.4% 5 *Very hard*
43.6% 6 *I do not need child care*
0.6% Don't Know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Skip logic: if I do not need child care then go to question E23
Skip logic: if don't know then go to question E23
Skip logic: if refused then go to question E23

Question number: E22
Variable name: ONSITE_CHILDCARE
Question: ***How helpful would onsite childcare be for you?***

60.3% 1 *Very helpful*
20.4% 2 *Somewhat helpful*
17.3% 3 *Not helpful*
2.0% Don't Know (volunteered, do not read)

Skip logic: IF QB9 is not equal to YES AND QB10 is not equal to YES then go to skip logic for E24

Question number: E23
Variable name: REASON_VACARE
Question: ***What is the MAIN reason you chose to use the VA health care services in the past 24 MONTHS?***

30.2% 1 *I have no other insurance*
7.7% 2 *It's the most convenient for me*
10.9% 3 *They have good quality of care*
5.3% 4 *They have good prescription benefits*
5.8% 5 *They are sensitive to needs of veterans*
21.4% 6 *They have care specific to my service-connected disability*
16.3% 7 *Some other reason?* (specify) (interviewer listens and types text)
2.6% Don't Know (volunteered, do not read)

Skip logic: IF QB11 is not equal to YES then go to introduction to QW questions

Question number: E24
Variable name: REASON_NONVA
Question: ***What is the MAIN reason you chose to use health care services outside of the VA in the past 24 MONTHS?***

23.2% 1 *I do not know if I am eligible for VA care*
39.2% 2 *I have insurance outside of the VA*
9.3% 3 *My non-VA care location is more convenient*
2.4% 4 *VA does not have the services I need*
0.6% 5 *VA does not have a women's clinic*
6.5% 6 *The quality of care outside the VA is better*
2.3% 7 *I do not feel like I belong at the VA*
15.0% 8 *Some other reason?* (specify) (interviewer listens and types text)
1.5% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

In this section I will use the term "Comprehensive Primary Care" which means having one provider who can provide your general medical care and your routine women's health care such as Pap smears, contraception, and menopause care.

Question number: W1
Variable name: RECEIVE_COMP_PRIMARY
Question: ***Are you currently getting Comprehensive Primary Care?***

79.3% 1 *Yes*
19.5% 2 *No*
1.1% Don't Know (volunteered, do not read)

Skip logic: if no then got to question W4
Skip logic: if don't know then go to question W4

Question number: W2
Variable name: RECEIVE_COMP_PRIMARY_CLINIC
Question: ***Are you receiving it at a women's only health clinic?***

23.6% 1 *Yes*
75.6% 2 *No*
0.8% Don't Know (volunteered, do not read)

IF QB9 is not equal to YES then go to skip logic for QW4

Question number: W3
Variable name: RECEIVE_COMP_PRIMARY_VA
Question: ***Are you receiving it at the VA?***

76.3% 1 *Yes*
23.0% 2 *No*
0.8% Don't Know (volunteered, do not read)

Skip logic: If QW1 equals YES then go to QW6

Question number: W4
Variable name: WHERE_PRIMARY
Question: ***Where do you get your primary care?***

50.8% 1 *Primary care or family health clinic*
5.7% 2 *Urgent care center*
1.3% 3 *Emergency department*
34.4% 4 *I do not get primary care*
7.8% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W5
Variable name: WHERE_PREVENTIVE_CARE
Question: ***Where are you getting women-specific preventive care such as breast exams and PAP smears?***

21.5% 1 *Primary care or family health clinic*
0.2% 2 *Urgent care center*
4.1% 3 *Clinic just for pap smears and breast exams*
26.6% 4 *My gynecologist*
2.9% 5 *Community health clinic (such as planned parenthood)*
37.1% 6 *You are not getting any women-specific care*
7.4% Don't Know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: W6
Variable name: IMPORTANCE_WOMEN_ONLY
Question: ***How important is it to receive all or MOST of your care from a clinic that is just for women?***

25.3% 1 *Very important*
24.4% 2 *Somewhat important*
24.6% 3 *Not very important*
25.1% 4 *Not at all important*
0.7% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W7
Variable name: IMPORTANCE_ONE_PROVIDER
Question: ***What about having just one provider provide your primary care AND your women's specific care?***

47.3% 1 *Very important*
27.0% 2 *Somewhat important*
15.3% 3 *Not very important*
9.0% 4 *Not at all important*
1.4% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W8
Variable name: IMPORTANCE_FEMALE_PROVIDER
Question: ***What about having a female provider for your women's specific health care services?***

41.5% 1 *Very important*
22.4% 2 *Somewhat important*
19.8% 3 *Not very important*
15.4% 4 *Not at all important*
0.9% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W9
Variable name: MAY_SEE_FEMALE
Question: ***How strongly do you agree with the following statement: At VA sites of care, women may see a female provider if they want to?***

38.0% 1 *Strongly agree*
17.8% 2 *Somewhat agree*
29.3% 3 *Neither agree nor disagree*
2.8% 4 *Somewhat disagree*
2.2% 5 *Strongly disagree*
9.9% Don't Know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

IF QB9 is not equal to YES then go to skip logic for the introduction to QSC questions

Now thinking only about your primary care experience(s) at your VA site of care in the past 24 MONTHS...

Question number: W10A
Variable name: PROVIDER_KNOWLEDGE
Question: ***How satisfied are you with your provider(s)' general medical knowledge?***

52.5% 1 *Completely satisfied*
24.7% 2 *Somewhat satisfied*
8.7% 3 *Neither satisfied nor dissatisfied*
6.9% 4 *Somewhat dissatisfied*
4.5% 5 *Completely dissatisfied*
2.6% Don't Know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: W10B
Variable name: PROVIDER_KNOWLEDGE_WOMEN
Question: ***How satisfied are you with your provider(s)' knowledge of women's specific health needs?***

52.6% 1 *Completely satisfied*
21.5% 2 *Somewhat satisfied*
11.0% 3 *Neither satisfied nor dissatisfied*
4.9% 4 *Somewhat dissatisfied*
4.0% 5 *Completely dissatisfied*
6.0% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W10C
Variable name: PROVIDER_UNDERSTANDS
Question: ***How satisfied are you with how well your provider(s) understands your needs and concerns as a woman veteran?***

56.7% 1 *Completely satisfied*
20.6% 2 *Somewhat satisfied*
8.4% 3 *Neither satisfied nor dissatisfied*
5.6% 4 *Somewhat dissatisfied*
5.2% 5 *Completely dissatisfied*
3.4% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W10D
Variable name: PROVIDER_SPENDS_TIME
Question: ***How satisfied are you with the amount of time your provider(s) spent with you?***

60.1% 1 *Completely satisfied*
19.6% 2 *Somewhat satisfied*
5.5% 3 *Neither satisfied nor dissatisfied*
6.3% 4 *Somewhat dissatisfied*
6.1% 5 *Completely dissatisfied*
2.3% Don't know (volunteered, do not read)

Question number: W10E
Variable name: PROVIDER_INFORMS
Question: ***How satisfied are you with the amount of information you received from your provider(s)?***

57.4% 1 *Completely satisfied*
23.2% 2 *Somewhat satisfied*
6.0% 3 *Neither satisfied nor dissatisfied*
5.9% 4 *Somewhat dissatisfied*
5.6% 5 *Completely dissatisfied*
1.8% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W11
Variable name: RESPECT_PRIMARY_PROV
Question: ***Considering all of your health care experiences at your VA site of care in the past 24 MONTHS, please indicate the LEVEL OF RESPECT you were shown by your primary care provider.***

(Read if necessary: 'Please consider all of your health care experience(s) at your VA site of care in the past 24 MONTHS)

71.2% 1 *A lot*
11.3% 2 *Some*
5.6% 3 *A little*
2.6% 4 *None*
7.8% 5 *Did you not see a primary care provider/ Did you not see any other type of provider/ Did you not interact with the office staff*
1.4% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W12
Variable name: RESPECT_OTH_PROV
Question: ***What about the LEVEL OF RESPECT you were shown by any other providers you may have seen, such as specialist physicians, nursing staff, or physical therapists.***

(Read if necessary: 'Please consider all of your health care experience(s) at your VA site of care in the past 24 MONTHS)

67.4% 1 *A lot*
14.4% 2 *Some*
5.9% 3 *A little*
2.6% 4 *None*
8.3% 5 *Did you not see a primary care provider/ Did you not see any other type of provider/ Did you not interact with the office staff*
1.4% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W13
Variable name: RESPECT_STAFF
Question: ***What about the LEVEL OF RESPECT you were shown by office staff at your clinic or facility?***

(Read if necessary: 'Please consider all of your health care experience(s) at your VA site of care in the past 24 MONTHS)

64.6% 1 *A lot*
17.6% 2 *Some*
8.5% 3 *A little*
2.6% 4 *None*
5.6% 5 *Did you not see a primary care provider/ Did you not see any other type of provider/ Did you not interact with the office staff*
1.0% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W14
Variable name: WVPM
Question: ***Many VA facilities have a staff member called the Women Veterans Program Manager or the W-V-P-M. Did you work with a W-V-P-M at the facility you went to?***

9.7% 1 *Yes*
82.9% 2 *No*
7.4% Don't know (volunteered, do not read)

Skip logic: if no then go to the introduction to QW15
Skip logic: if don't know then go to the introduction to QW15

Question number: W14A
Variable name: WVPM_HELPFUL
Question: ***How much do you agree or disagree with the following statement: The W-V-P-M was helpful with getting the health care and services I needed?***

68.7% 1 *Strongly agree*
15.6% 2 *Somewhat agree*
7.2% 3 *Neither agree nor disagree*
1.8% 4 *Somewhat disagree*
5.9% 5 *Strongly disagree*
0.9% Don't know (volunteered, do not read)

Question number: W15A
Variable name: VA_QUALITY_CARE
Question: ***How much would you agree or disagree with the following statement: The VA health care system provides quality health care.***

46.0% 1 *Strongly agree*
31.2% 2 *Somewhat agree*
8.9% 3 *Neither agree nor disagree*
8.2% 4 *Somewhat disagree*
4.8% 5 *Strongly disagree*
0.9% Don't know (volunteered, do not read)

Question number: W15B
Variable name: VA_WELCOMING
Question: ***How much would you agree or disagree with the following statement: The VA health care sites of care are welcoming to women.***

50.1% 1 *Strongly agree*
26.5% 2 *Somewhat agree*
10.3% 3 *Neither agree nor disagree*
5.8% 4 *Somewhat disagree*
4.8% 5 *Strongly disagree*
2.4% Don't know (volunteered, do not read)

Question number: W15C
Variable name: VA_EQUAL_TO_PRIVATE
Question: ***How much would you agree or disagree with the following statement: The VA providers' skills are equal to private sector.***

47.8% 1 *Strongly agree*
23.7% 2 *Somewhat agree*
8.3% 3 *Neither agree nor disagree*
8.3% 4 *Somewhat disagree*
8.3% 5 *Strongly disagree*
3.7% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: W15D
Variable name: VA_SPECIALIZED_FOR_WOMEN
Question: ***How much would you agree or disagree with the following statement: The VA health care system provides specialized services for women.***

48.0% 1 *Strongly agree*
24.3% 2 *Somewhat agree*
11.7% 3 *Neither agree nor disagree*
5.0% 4 *Somewhat disagree*
5.0% 5 *Strongly disagree*
6.0% Don't know (volunteered, do not read)

IF QB9 is not equal to YES then go to the introduction to the QMH questions

Women's experiences when coming to a VA site of care are very important. In this next section, I will ask you about your experiences at VA sites of care.

This set of questions asks about your opinion of the facilities in which care is delivered within the VA. Please indicate how much you agree or disagree with the following statements:

Question number: SC1A
Variable name: FACILITY_CLEAN
Question: ***The physical facility was well-maintained and clean.***

69.4% 1 *Strongly agree*
21.3% 2 *Somewhat agree*
3.9% 3 *Neither agree nor disagree*
2.9% 4 *Somewhat disagree*
1.4% 5 *Strongly disagree*
1.0% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: SC1B
Variable name: PARKING_ACCESSIBLE
Question: ***The parking areas were accessible.***

50.6% 1 *Strongly agree*
20.9% 2 *Somewhat agree*
3.1% 3 *Neither agree nor disagree*
8.5% 4 *Somewhat disagree*
15.3% 5 *Strongly disagree*
1.6% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: SC1C
Variable name: PARKING_SAFE
Question: ***I could safely get from the parking area to the facility.***

70.3% 1 *Strongly agree*
18.3% 2 *Somewhat agree*
2.8% 3 *Neither agree nor disagree*
3.5% 4 *Somewhat disagree*
3.8% 5 *Strongly disagree*
1.3% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: SC1D
Variable name: CHECK_IN_PRIVATE
Question: ***The check-in areas had adequate privacy.***

45.5% 1 *Strongly agree*
27.9% 2 *Somewhat agree*
5.0% 3 *Neither agree nor disagree*
10.6% 4 *Somewhat disagree*
9.8% 5 *Strongly disagree*
1.1% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: SC1E
Variable name: WAITING_AREA_WELCOMING
Question: ***The waiting areas were comfortable and welcoming.***

54.2% 1 *Strongly agree*
28.4% 2 *Somewhat agree*
5.7% 3 *Neither agree nor disagree*
6.1% 4 *Somewhat disagree*
4.7% 5 *Strongly disagree*
0.8% Don't know (volunteered, do not read)

Question number: SC1F
Variable name: EXAM_ROOM_PRIVACY
Question: ***I had adequate privacy in the exam room.***

85.6% 1 *Strongly agree*
9.9% 2 *Somewhat agree*
1.5% 3 *Neither agree nor disagree*
1.1% 4 *Somewhat disagree*
1.0% 5 *Strongly disagree*
1.0% Don't know (volunteered, do not read)

Question number: SC1G
Variable name: EXAM_ROOM_CLEAN
Question: ***The exam room was clean.***

84.6% 1 *Strongly agree*
11.3% 2 *Somewhat agree*
1.5% 3 *Neither agree nor disagree*
1.1% 4 *Somewhat disagree*
0.5% 5 *Strongly disagree*
1.0% Don't know (volunteered, do not read)

Question number: SC1H
Variable name: RESTROOM_ACCESSIBLE
Question: ***The women's restrooms were accessible.***

78.0% 1 *Strongly agree*
11.3% 2 *Somewhat agree*
4.2% 3 *Neither agree nor disagree*
1.7% 4 *Somewhat disagree*
1.6% 5 *Strongly disagree*
3.3% Don't Know

Question number: SC1I
Variable name: FAMILY_WAITING_AREA
Question: ***There was a place for my family members or caregivers to wait for me.***

67.4% 1 *Strongly agree*
13.3% 2 *Somewhat agree*
8.3% 3 *Neither agree nor disagree*
1.8% 4 *Somewhat disagree*
1.9% 5 *Strongly disagree*
7.1% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: SC2
Variable name: INP_STAY
Question***: In the last 24 months, did you have an INPATIENT STAY OTHER THAN FOR MENTAL HEALTH REASONS at a VA Medical Center where you were admitted to the hospital and stayed overnight?***

8.8% 1 *Yes*
90.5% 2 *No*
0.7% Don't know (volunteered, do not read)

Skip logic: if no then go to question SC4
Skip logic: if don't know then go to question SC4

Thinking about your INPATIENT STAY at a VA Medical Center within the last 24 months, please indicate you how much you agree or disagree with the following statements:

Question number: SC3A
Variable name: INP_ADMISSION_PROCESS
Question: ***The admission process was easy.***

67.2% 1 *Strongly agree*
17.1% 2 *Somewhat agree*
5.1% 3 *Neither agree nor disagree*
4.8% 4 *Somewhat disagree*
4.5% 5 *Strongly disagree*
1.4% Don't know (volunteered, do not read)

Question number: SC3B
Variable name: INP_ROOM_CLEAN
Question: ***My room was clean and had the equipment I needed.***

75.7% 1 *Strongly agree*
14.7% 2 *Somewhat agree*
1.3% 3 *Neither agree nor disagree*
2.6% 4 *Somewhat disagree*
4.8% 5 *Strongly disagree*
0.9% Don't know (volunteered, do not read)

Question number: SC3C
Variable name: INP_SAFE
Question: ***I felt safe during my inpatient stay.***

82.0% 1 *Strongly agree*
9.5% 2 *Somewhat agree*
2.0% 3 *Neither agree nor disagree*
3.5% 4 *Somewhat disagree*
2.6% 5 *Strongly disagree*
0.4% Don't know (volunteered, do not read)

Question number: SC3D
Variable name: INP_PRIVATE_BATH
Question: ***I had access to a private bathroom during my stay.***

82.1% 1 *Strongly agree*
5.1% 2 *Somewhat agree*
0.8% 3 *Neither agree nor disagree*
1.8% 4 *Somewhat disagree*
9.5% 5 *Strongly disagree*
0.8% Don't know (volunteered, do not read)

Question number: SC3E
Variable name: INP_SECURE_DOOR
Question: ***I was able to secure my door at night during my stay.***

40.0% 1 *Strongly agree*
8.0% 2 *Somewhat agree*
17.4% 3 *Neither agree nor disagree*
5.2% 4 *Somewhat disagree*
19.5% 5 *Strongly disagree*
9.8% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: SC3F
Variable name: INP_COMFORT_SHOWERING
Question: ***I felt comfortable while showering.***

57.9% 1 *Strongly agree*
7.2% 2 *Somewhat agree*
11.9% 3 *Neither agree nor disagree*
3.6% 4 *Somewhat disagree*
7.4% 5 *Strongly disagree*
12.0% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: SC3G
Variable name: INP_ADMISSION_QUICK
Question: ***The admission process did not take a long time.***

61.7% 1 *Strongly agree*
10.8% 2 *Somewhat agree*
4.6% 3 *Neither agree nor disagree*
6.7% 4 *Somewhat disagree*
13.9% 5 *Strongly disagree*
2.3% Don't know (volunteered, do not read)

Question number: SC4
Variable name: MH_STAY
Question: ***In the last 24 months, did you have a MENTAL HEALTH RELATED INPATIENT STAY at a VA Medical Center or Community Based Outpatient Clinic?***

2.8% 1 *Yes*
96.6% 2 *No*
0.6% Don't know (volunteered, do not read)

Skip logic: if no then go to the introduction to QMH questions
Skip logic: if don't know then go to the introduction to QMH questions

Thinking about your MENTAL HEALTH INPATIENT STAY at a VA Medical Center or Community Based Outpatient Clinic within the last 24 months, Please indicate how much you agree or disagree with the following statements:

Question number: SC5A
Variable name: MH_ADMISSION_PROCESS
Question: ***The admission process was easy.***

48.0% 1 *Strongly agree*
18.5% 2 *Somewhat agree*
7.3% 3 *Neither agree nor disagree*
17.4% 4 *Somewhat disagree*
7.3% 5 *Strongly disagree*
1.6% Don't know (volunteered, do not read)

Question number: SC5B
Variable name: MH_ROOM_CLEAN
Question: ***My room was clean and had the equipment I needed.***

57.4% 1 *Strongly agree*
18.3% 2 *Somewhat agree*
7.1% 3 *Neither agree nor disagree*
6.0% 4 *Somewhat disagree*
8.8% 5 *Strongly disagree*
2.4% Don't know (volunteered, do not read)

Question number: SC5C
Variable name: MH_SAFE
Question: ***I felt safe during my inpatient stay.***

58.1% 1 *Strongly agree*
17.8% 2 *Somewhat agree*
2.7% 3 *Neither agree nor disagree*
5.5% 4 *Somewhat disagree*
12.4% 5 *Strongly disagree*
3.4% Don't know (volunteered, do not read)

Question number: SC5D
Variable name: MH_PRIVATE_BATH
Question: ***I had access to a private bathroom during my stay.***

68.7% 1 *Strongly agree*
11.8% 2 *Somewhat agree*
3.3% 3 Neither agree nor disagree
1.8% 4 *Somewhat disagree*
7.2% 5 *Strongly disagree*
7.2% Don't know (volunteered, do not read)

Question number: SC5E
Variable name: MH_SECURE_DOOR
Question: ***I was able to secure my door at night during my stay.***

37.2% 1 *Strongly agree*
8.1% 2 *Somewhat agree*
10.1% 3 *Neither agree nor disagree*
5.8% 4 *Somewhat disagree*
29.2% 5 *Strongly disagree*
9.6% Don't know (volunteered, do not read)

Question number: SC5F
Variable name: MH_COMFORT_SHOWERING
Question: ***I felt comfortable while showering.***

46.7% 1 *Strongly agree*
8.7% 2 *Somewhat agree*
7.4% 3 *Neither agree nor disagree*
13.1% 4 *Somewhat disagree*
16.8% 5 *Strongly disagree*
7.5% Don't know (volunteered, do not read)

Question number: SC5G
Variable name: MH_ADMISSION_QUICK
Question: ***The admission process did not take a long time.***

45.5% 1 *Strongly agree*
11.6% 2 *Somewhat agree*
5.4% 3 *Neither agree nor disagree*
7.2% 4 *Somewhat disagree*
22.3% 5 *Strongly disagree*
8.0% Don't know (volunteered, do not read)

In the next section, I will ask you some questions about mental health diagnoses and care. You are free to skip any question you feel uncomfortable answering, and I will move onto the next question.

Question number: MH1
Variable name: TBI
Question: ***Have you ever been diagnosed with a traumatic brain injury (TBI)?***

2.5% 1 *Yes*
96.7% 2 *No*
0.8% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH2
Variable name: PTSD
Question: ***Have you ever been diagnosed with post traumatic stress disorder (PTSD)?***

12.7% 1 Yes
85.8% 2 No
1.3% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH3
Variable name: DEPRESSION
Question: ***Have you ever been diagnosed with depression?***

33.4% 1 *Yes*
64.9% 2 *No*
1.5% Don't know (volunteered, do not read)
0.2% Refused (volunteered, do not read)

Question number: MH4
Variable name: NEED_MH_SERVICES
Question: ***Have you ever felt you needed mental health services related either to your military service or to any other life situation?***

39.8% 1 *Yes*
58.3% 2 *No*
1.6% Don't know (volunteered, do not read)
0.3% Refused (volunteered, do not read)

Question number: MH5
Variable name: HESITANT_TO_SEEK_MH
Question: ***Have you ever felt hesitant to seek or receive needed mental health care services?***

24.0% 1 *Yes*
74.4% 2 *No*
1.4% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Thinking about why you felt hesitant to seek care for mental health care services, please tell me how much you agree or disagree with the following statements:

Question number: MH6A
Variable name: MHCARE_THINK_LESS_OF_MYSELF
Question: ***I would think less of myself.***

10.3% 1 *Strongly agree*
20.8% 2 *Somewhat agree*
14.2% 3 *Neither agree nor disagree*
15.2% 4 *Somewhat disagree*
38.1% 5 *Strongly disagree*
1.5% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: MH6B
Variable name: MHCARE_OTHERS_THINK_LESS
Question: ***Others would think less of me.***

23.7% 1 *Strongly agree*
22.3% 2 *Somewhat agree*
9.0% 3 *Neither agree nor disagree*
12.2% 4 *Somewhat disagree*
31.0% 5 *Strongly disagree*
1.7% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: MH6C
Variable name: MHCARE_AFFECT_JOB
Question: ***It could negatively affect my job.***

31.7% 1 *Strongly agree*
20.1% 2 *Somewhat agree*
9.6% 3 *Neither agree nor disagree*
8.8% 4 *Somewhat disagree*
26.9% 5 *Strongly disagree*
2.8% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: MH6D
Variable name: MHCARE_AFFECT_RELATIONSHIP
Question: ***It could affect my relationship with my spouse, children or family.***

13.4% 1 *Strongly agree*
17.6% 2 *Somewhat agree*
9.1% 3 *Neither agree nor disagree*
11.7% 4 Somewhat disagree
46.6% 5 *Strongly disagree*
1.6% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: MH6E
Variable name: MHCARE_NOT_HELPFUL
Question: ***I am not sure that mental health care will help me.***

12.9% 1 *Strongly agree*
22.4% 2 *Somewhat agree*
14.0% 3 *Neither agree nor disagree*
13.5% 4 *Somewhat disagree*
34.9% 5 *Strongly disagree*
2.3% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH6F
Variable name: MHCARE_WORRIED_ABOUT_MEDS
Question: ***I am worried about medicines used to treat mental health problems.***

37.3% 1 *Strongly agree*
23.6% 2 *Somewhat agree*
8.3% 3 *Neither agree nor disagree*
10.3% 4 *Somewhat disagree*
19.1% 5 *Strongly disagree*
1.3% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH6G
Variable name: MHCARE_PREFER_RELIG
Question: ***I prefer to try spiritual or religious counseling.***

19.8% 1 *Strongly agree*
19.3% 2 *Somewhat agree*
17.5% 3 *Neither agree nor disagree*
14.2% 4 *Somewhat disagree*
27.0% 5 *Strongly disagree*
2.0% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH7
Variable name: MHCARE_SEX_ABUSE
Question: ***In your life, did you ever receive uninvited or unwanted sexual attention such as touching, cornering, pressure for sexual favors, etc.?***

41.7% 1 *Yes*
54.1% 2 *No*
3.4% Don't know (volunteered, do not read)
0.8% Refused (volunteered, do not read)

Question number: MH7A
Variable name: MHCARE_SEX_ABUSE_MIL
Question: ***Did this occur while in the military?***

70.0% 1 Yes
29.1% 2 *No*
0.7% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: MH8
Variable name: MHCARE_SEX_ABUSE_FORCE
Question: ***In your life, did anyone ever use force or the threat of force to have sex with you against your will?***

24.0% 1 *Yes*
71.0% 2 *No*
4.0% Don't know (volunteered, do not read)
0.9% Refused (volunteered, do not read)

Skip logic: if no then go to skip logic for QMH9
Skip logic: if don't know then go to skip logic for QMH9
Skip logic: if refused then go to skip logic for QMH9

Question number: MH8A
Variable name: MHCARE_SEX_ABUSE_FORCE_MIL
Question: ***Did this occur while in the military?***

55.9% 1 *Yes*
43.0% 2 *No*
1.0% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Skip logic: If QMH7 is not equal to YES AND QMH8 is not equal to YES then go to the introduction to QGH questions

Question number: MH9
Variable name: MHCARE_SEX_ABUSE_AVOID_VA
Question: ***Did you ever avoid using the VA because of this(these) experience(s)?***

10.6% 1 *Yes*
88.3% 2 *No*
1.0% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: G1
Variable name: HEALTH_STATUS
Question: ***How would you describe your general health status?***

13.1% 1 *Excellent*
34.7% 2 *Very good*
32.1% 3 *Good*
15.6% 4 *Fair*
4.1% 5 *Poor*
0.3% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: G2
Variable name: MH_STATUS
Question: ***How would you describe your mental health status?***

24.3% 1 *Excellent*
34.7% 2 *Very good*
25.3% 3 *Good*
12.3% 4 *Fair*
2.6% 5 *Poor*
0.8% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: G3
Variable name: LIKE_VA_TO_KNOW
Question: ***Before the final section, I want to provide the opportunity for you to share any feedback you may have regarding your perceptions of, or experiences with, the health system within the Department of Veterans Affairs. What would you like the VA to know?***

68% 1 Record response
32% 3 No/no comments/nothing else

Thank you for sharing your feedback about your healthcare experiences. Now I just have some general questions about you.

Question number: D1
Variable name: BIRTH_YEAR
Question***: In what year were you born?***

99% Numeric response

Question number: D2
Variable name: MARITAL
Question: ***Are you…?***

52.1% 1 *Married or living as married*
3.2% 2 *Domestic partnership or civil union*
21.8% 3 *Divorced*
2.9% 4 *Separated*
3.7% 5 *Widowed*
15.2% 6 *Never married*
1.1% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: D3
Variable name: ETHNICITY
Question: ***Are you of Hispanic, Latino or Spanish origin?***

9.9% 1 *Yes*
89.2% 2 *No*
0.1% Refused (volunteered, do not read)

Question number: D4
Variable name: RACE
Question: ***Regarding your racial or ethnic background, how do you prefer to identify yourself? You may choose one or more options.***

(Select all that apply)

4.3% 1 *American Indian or Alaskan Native*
1.8% 2 *Asian*
22.1% 3 *Black or African American*
0.9% 4 *Native Hawaiian or Other Pacific Islander*
69.1% 5 *White or Caucasian*
4.4% 6 *Another racial or ethnic group?* (Specify) (Interviewer listens and types as text)

Question number: D5
Variable name: EDUCATION
Question: ***What is the highest grade or year of school you have completed?***

0.1% 1 *Less than a high school graduate or GED*
7.4% 2 *High school graduate or GED*
4.9% 3 *Trade, vocational or technical training after high school*
42.1% 4 *Some college or an associate's degree*
27.2% 5 *Bachelor's degree*
17.5% 6 *Graduate degree (MD, PHD, MA, JD)*
0.7% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: D6
Variable name: EMPLOYMENT
Question: ***What is your current employment status?***

58.7% 1 *Employed for wages or salary*
5.0% 2 *Self-employed*
7.3% 3 *Unable to work (includes disabled)*
5.9% 4 *Unemployed and looking for work (includes recently laid off)*
4.9% 5 *A full-time homemaker*
4.1% 6 *A full-time student*
10.3% 7 *Retired*
0.8% 8 *A full-time caregiver (to a child or adult parents)*
0.7% 9 *A volunteer (does volunteer work)*
1.2% 10 *Some other type of employment that wasn't mentioned?* (specify) (Interviewer listens and types as text)
1.0% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: if unable to work (includes disabled) then go to QD8
Skip logic: if unemployed and looking for work (includes recently laid off) then go to QD8

Question number: D7
Variable name: UNEMPLOYED
Question: ***At any time in the last 24 months were you unemployed when you wanted to be working?***

16.6% 1 *Yes*
82.5% 2 *No*
0.7% Don't know (volunteered, do not read)
0.1% Refused (volunteered, do not read)

Question number: D8
Variable name: NO_INSURANCE
Question: ***In the last 24 months, was there any time when you had no healthcare insurance or coverage?***

17.4% 1 *Yes*
82.2% 2 *No*
0.4% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Skip logic: if no then go to QD10

Question number: D9
Variable name: HAVE_INSURANCE
Question: ***Do you currently have any type of health care insurance for yourself?***

50.3% 1 *Yes*
48.8% 2 *No*
0.7% Don't know (volunteered, do not read)
0.2% Refused (volunteered, do not read)

Skip logic: if no then go to QD11

Question number: D10
Variable name: INSURANCE_TYPE
Question: ***What type of health care insurance or health coverage do you have for yourself?***

24.7% 1 *VA health coverage*
56.6% 2 *Employer-based or private health insurance*
27.6% 3 *TRICARE (in any form)*
3.3% 4 *Medicaid*
10.5% 5 *Medicare*
3.9% 6 *Some other coverage that I haven't mentioned?* (specify) (Interviewer listens and types as text)

Question number: D11
Variable name: HOMELESS
Question: ***At any time in the last 24 MONTHS have you been homeless?***

1.9% 1 *Yes*
97.8% 2 *No*
0.2% Don't know (volunteered, do not read)
0.0% Refused (volunteered, do not read)

Question number: D12
Variable name: CONFIRM_ZIP
Question: ***I would like to confirm the ZIP Code where you reside. Our records currently show your ZIP code as [ZIP]. Is this still correct?***

83.7% 1 Yes
16.2% 2 No
0.1% 3 No Ref

Skip logic: if yes then go to QD13
Skip logic: if refused then go to QD13

Question: D12A
Variable name: CORRECT_ZIP
Question: ***May I please have your zip code?***

16% Numeric response

Question number: D13
Variable name: INCOME
Question: ***Can you tell me which of these categories BEST reflects your total annual household income?***

5.5% 1 *10,000 or less*
7.7% 2 *10,001 to 20*
9.8% 3 *20,001 to 30*
10.9% 4 *30,001 to 40*
10.4% 5 *40,001 to 50*
30.4% 6 *50,001 to 100,000*
16.6% 7 *Over $100,000*
7.7% Don't know (volunteered, do not read)
1.1% Refused (volunteered, do not read)

[MS.] [First Name] [Last Name] , we really appreciate your participation in this survey. Your input will help the VA make important decisions about delivery of information and healthcare services to women

Veterans. I have one final question before you go.

Question number: D14
Variable name: SIGNIFCANT_BARRIER
Question: ***Which of the following statements have been significant barriers that have kept you from using VA care now or in the past? You may choose one or more.***

(If necessary, PROBE: "...is this a significant barrier that has kept you from using VA care now or in the past?)

46.2% 1 *I don't understand my benefits?*
39.5% 2 *I haven't been provided with any information about VA healthcare?*
3.3% 3 *I have no way to get to a VA facility?*
16.3% 4 *The VA is too far away?*
8.7% 5 *The VA hours are inconvenient?*
3.3% 6 *I have no access to child care?*
3.6% 7 *VA facilities lack privacy or safety?*
8.6% 8 *VA providers are not sensitive to women's needs?*
11.9% 9 *There is not enough access to women's services?*
5.4% 10 *I am embarrassed or afraid to seek mental health services?*
14.2% 11 *Any other significant barrier that I haven't already mentioned?* (specify)
(Interviewer listens and types as text)

If respondent selected only one statement or don't know or refused in D14 then go to thank you script

Question number: D14A
Variable name: MOST_SIGNIFCANT_BARRIER
Question: ***Of the statements you chose, which describes the MOST significant barrier that has kept you from using VA care now or in the past? Your answers were...***

(IF MORE THAN ONE IS CHOSEN, PROBE: "Which one represents the MOST significant barrier that has kept you from using VA care now or in the past?)

33.5% 1 I don't understand my benefits
30.9% 2 I haven't been provided with any information about VA healthcare
0.9% 3 I have no way to get to a VA facility
8.5% 4 The VA is too far away
2.8% 5 The VA hours are inconvenient
0.6% 6 I have no access to child care
0.9% 7 VA facilities lack privacy or safety
2.8% 8 VA providers are not sensitive to women's needs
2.7% 9 There is not enough access to women's services
1.8% 10 I am embarrassed or afraid to seek mental health services
12.2% 11 Other
2.3% Don't know (volunteered, do not read)

THANKS.

I want to thank you for your time and answers to our questions. Good bye.

Study of Barriers for Women Veterans to VA Health Care

Appendix E

Comparison to the National Survey of Women Veterans (NSWV)

1.0 Introduction

In 2010, President Barack Obama signed the Caregivers and Veterans *Omnibus Health Services Act*; within that legislation, section 201 of Public Law 111-163 outlines direction for an independent study to evaluate the effect that nine identified barriers have on women Veterans receiving health care through VA. By evaluating the effect that these barriers have on women Veterans and their access to care, the VA may be able to strategically implement changes to better serve women and increase utilization of services by women Veterans in need of care.

As required by the Public Law, the Barriers to Care study was designed to build upon previous research done by VA. The National Survey of Women Veterans (NSWV) was conducted in 2008-2009 and collected 3,611 completed surveys. The new study of Barriers to Care for Women Veterans expands upon the initial framework developed for the NSWV with an enhanced design and larger study population. The Barriers to Care study surveyed more than twice the number of women Veterans as NSWV and increased the surveyed population of women Veterans nation-wide by a factor of 2.4.

2.0 Limitations of comparison

Like the Barriers to Care study, the NSWV was conducted by Computer Assisted Telephone Interviewing (CATI). While the Barriers to Care study was designed, in part, to facilitate comparisons to the NSWV, there are some distinct differences in study design. The following discussion highlights those differences as limitations to consider in the comparison.

2.1 Sample data

The sample for the NSWV survey was stratified by then-current VA care use (VA user; VA non-user) and three periods of military service (pre-Vietnam era; Vietnam era to present, excluding OEF/OIF; and OEF/OIF). OEF/OIF women Veterans were oversampled. Users of VA care were identified through the National Patient Care Databases for FY07 Qtr 4 – FY08 Qtr 3, while non-users were identified through multiple sources including records from the VHA National Enrollment Database (NED), Veterans Benefits Administration (VBA), and the Department of Defense (DoD) Defense Enrollment and Eligibility Record System (DEERS) database.

The Barriers to Care study selected all potential users (inpatient and outpatient) and non-users of VA care from the U.S. Veterans Eligibility Trends and Statistic (USVETS) database. The USVETS database is maintained by the VA's National Center for Veterans Analysis and Statistics (NCVAS) which supports planning, analysis, and decision-making activities through the collection, validation, analysis, and dissemination of key statistics on Veteran population and VA programs. The USVETS data received for this sample was stratified by user status and Veterans Integrated Service Network (VISN), oversampling for non-users.

2.2 Weighting

The NSWV weights were developed from the inverse of the probabilities of inclusion in the sample, with the probability of inclusion determined from the relative size of the survey stratum with respect to the population. The denominator used for all coverage estimates were based on VetPop2007 estimates for the women veteran population as of September 30, 2008, and NED statistics of the VA enrollee and VA user populations.

In contrast, the stratified sample design used for the Barriers to Care study required a typical four stage weighting design for response data. This included calculation of: 1) base weights -- the inverse of the probability of selection for a given individual from within the population; 2) non-response propensity score adjusted weights -- the inverse of the response probabilities measured through logistic regression; 3) post stratification weights -- to correct the interim weights to come into alignment, as applicable, with the populations they represent; and 4) final weights -- equal to the product of the base, non-response, and post stratification weights. With sample strata including VISN and user/non-user status, the Barriers to Care survey design and methodology results in more accurate estimates of the national female Veteran population's perception and experience than the previous study. The more complex sampling design also better supports sub-population analyses. The Definitions of users and non-users of VA health care previous study did not outline non-response bias calculations, meaning that the results are more biased towards the opinions of women who were more likely to respond based on their demographics, such as age. Age is commonly found to be correlated with increased satisfaction, therefore biasing earlier results towards a more positive outlook.

2.3 Definitions of users and non-users of VA health care

Both the NSWV and the Barriers to Care survey stratified the sample by use/non-use of VA care, but ultimately conducted analyses using self-reported user status obtained from respondents through the survey instrument. In the NSWV, user status was defined as receiving care from the VA in the past 12 months, while the Barriers to Care survey defined user status as receiving care from the VA in the past 24 months. The NSWV selected 12 months to reduce recall bias, while the Barriers to Care survey selected 24 months to better capture the experiences and opinions of women Veterans who may rely on the VA for health care, but receive care infrequently.

2.4 Definitions of Service era

The Barriers to Care survey and NSWV differ slightly in their approximation of Service era of women Veterans. This is due to the fact that the NSWV study asked women Veterans for the year and date of their service entrance and exit, whereas the Barriers to Care survey asked only for a year of service entrance and exit. Service era in the Barriers to Care survey was calculated to match, as closely as possible, the NSWV definitions of Service era, but some differences do exist. For example, OEF/OIF in the NSWV has a start date of September 11, 2001, whereas the Barriers to Care survey begins the definition of OEF/OIF

in 2002 as a close approximation because the majority of 2001 fell outside the OEF/OIF range.

2.5 Scope

The purpose of the NSWV was two-fold: (1) to quantify women Veterans' health care needs, experiences with VA health care, and barriers to VA health care use across different periods of military service; and (2) to assess women Veterans' preferences for potential actions to address those barriers to care. To meet this purpose, the survey instrument included validated scales to screen for depression, anxiety disorders, Post-Traumatic Stress Disorder, and alcohol abuse or dependence, as well as questions about the respondent's self-reported health care needs, perception of the VA hospital or clinic environment, and the quality and availability of health care services for women. In contrast, the Barriers to Care survey is designed to specifically evaluate the nine identified barriers to care as stated in the Public Law resulting in a targeted focus on these barriers to care with less emphasis on clinical indicators of health status and health care needs.

Due to this difference in scope, the number of questions available to compare between the two studies is limited.

2.6 Question text and response options

While the Barriers to Care survey was designed to offer comparisons to the NSWV, development of the survey also involved learning from previous work and generating slightly altered questions designed to gather new information that would inform barriers to care for women Veterans. Because of these differences in survey development, some comparison between the Barriers to Care survey and the NSWV are feasible, but most results are not directly comparable.

3.0 Methods

To conduct the work required by the Public Law, researchers first reviewed the National Survey of Women Veterans' final report for available comparisons. Data from the Barriers to Care survey was then assessed using SAS-callable SUDAAN to allow for appropriate variance estimation given the complex sample design of the Barriers to Care survey. This complex survey design allows generalization of results to the greater women Veteran population of the United States.

4.0 Results

Since the scope and purpose of the two projects was dissimilar in many respects, the most easily comparable elements between the Barriers to Care survey and the NSWV are the demographic questions. A smaller sub-set of comparisons is done on questions that relate to the barriers outlined in the Public Law.

Results from the Barriers to Care survey were assessed similarly to those in the NSWV. While the Barriers to Care survey has a focus on user/non-user status, the NSWV had a focus on Service era. Therefore, in this comparison all percents shown are percents within a Service era category.

Responses from the Barriers to Care study are representative of the 2012 women Veteran population, as defined by the sample source, the USVETS database.

4.1 User status

Exhibits 1 and 2 display the user status population estimates of women Veterans from each of the surveys within a given Service era. Both the NSWV and Barriers to Care surveys used weighted data in the analysis, allowing for the calculation of population estimates. Thus, in all exhibits where weighted data is referenced, the wt(%) in the column label indicates estimated population proportions. The NSWV study found that the OEF/OIF service era had the largest proportion of users compared to the other two eras and estimated that of all OEF/OIF Veterans in the population 35% were users. In contrast, the Barriers to Care study found that the Pre-Vietnam Service era had the largest proportion of users and estimated that of all Pre-Vietnam Veterans in the population 38% were users.

Exhibit 1. User status of women Veterans from the NSWV by Service era

Current VA User	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Yes	15.1%	12.6%	35.0%
No	84.9%	87.4%	65.0%

Exhibit 2. Service Era of women Veterans in 2012 (Barriers to Care Survey), by user status

Current VA User	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
Yes	38.0%	22.0%	27.0%
No	62.0%	78.0%	74.0%

4.2 Demographics

Exhibits 3 thru 20 display demographic data for women Veterans in 2008 (NSWV) and 2012 (Barriers to Care). While Service eras are not directly comparable, some general trends are identified. The average age of women Veterans in each Service era is lower now as compared to 2008. For the pre-Vietnam era, this could be due to older women passing away. The majority of women Veterans are white, with more recent Service eras being more diverse in race and ethnicity. More women in 2012 are reporting higher education levels than in 2008. The proportion of women Veterans who are married/divorced has stayed the same over time, as has employment by Service era. More women Veterans today are reporting lower incomes than in 2008. More women today are reporting fair or good health compared to excellent or very good in 2008.

Exhibit 3. Average age of women Veterans in 2008 (NSWV), by Service era

Age	Pre-Vietnam	Vietnam Era to Present (non-OEF/OIF)	OEF/OIF to present
Mean	82.1 years	52.5 years	37.7 years

Exhibit 4. Average age of women Veterans in 2012 (Barriers to Care Survey), by Service era

Age	Pre-Vietnam	Vietnam to Pre OEF/OIF	OEF/OIF to present
Mean	76.94 years	50.67 years	36.79 years

Exhibit 5. Race demographics of women Veterans in 2008 (NSWV), by Service era

Race demographics	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
White	91.2%	75.7%	59.9%
Black or African American	1.3%	12.2%	21.3%
American Indian or Alaska Native	0.4%	1.0%	1.3%
Asian or Pacific Islander	0.1%	1.1%	1.3%
Two or more races	0.2%	2.1%	2.3%
Other	0.4%	4.6%	11.8%
Not specified	6.5%	3.4%	2.2%

Exhibit 6. Race demographics of women Veterans in 2012 (Barriers to Care), by Service era

Race demographics	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
White or Caucasian	90.0%	73.0%	68.0%
Black or African American	5.0%	22.0%	25.0%
American Indian or Alaska Native	8.0%	5.0%	4.0%
Native Hawaiian or Pacific Islander	**	1.0%	1.0%
Asian	NA	1.0%	3.0%
Other	**	4.0%	6.0%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 7. Hispanic, Latino, or Spanish origin of women Veterans in 2008 (NSWV), by Service era

Hispanic, Latino, or Spanish origin	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Yes	0.5%	4.9%	13.6%
No	99.5%	95.1%	86.4%

Exhibit 8. Hispanic, Latino, or Spanish origin of women Veterans in 2012 (Barriers to Care Survey), by Service era

Hispanic, Latino, or Spanish origin	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
Yes	**	8.0%	15.0%
no	98.0%	92.0%	86.0%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 9. Education demographics of women Veterans in 2008 (NSWV), by Service era

Education	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
1-Less Than A High School Graduate Or GED	3.3%	0.0%	0.2%
2-High School Graduate Or GED	22.3%	8.4%	11.9%
3-Trade/Vocational Or Technical Training After High School	9.3%	6.1%	2.3%
4-Some College Or Associate's Degrees	33.2%	34.7%	46.6%
5-Bachelor's Degree	15.8%	19.5%	23.9%
6-Graduate Degree	16.1%	31.2%	15.1%

Exhibit 10. Education demographics of women Veterans in 2012 (Barriers to Care), by Service era

Education	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
1-Less Than A High School Graduate Or GED	NA	NA	NA
2-High School Graduate Or GED	27.0%	8.0%	5.0%
3-Trade/Vocational Or Technical Training After High School	12.0%	6.0%	3.0%
4-Some College Or Associate's Degrees	36.0%	43.0%	42.0%
5-Bachelor's Degree	15.0%	26.0%	31.0%
6-Graduate Degree	10.0%	17.0%	20.0%

Exhibit 11. Marital status demographics of women Veterans in 2008 (NSWV), by Service era

Marital Status	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Married	25.6%	63.3%	57.8%
Divorced	12.8%	13.1%	17.8%
Separated	1.8%	2.7%	3.3%
Widowed	47.1%	3.0%	0.4%
Never married	12.8%	17.8%	20.8%

Exhibit 12. Marital status demographics of women Veterans in 2012 (Barriers to Care), by Service era

Marital Status	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
Married/living as married	29.8%	52.4%	54.9%
Domestic partnership/civil union	**	3.4%	3.3%
Divorced	17.3%	25.0%	17.4%
Separated	**	3.1%	2.7%
Widowed	41.1%	4.0%	0.8%
Never married	10.1%	12.1%	21.0%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 13. Employment status of women Veterans in 2008 (NSWV), by Service era

Employment	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Working	4.1%	52.0%	67.2%
Retired	85.9%	24.7%	2.5%
Disabled	4.4%	4.5%	2.7%
Unemployed	0.2%	6.0%	7.5%
Other	5.4%	12.8%	20.0%

Exhibit 14. Employment status of women Veterans in 2012 (Barriers to Care), by Service era

Employment	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
Employed for wages or salary	**	60.0%	62.1%
Self-employed	**	5.8%	4.0%
Unable to work (includes disabled)	2.6%	9.8%	3.7%
Unemployed and looking for work (includes recently laid off)	**	5.6%	7.0%
A full-time homemaker	7.5%	4.0%	6.5%
A full-time student	0.0%	1.6%	8.6%
Retired	79.1%	11.0%	4.9%
A full-time caregiver (to a child or adult parents)	**	1.0%	0.5%
A volunteer (does volunteer work)	**	0.7%	0.6%
Other	**	0.5%	2.3%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 15. Income level of women Veterans in 2008 (NSWV), by Service era

Income Category	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
$10,000 OR LESS	17.1%	3.1%	2.1%
$10 TO $20,000	14.9%	4.0%	8.1%
$20 TO $30,000	17.9%	11.5%	10.7%
$30 TO $40,000	19.3%	10.0%	13.9%
$40 TO $50,000	10.9%	9.5%	8.7%
$50 TO $100,000	16.8%	43.9%	42.0%
OVER $100,000	3.2%	18.0%	14.5%

Exhibit 16. Income level of women Veterans in 2012 (Barriers to Care), by Service era

Income Category	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
$10,000 OR LESS	13.0%	6.0%	6.0%
$10 TO $20,000	23.0%	8.0%	7.0%
$20 TO $30,000	29.0%	10.0%	12.0%
$30 TO $40,000	15.0%	12.0%	12.0%
$40 TO $50,000	9.0%	12.0%	11.0%

Income Category	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
$50 TO $100,000	9.0%	34.0%	35.0%
OVER $100,000	2.0%	19.0%	17.0%

Exhibit 17. Combat experience of women Veterans in 2008 (NSWV), by Service era

Served in Combat Zone	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Yes	10.2%	15.2%	71.2%
No	89.8%	84.8%	28.8%

Exhibit 18. Combat experience of women Veterans in 2012 (Barriers to Care), by Service era

Served in Combat Zone	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
YES	**	11.7%	43.6%
NO	97.0%	88.3%	56.4%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

Exhibit 19. Self-reported health status of women Veterans in 2008 (NSWV), by Service era

Self-reported Health Status	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)
Excellent	12.5%	19.6%	18.3%
Very good	21.0%	33.4%	34.7%
Good	26.8%	30.7%	32.1%
Fair	28.7%	14.0%	10.7%
Poor	10.8%	2.3%	4.1%

Exhibit 20. Self-reported health status of women Veterans in 2012 (Barriers to Care), by Service era

Self-reported Health Status	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)
Excellent	13.1%	12.1%	14.7%
Very good	34.5%	33.4%	37.4%
Good	30.6%	33.6%	30.3%
Fair	15.7%	15.9%	15.1%
Poor	6.1%	5.0%	2.6%

4.3 Integrated Care

From 2008 (NSWV) to 2012 (Barriers to Care), a similar level of VA users rate the importance of receiving both women's and general health care from the same provider or clinic, also known as integrated care, as *very important or somewhat important* (78.2% NSWV, 80.2% Barriers to Care). However, among non-users this health care setting appears to have become more important (66.3% NSWV, 73.9% Barriers to Care). It is important to note the differences in the wording of this question across instruments. In the NSWV study this question was asked as, "*When it comes to making decisions about where*

to go for healthcare, how important to you is being able to get both your gynecological care and your general health care all in one place?" The Barriers to Care survey phrased this as, *"How important is it to you to have one provider provide your primary care and your women's specific care?"* This distinction in question wording is important when comparing results. Therefore, researchers recommend viewing these results as similar, but not directly comparable. Exhibits 21-25 display the results related to integrated care.

Exhibit 21. Importance of receiving integrated care in the same care setting in 2008 (NSWV), by Service era

Importance of receiving both gynecologic care and general health care all in one place	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Very important	55.8%	42.7%	44.5%
Somewhat important	22.4%	21.7%	21.8%
Not very important	12.8%	16.7%	16.1%
Not at all important	9.0%	18.9%	17.5%

Exhibit 22. Importance of receiving integrated care in the same care setting in 2012 (Barriers to Care), by Service era

Importance of having one provider provide primary care and women specific care	VA Users (pop%)	VA Non-Users (pop%)	Overall (pop%)
Very important	56.4%	45.4%	48.0%
Somewhat important	23.8%	28.5%	27.4%
Not very important	11.7%	16.6%	15.5%
Not at all important	8.1%	9.5%	9.1%

When looking at the importance of receiving care from a clinic just for women, the proportion of users now (Barriers to Care) who rated this *very important or somewhat important* is less than the proportion in 2008 (NSWV) (60% Barriers to Care, 69.1% NSWV), although for non-users this importance seems to have gone up (46.8% Barriers to Care, 41% NSWV). A difference in survey instruments may account for these differences. In the NSWV study this question asked *"How important is it for you to get your women's health care from a doctor or clinic that is just for women?"* while the Barriers to Care survey phrased this as *"How important is it to receive all or most of your care from a clinic that is just for women?".* Researchers recommend not comparing these statistics directly due to the difference in instruments; however, in general, scores across years and instruments are on the same scale (in the 60-70% range for users, and 40-50% scale for non-users).

Exhibit 23. Importance of receiving integrated care in a women's clinic in 2008 (NSWV), by Service era

Importance of getting women's health care from doctor or clinic just for women	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Very important	42.4%	18.4%	21.8%
Somewhat important	26.7%	22.6%	26.6%
Not very important	19.0%	32.1%	30.3%

Importance of getting women's health care from doctor or clinic just for women	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Not at all important	11.8%	22.9%	21.3%

Exhibit 24. Importance of receiving integrated care in a women's clinic in 2012 (Barriers to Care), by Service era

Importance of getting women's health care from doctor or clinic just for women	VA Users (pop%)	VA Non-Users (pop%)	Overall (pop%)
Very important	35.6%	22.2%	25.4%
Somewhat important	24.4%	24.6%	24.5%
Not very important	21.0%	26.0%	24.8%
Not at all important	19.0%	27.3%	25.2%

The perception, or reality, of a woman Veteran being able to see a female provider if she wishes may be very important to her choice of whether to seek care at VA or from a civilian provider. In 2008 the NSWV study reported 86.1% of users and 71.3% of non-users agreeing with the statement *"At VA sites of care women may see a female provider if they wish" strongly* or *somewhat.* In 2012, the Barriers to Care survey measured agreement with the same statement, *strongly* or *somewhat* for 71.3% of users and 58.3% of non-users.

Exhibit 25. Agreement that a woman may see a female provider if she wishes in 2008 (NSWV), by Service era

May see female provider at VA if you wish	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Strongly agree	65.8%	26.3%	32.9%
Somewhat agree	20.3%	45.0%	40.8%
Somewhat disagree	7.1%	16.2%	14.7%
Strongly disagree	6.8%	12.5%	11.6%

Exhibit 26. Agreement that a woman may see a female provider if she wishes in 2012 (Barriers to Care), by Service era

May see female provider at VA if you wish	VA Users (pop%)	VA Non-Users (pop%)	Overall (pop%)
Strongly agree	52.0%	38.8%	42.2%
Somewhat agree	20.1%	19.5%	19.7%
Neither agree nor disagree	20.3%	37.0%	32.6%
Somewhat disagree	3.8%	2.8%	3.1%
Strongly disagree	3.8%	1.9%	2.4%

4.4 Gender sensitivity

Both questionnaires asked women Veterans to rate their satisfaction with VA providers' provision of care to women. For satisfaction with *knowledge of women's health issues*, 59.1% of users in 2008 (NSWV) indicated they were *extremely satisfied* or *very satisfied* with this skill. In 2012, a similar percentage (56% of users) indicated they *were completely satisfied* or *somewhat satisfied* with this skill. Data for non-users is not available for

comparison as the Barriers to Care survey only asked users of VA health care to provide comment on their VA provider. It should also be noted that in the NSWV survey the question asked women to consider VA 'health professionals' whereas the Barriers to Care study asked women to rate "their provider". Health professionals could be interpreted as multiple staff members within a clinic, and not just the provider. Given the difference in response scale for this question and scope, we believe the differences found for these measures should not be considered comparable even though, on the surface, they appear closely related. Likewise, for satisfaction with *sensitivity to the concerns of women*, 62.1% of users in 2008 (NSWV) rated their satisfaction with this skill as *extremely satisfied* or *very satisfied*, while in 2012 (Barriers to Care) 80.2% of users rated satisfaction with this skill as *completely satisfied* or *somewhat satisfied*. Direct comparison between these two numbers is not recommended.

Exhibits 27 thru 30 display the results related to Gender Sensitivity.

Exhibit 27. Satisfaction with provider's knowledge of women's health issues in 2008 (NSWV), by Service era

Satisfaction with provider knowledge of women's health issues	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Extremely satisfied	22.4%	17.5%	18.2%
Very satisfied	36.7%	44.5%	43.4%
Satisfied	19.9%	20.2%	20.2%
Somewhat satisfied	16.7%	15.0%	15.2%
Not at all satisfied	4.3%	2.7%	2.9%

Exhibit 28. Satisfaction with provider's knowledge of women's health issues in 2012 (Barriers to Care), by Service era

Satisfaction with provider knowledge of women's health issues	Users (pop%)	Users (95% CI)
Completely satisfied	56.0%	(54 - 58)
Somewhat satisfied	22.9%	(21 - 25)
Neither satisfied nor dissatisfied	11.7%	(10 - 13)
Somewhat dissatisfied	5.2%	(4 - 6)
Completely dissatisfied	4.2%	(3 - 5)

Exhibit 29. Satisfaction with provider's sensitivity to women's concerns in 2008 (NSWV), by Service era

Satisfaction with providers' sensitivity to concerns of women	VA Users (pop%)	VA Non-users (pop%)	Overall (pop%)
Extremely satisfied	22.8%	19.0%	19.5%
Very satisfied	39.3%	49.1%	47.7%
Satisfied	17.5%	17.4%	17.4%
Somewhat satisfied	14.5%	11.6%	12.0%
Not at all satisfied	5.9%	3.0%	3.4%

Exhibit 30. Satisfaction with provider's sensitivity to women's concerns in 2012 (Barriers to Care), by Service era

Satisfaction with providers' sensitivity to concerns of women	Users (pop%)	Users (95% CI)
Completely Satisfied	58.8%	(57 - 61)
Somewhat Satisfied	21.4%	(20 - 23)
Neither Satisfied Nor Dissatisfied	8.7%	(7 - 10)
Somewhat Dissatisfied	5.8%	(5 - 7)
Completely Dissatisfied	5.3%	(4 - 6)

4.5 Barriers to Care

Both the NSWV and Barriers to Care instruments asked women Veterans to provide their reason for using VA health care or non-VA health care using a closed-ended list developed by the study teams. The Barriers to Care survey based the list on the NSWV survey, but altered the response options to glean new findings that may have been missed in the previous study. In 2008, the most common reason that women Veterans listed for using VA health care included *cost of care* (18.6% overall) and *care for service connected disabilities* (16.6% overall). In 2012, the most common reason that women Veterans listed were *I have no other insurance* (30.9% overall) and *care specific to service connected disabilities* (22% overall). The main reasons why women Veterans choose VA health care appears to remain the same, having a financially-related need to seek care that is more affordable and the preference for care that is specific to service-connected disabilities.

Exhibits 31 thru 35 display the results of these questions.

Exhibit 31. Main reason for choosing VA in 2008 (NSWV), by Service era

Main reason for choosing VA	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)	Overall (pop%)
Costs less	17.4%	18.6%	20.1%	18.6%
Cannot get services at non-VA facility	2.2%	2.8%	2.6%	2.7%
Location is convenient	5.2%	4.4%	4.4%	4.5%
Higher quality of care	9.0%	7.5%	2.6%	7.1%
Has women's health clinics	2.9%	3.0%	4.6%	3.1%
Provider prescription benefits	32.1%	6.7%	3.5%	10.2%
Only source of care available	2.7%	6.8%	8.3%	6.3%
Likes MDs, been using for years	19.5%	16.7%	8.8%	16.2%
Care for service connected disability	1.6%	18.8%	22.4%	16.6%
Provides mental health services	1.1%	2.6%	8.7%	3.1%
Lost or inadequate insurance	6.2%	12.4%	14.1%	11.6%

Exhibit 32. Main reason for choosing VA in 2012 (Barriers to Care) by Service era

Main reason for choosing VA	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)	Overall (pop%)
I have no other insurance	10.6%	33.2%	29.9%	30.9%
It's the most convenient for me	12.6%	6.9%	8.8%	7.9%
They have good quality of care	23.1%	12.8%	7.3%	11.1%
They have good prescription benefits	28.4%	5.2%	3.6%	5.4%
They are sensitive to needs of veterans	**	5.7%	6.8%	5.9%
They have care specific to my service-connected disability	**	21.2%	25.2%	22.0%
Other	18.4%	14.9%	18.4%	16.7%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

When looking at reasons that women Veterans choose to receive care outside of VA, both the 2008 and 2012 populations indicated they did so most often because *they had other insurance* (38.8% NSWV, 39.8% Barriers to Care). In 2008, the second most common reason for choosing care outside of VA was that *other locations are more convenient*, while the 2012 women Veteran population selected a new response option of *I don't know if I'm eligible for care* (23.5%).

Exhibit 33. Main reason for choosing non-VA care in 2008 (NSWV), by Service era

Main reason for choosing non-VA	Pre-Vietnam Era (pop%)	Vietnam Era to Present (non-OEF/OIF) (pop%)	OEF/OIF (pop%)	Overall (pop%)
Have other insurance	40.9%	38.9%	38.8%	39.2%
Other locations more convenient	35.4%	27.0%	21.0%	28.0%
Other providers more sensitive to women	3.5%	1.2%	1.5%	1.5%
Costs less	2.3%	1.1%	1.4%	1.3%
Difficult to get appointment at VA	1.3%	2.2%	10.2%	2.4%
Higher quality of care	3.7%	5.3%	6.2%	5.1%
VA not appropriate for women	0.3%	1.0%	1.0%	0.9%
Use VA as backup	0.8%	0.5%	1.1%	0.6%
Use VA for prescriptions only	1.5%	0.9%	0.3%	0.9%
Didn't know entitled	2.8%	13.7%	11.3%	12.0%
Didn't know how to apply	1.6%	1.8%	5.2%	1.9%
Don't feel belong at VA	5.4%	5.7%	2.0%	5.5%
VA didn't offer needed services	0.3%	0.1%	0.0%	0.1%
Did not think was eligible	0.2%	0.7%	0.0%	0.6%

Exhibit 34. Main reason for choosing non-VA care in 2012 (Barriers to Care), by Service era

Main reason for choosing non-VA	Pre-Vietnam (pop%)	Vietnam to Pre OEF/OIF (pop%)	OEF/OIF to present (pop%)	Overall (pop%)
I do not know if I am eligible for VA care	**	25.8%	20.4%	23.5%
I have insurance outside of the VA	37.3%	42.6%	35.2%	39.8%
My non-VA care location is more convenient	19.9%	6.8%	13.6%	9.5%
VA does not have the services I need	**	2.2%	2.8%	2.4%
VA does not have a women's clinic	**	0.5%	0.8%	0.6%
The quality of care outside the VA is better	**	6.0%	7.8%	6.6%
I do not feel like I belong at the VA	**	2.4%	2.1%	2.3%
Other	22.8%	13.8%	17.3%	15.3%

** Unreliable estimates. Coefficient of variation is ≥ 0.30.

5.0 Summary

Comprehensive comparisons between the NSWV and Barriers to Care studies are difficult due to differences in both question wording and answer scales. However, some simple comparisons can be performed. Across the studies, VA users agreed in similar proportions about the importance of receiving both women-specific care as well as primary care from the same location.

Integrated care for users of VA health systems continues to be important, with 80% of users rating this aspect of care *very important* or *somewhat important* across years. Importance of receiving care in a clinic just for women also continues to be rated highly with above 60% of users rating it *very important* or *somewhat important*.

Women Veterans report satisfaction with providers' knowledge of women's health issues. While not directly comparable between surveys, this factor was above 55% in both 2008 and 2012 among VA users for 'top-two' satisfaction (*extremely* and *very satisfied* in 2008 and *completely* and *somewhat satisfied* in 2012). Comparatively, ratings for satisfaction with providers' sensitivity to the concerns of women were over 60% in both 2008 and 2012 for 'top-two' satisfaction (*extremely* and *very satisfied* in 2008 and *completely* and *somewhat satisfied* in 2012). These are viewed as general trends; direct comparison of these statistics is not recommended.

In both studies, the most common reason to use or not use VA health care was related to *cost of care or lack of other insurance* and *care specific to service-connected disabilities*. The most popular reason for choosing care outside of VA (and at roughly the same magnitude) for both studies was *having insurance outside of the VA*.

Study of Barriers for Women Veterans to VA Health Care

Appendix F

In Their Own Words: What Women Veterans Want VA to Know

1.0 Introduction

Public Law 111-163, Section 201 also stated the need to identify any other barriers to care that may not be included in the original nine elements. To identify new barriers, an open-ended question was included at the end of the Barriers to Care survey. The question read, *"I want to provide the opportunity for you to share any feedback you may have regarding your perceptions of, or experiences with, the health system within the Department of Veterans Affairs. What would you like VA to know?"*

The feedback received from this question provides important qualitative information that enhances the information gained from the quantitative data produced from the rest of the survey. Qualitative research helps to expand the concepts of a study, especially for complex and sensitive topics. Quantitative questions in research are necessarily constrained by the specific research question being addressed, the historical and practical knowledge of the researchers, the chosen wording for the questions and the interpretation of the question by the respondent. While the interpretation of the question will still impact responses for qualitative data, in general, qualitative questions provide an open slate to gather information of import to the respondents, which the researchers may not have touched on, or which the quantitative question set did not allow for needed elaboration.

Altarum delivered the qualitative data collected from this question in a de-identified file of verbatim comments. In this appendix, we provide a discussion of dominant themes and representative comments from those themes. We found the qualitative feedback gathered to provide rich insights into the varied experiences of women Veterans, and we recommend further analysis of these comments to provide additional insights into potential barriers to care for women Veterans.

2.0 Methods

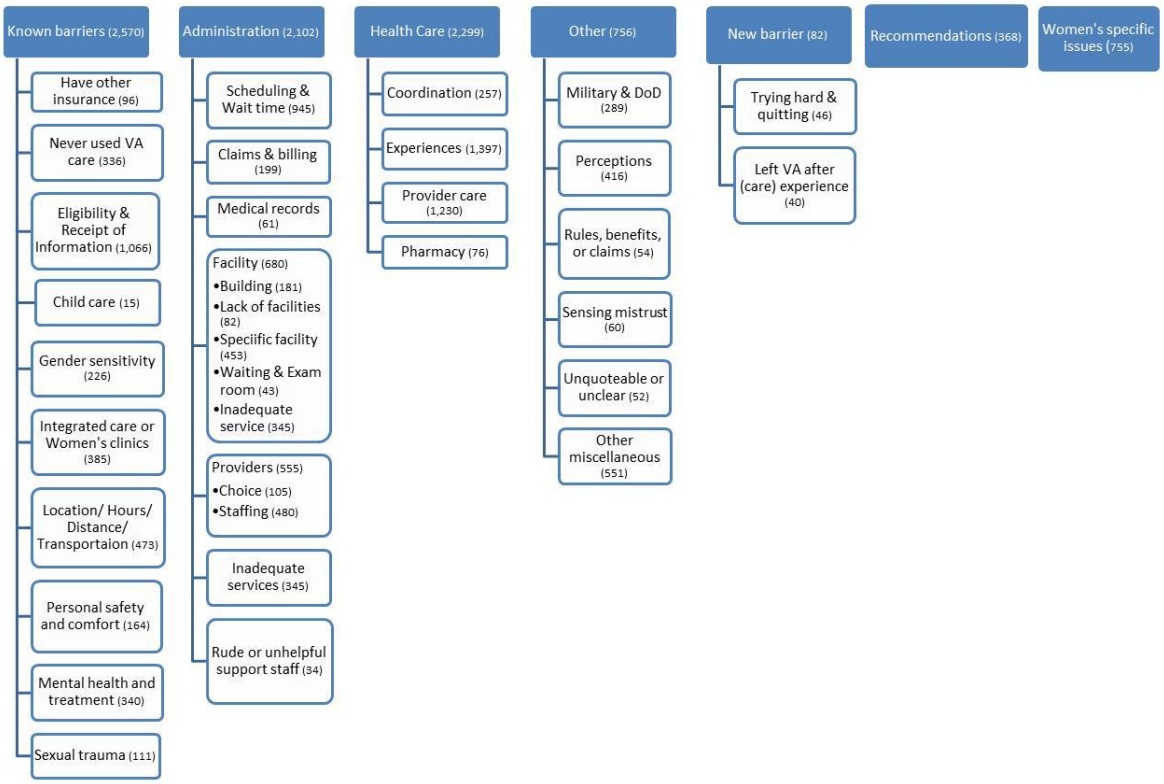
Interviewers recorded women Veterans' responses to the open-ended question as audio files. The audio files were then transcribed and assigned to thematic bins to categorize their statements using the qualitative analysis program NVivo. One comment could be assigned to multiple bins (also known as codes) based on the content of that comment. Thus, this appendix will often refer to the number of codes assigned, not the number of comments. Thematic bins were first created based on a subset of responses, and then continuously updated as the remaining comments were coded. Exhibit 1 displays the thematic bins in a tree diagram; there are seven bins in total and these include:

- Known barriers
- Administration
- Health care
- Other
- New barrier

- Recommendation
- Women's specific issues

The bins for *Recommendation* and *Women's specific issues* were included as a cross-reference for researchers to quickly identify and review comments that are related to a woman's experience at the VA that only occurred because of her gender, or to comments that were given as a recommendation for VA to consider.

Exhibit 1: Thematic Bins



3.0 Results

Out of 8,532 respondents, 2,767 (32%) of women chose not to leave a comment in response to this question. The remaining women (5,765, 68%) provided one or more comments which were recorded, transcribed, and coded into thematic bins.

The most common t themes were the first three from the exhibit above: *Known barriers (*as identified in the Public Law*)*, *Administration*, and *Health care*. Most of the comments under *Known barriers* were related to *Eligibility and receipt of information* (1,066 out of 2,570; 41%). Most of the comments under *Administration* were related to *Scheduling and appointment wait time* (945 out of 2,102; 45%). Most of the comments under *Health care*

were related to positive or negative *Health care experiences* (1,397 out of 2,299; 61%) and specific descriptions of *Provider care* (1,230 out of 2,299; 54%).

3.1 Positive comments

While the open-ended survey question was intended to elicit feedback from women Veterans that would help identify any new barriers to care not outlined in the Public Law, many women Veterans had only positive comments to share about VA. Examples of these comments are shown in Exhibit 2.

Exhibit 2 Examples of positive comments provided by women Veterans

Person	Open-ended Comment
Woman A	*"That I'm thankful for the VA. I get excellent care. I have a wonderful primary care provider. Anytime I've needed specialty care it's been easily arranged. I have really no complaints, the ease of ordering refill prescriptions with the My HealtheVet is wonderful. I'm just, I've heard of people having bad experiences with the VA, but I've not been that person. Every experience I've had in the VA health system has been very positive and I am truly thankful that I have the health care that I do."*
Woman B	*"I'm very pleased with the care. It's a small clinic. Everything about it is perfect. I have no complaints and people know me by name when I walk in and I feel at home and comfortable there."*
Woman C	*"That the care is excellent. The staff is excellent. I have been very pleased with everyone and everything that I have received from the VA. Keep up the good work."*
Woman D	*"That they're very -- in the past, they have not been that accommodating to women. Now I have found that in the three facilities that I have used, they were very open, very welcoming to women veterans so I find that there has been a positive progression. You know, yeah, the other thing I find is that they are always thanking when I go. I'm always thanked for my service and that's meant a lot…"*

3.2 Comments Related to the Barrier of Comprehension of Eligibility

One of the most frequently commented barriers to care shown by this and previous studies is comprehension of eligibility for VA care. The open-ended comments provided valuable insight as to how VA might improve their efforts to educate women about eligibility. Women, in their own words, described a system that is difficult to understand and difficult to find the right person to help; they perceive that they are hitting a 'brick wall' so to speak. Examples of these comments are shown in Exhibit 3.

Exhibit 3 Examples of comments left by women Veterans about difficulty getting or understanding information about VA eligibility

Person	Open-ended Comment
Woman E	*"…the eligibility requirements on the VA website are not very easy to understand…I am fairly certain that I don't qualify for VA care based on my income, but I'm not sure and I'm a physician. I'm fairly well educated on kind of understanding the health care system and I still don't get the VA website. So if a college educated physician doesn't understand it the eligibility requirements to expect somebody who got out of the military with a high school education as E4, it just doesn't seem like that's as clear as they might think."*
Woman F	*"Make it easier to figure out if you're even qualified to use the VA because I would use them. I'd happy to pay for them but I don't just because I've tried before. I've called representatives, looked online, done both questionnaires to see if I'm qualified and specific to my situation and the minimal time that I did serve…. I can't figure out if I'm qualified or not so I just pretty much gave up trying."*
Woman G	*"There's not a lot of knowledge and the website is very confusing. I just don't know about the VA and when I do try to go on the website to try to find out, like, about filing my claim for my service-connected issues and trying to get help, I can't find, I just get so frustrated and a lot of times they want you to print off forms or you can't just do it online so it's, I find the website to be non-user friendly."*
Woman H	*"Well, the people at the registration office -- well, just this guy, <NAME> who registered me was not very friendly and when I was trying to get information from the other people, like, in the facility: nothing. So I never got to, I just, like, got fed up and I left and I never went back to even ask about care or anything."*

These comments demonstrate that some women who do not currently use VA have tried, but were unable to overcome the obstacle of determining eligibility. These non-users may have been converted to users if the system requirements were more understandable or more navigable. These comments also demonstrate a common recommendation from women Veterans to VA to review the content and readability of eligibility information displayed on their website.

3.3 Comments Related to New Barriers to Care

Through this qualitative review of open-ended comments, researchers identified two new barriers as dominant themes which were not already outlined in the Public Law. These new barriers include *Left VA after care experience* and *Trying hard and quitting*. Comments falling under each of these bins are often related, but *Left VA after care experience* includes comments more related to health care or health care providers rather than a general experience trying to get into VA or to get care.

Left VA after Care Experience

Representative comments of the thematic bin *Left VA after care experience* are shown in Exhibit 4.

Exhibit 4 Examples of comments left by women Veterans that fall into a new barrier category: left VA after care experience

Person	Open-ended Comment
Woman I	*"Well, as far as the mental health goes, it's difficult to get a timely appointment. They changed providers on me and I was not able to make a choice as to who I had for mental health so I have thus stopped going."*
Woman J	*"I would love for them to know when it comes to women's exams that I don't do that anymore at the VA because I got tired of going every year and having a different doctor. You know, it's very frustrating when you have to explain every year everything that's ever gone on in the past to a new doctor. You know, and that's why I don't go to them anymore because I just got tired of it…you just feel like a number. Other than that, I think the care is -- I have had excellent care."*
Woman K	*"The primary healthcare provided was so terrible, I will never go back..."*
Woman L	*"That sometimes they let me down as far as with certain circumstances especially when I applied for my disability and I had to explain my situation. Basically they make it seem like it's made up and just because they can't find information on their end or I'm having a hard time getting to where the situation has occurred they think that I'm telling a lie but it is actually happened. And nobody understand what I go through because they're not in my shoes. When you say something they twist it around or say something positive and basically build you up and break you back down based on basically assumptions. That's probably why I haven't been back to see my doctor because I just don't feel like, I feel ten times worse leaving than when I went there. So I figured I'll just wing it on my own."*

This new barrier to care, which was not outlined in the Public Law, highlights that the quality of care, continuity of care, and availability of care have an impact on the number of women Veterans who choose to stay with VA and continue to receive care that they are eligible for.

Trying Hard and Quitting

Representative comments of the new barrier *Trying hard and quitting* are shown in Exhibit 5.

Exhibit 5 Examples of comments from woman Veterans regarding their failed attempts to get health care through the VA system, leading to their seeking care elsewhere

Person	Open-ended Comment
Woman M	*"…I had a pinched nerve in my shoulder that I tried to care for and I was given a letter that stated there was a waiting list and after six months of waiting, I just gave up on it. I never did get an appointment."*

Person	Open-ended Comment
Woman N	*"I would like the VA to know that it's very difficult to get anybody to answer the phone. I would like the VA to know that it's very difficult to get an appointment. I would like them to know that the people are very rude. When you try to get an appointment or get any answers, they act as if it's an inconvenience to even call. The reason I seek outside help is because I can at least get them to call me back or book an appointment and I've had to pay for all of my healthcare, which includes my women's health and mental health because trying to get care at the VA is either impossible, nearly impossible, or it's just they make it so hard to get an appointment that it's just not worth it to me."*
Woman O	*"Well, I have been enrolled and dis-enrolled by my primary care clinic, my red team clinic at the VA three times. Every time I've gone in, they say, "you're not, we don't have a record of you," or "it's showing here that you dis-enrolled yourself," when that was never the case. So I love my doctor there. I never had a problem with healthcare or anything but it just seemed like it was the infrastructure and the administration that was always messing up. So it was just easier for me to go to a clinic that was closer to me that's covered by both TRICARE and my husband's insurance. But apart from that, I mean, I've always liked the VA. As I said, I like my doctor very much. I like the whole team."*

3.4 VA Appointing Processes as a Barrier to Care

Comments binned with the newly identified barriers *Left VA after care experience* and *Trying hard and quitting* also touch upon some important findings from comments under the *Administration* bin. Specifically, comments related to *Appointment scheduling and wait time*, which had the highest number of coded comments under *Administration* and the third highest number of codes out of any sub-bin in the study, suggest it is a significant barrier to woman Veterans receiving health care at VA. Examples of these comments are shown in Exhibit 6.

Exhibit 6 Example comments from women Veterans reporting issues with VA's appointing system

Person	Open-ended Comment
Woman P	*"For the last several years, every appointment that I had was rescheduled with notification the day before or while I was en-route to the appointment. My last appointment I had was rescheduled five minutes before I got there to the appointment. I had to take a day off of work for this appointment …"*
Woman Q	*"Their wait times are ridiculous. Their system for their appointment system, they don't call you. They send you a letter in the mail and if you don't get the letter, they cut you off. And really that's it. It's a huge turnoff."*
Woman R	*"I would like them to know that it shouldn't take a year to get in to see some of these specialists like for pulmonary because when you can't breathe, a year's a long time to have to wait to see somebody, especially when you've been to the emergency room five or six times and they still can't get you in..."*

While scheduling and appointment wait time is already a target of VA improvement plans, the open-ended comments here may provide some specific insights as to what aspects of the appointment system could be improved to overcome barriers to care.

3.5 Administrative staffing as a Barrier to Care

Related to women Veterans' comments about difficulty with VA's appointing system, and the new barrier *Trying hard and quitting*, some women specifically state that administrative support staff were a barrier to receiving appointments at VA and feeling welcome. Examples of these comments are shown in Exhibit 7.

Exhibit 7 Examples of comments from women Veterans about VA's administrative support staff

Person	Open-ended Comment
Woman S	*"The initial quality of care begins with the front desk and if the front desk is not receptive or responsive to the things that you tell them and pretty much just put you off. That's what puts a lot of people off from going to the VA, the personnel that work there at the desk that you have to directly deal with. …I've actually called, of course, and I stood directly in front of them and called and they did not answer the phone."*
Woman T	*"…It's hard to get an appointment when you need it. You know, they need to at least answer the phones and when we talk to someone when they finally do answer the phones, they are very rude over the telephone. It makes you not want to deal with the VA."*
Woman U	*"I think they have problems with office staff. It's not the doctors. The doctors, I think, do an outstanding job. The office staff, scheduling appointments. Some of them are door blockers. I call them door blockers…"*
Woman V	*"Well, I think that for, probably I would say that the biggest complaint that I had or have with the VA is their support people, the people that are checking you in, that type of thing. They don't seem to have --not so much the, not in the women's clinic --but in any other of the clinics that you go to that you seek care in for some reason because it's not related to women's health, the people that you deal with, I've seen them be very rude to the male veterans there. They're not compassionate, they're not understanding. It's like a "don't bother me," you know, kind of situation and I think that's the biggest complaint that I've had at the VA, that the support, you know, administrative people there, they don't have the level of care that they need to give to the veterans. As a matter of fact, in one of the clinics, I heard yelling at a veteran over the phone and using foul language and women sitting in the waiting room hearing all of this. You know, and other veterans, I don't like that. That doesn't happen when you go outside of the VA because it's a competition and in the VA, because they think they can't be fired, you know, whatever they do because of whatever they're not going to get fired, where when you go to a regular clinic, they're helpful, they seem to care, they want to make sure you're comfortable and they're pleasant and that kind of thing. But the VA doesn't come across like that."*

While the majority of women Veterans did not report negative comments about VA's administrative staff, it's relation to difficulties with the VA appointing system and negative experiences that discouraged women from continuing to seek care at VA makes it an emerging new barrier that VA may wish to consider in future work to improve access to care for women, and all Veterans, as well as patient satisfaction and retention.

4.0 Summary

Open-ended comments from women Veterans provide a wealth of information that VA may use to further understand the quantitative data collected by the Barriers to Care survey. Altarum took these comments and thematic trends into account when writing the recommendations section for the Barriers to Care final report. We highly encourage VA leaders and researchers to read the open-ended comments from this study to evaluate recommendations from women Veterans themselves as to how VA may improve, as well as to evaluate negative comments for potential case studies of VA sites of care that could be performing better.