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The Focus They Deserve: Improving Women Veterans' Health Care Access

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ABSTRACT

Purpose: Veterans Health Administration (VHA) initiatives aim to provide veterans timely access to quality health care. The focus of this analysis was provider and staff perspectives on women veterans' access in the context of national efforts to improve veterans' access to care.

Methods: We completed 21 site visits at Veterans Health Administration medical facilities to evaluate the implementation of a national access initiative. Qualitative data collection included semistructured interviews ($n = 127$), focus groups ($n = 81$), and observations with local leadership, administrators, providers, and support staff across primary and specialty care services at each facility. Deductive and inductive content analysis was used to identify barriers, facilitators, and contextual factors affecting implementation of initiatives and women veterans' access.

Results: Participants identified barriers to women veterans' access and strategies used to improve access. Barriers included a limited availability of providers trained in women's health and gender-specific care services (e.g., women's specialty care), inefficient referral and coordination with community providers, and psychosocial factors (e.g., childcare). Participants also identified issues related to childcare and perceived harassment in medical facility settings as distinct access issues for women veterans. Strategies focused on increasing internal capacity to provide on-site women's comprehensive care and specialty services by streamlining provider training and credentialing, contracting providers, using telehealth, and improving access to community providers to fill gaps in women's services. Participants also

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highlighted efforts to improve gender-sensitive care delivery.
Conclusions: Although some issues affect all veterans, problems with community care referrals may disproportionately affect women veterans' access owing to a necessary reliance on community care for a range of gender-specific services.

Women represent less than 10% of U.S. veterans (National Center for Veterans Analysis and Statistics, 2017). However, the number of women veterans receiving Veterans Health Administration (VHA) care has increased by 22.1%, from 423,642 in 2014 to 517,241 in 2018 (Department of Veterans Affairs, 2020). Looking forward, the VHA anticipates this population will continue to increase, from 9.4% of the U.S. veteran population in 2015 to 16.3% of the U.S. veteran population by 2043 (Congressional Research Service, 2020). Since 2006, the VHA has increased attention to gender differences in quality and performance measures to identify gaps in women veterans' quality of care, respond to the needs of the growing women veteran population, and decrease gender health disparities (Whitehead, Czarnogorski, Wright, Hayes, & Haskell, 2015; Wright, Schaeger, Reyes-Harvey, & Francis, 2012; VHA, 2012).

Efforts to improve women veterans' health care access have included implementation of gender-sensitive comprehensive primary care (Yano, Haskell, & Hayes, 2014) and gender-specific specialty services (Kimerling et al., 2015; Zuchowski et al., 2017), maternity care coordination (Cordasco et al., 2018; Mattocks, Kroll-Desrosiers, Kinney, & Singer, 2019; Katon et al., 2018), the development of separate women's health clinics (Kehle-Forbes et al., 2017), and improving contracted care with community providers (Mattocks, Yano, Brown, Casares, & Bastian, 2018). However, women veterans continue to face unique barriers to accessing VHA health care, such as limited availability of women's health trained providers, limited on-site gender-specific services (Cordasco et al., 2015), delayed access to community care (Mattocks et al., 2018), and stranger harassment at VHA medical facilities (Dyer et al., 2019; Kehle-Forbes et al., 2017; Klap et al., 2019).

This evaluation focused on site level efforts to improve veterans' access to care by implementing standards and strategies as part of a comprehensive systemwide national initiative, MyVA Access (U.S. Department of Veterans Affairs, 2016; now known as ChooseVA). The aims of the initiative included decreasing wait times, increasing availability and delivery of services (e.g., extended hours, virtual care), and improving community care access across all sites and service lines. Although this initiative represented the largest effort to improve access to VHA care to date, there has been little research published on this initiative thus far. Pringle et al. (2019) found that these efforts were associated with improvements in wait times, increased patient satisfaction, and decreased patient complaints. Another study (Moldestad et al., 2020) described staff perspectives on implementation challenges focused on adherence to performance standards for scheduling (e.g., 30 days) which conflicted with patient-centered scheduling practices. However, these studies presented no findings specific to women veterans. This article describes local site efforts to improve women veterans' access to care as a critical component of the VHA's aim of improving veterans' access to care.

Methods

Qualitative team members included 20 health services researchers with backgrounds in public health, medicine, nursing, psychology, communication, sociology, and health sciences. Team members' qualitative experience ranged from novice to advanced. The senior qualitative methodologist (G.S.) supervised data collection and analyses. This work was conducted as health care operations (VHA Handbook 1058.05) and did not require Institutional Review Board review. Employee unions reviewed the interview instruments before its administration. Participation was voluntary.

Study Setting and Sample

Twenty-five VHA facilities were purposively sampled to maximize heterogeneity by accounting for variation in contextual site characteristics across geographic region; rurality using Rural–Urban Commuting Area Codes (Rural Health Research Center, n.d.); and internal self-reported access performance ratings. Rural sites were oversampled to increase diversity of perspectives. Sites participating in other concurrent site evaluations were excluded to reduce participation burden. Each site identified their MyVA Access improvement efforts implemented to meet their local patient population needs. Interviews and focus groups were completed with local site leadership and administrators (e.g., department administration leadership, clinical chiefs of staff, medical center executive leadership); clinical care providers; and clinical and support staff across primary care, specialty care (e.g., surgery, oncology, neurology, rehabilitation), and mental health services (e.g., primary care mental health, specialty mental health). Clinical care providers included, but were not limited to, medical doctors, physician assistants, nurse practitioners, and clinical pharmacists. Clinical and support staff included licensed practical nurses, registered nurses, medical assistants, and clinical and non-clinical staff in a range of support roles (e.g., scheduling, telehealth coordination). Focus groups varied and consisted of participant roles based on clinic (e.g., primary care, mental health, specialty care clinics), department setting (e.g., call center, community care coordination) and other heterogenous teams (e.g., access improvement team).

Measures and Procedures

Sixteen team members were assembled into two- to three-person teams to conduct site visits. Site visits were conducted over approximately three days each between July and November 2017. Data collection included semistructured field observations, interviews, and focus groups to capture the experiences of individuals tasked with implementing the access initiative (Appendix A) into health care operations. We used a semi-structured interview and focus group guide (Appendix B) to collect detailed descriptions of sites' implementation efforts pertaining to core principles outlined in the VHA access strategic plan, including tools or strategies used to enhance access (VHA, 2016, MyVA Access Implementation Guidebook Version 2.1). Structured probes were used to elicit details using participants' verbatim words or phrases. Semistructured observations (Appendix C; Mulhall, 2002) included three guided tours at each site focused on the site's 1) overall access efforts, 2) most

successful efforts, and 3) challenges or problems with access. Opportunistic observations and interviews focused on the sites' settings and processes. Interviews and focus groups lasted approximately 1 hour and were audio recorded and transcribed.

Analysis

ATLAS.ti (version 7.5.10, Scientific Development GmbH) was used for data management, coding, and analysis. Twelve members of the qualitative team conducted deductive and inductive content analysis (Elo & Kyngäs, 2008). Deductive content analysis consisted of identifying quotes and phrases that fit within a priori categories (Access core principles; Appendix A), including barriers and facilitators to care and strategies to improve access. Inductive content analysis entailed open and unstructured coding, allowing for the identification of emergent, previously unidentified themes; environmental and contextual factors; and capturing the complexity of implementation efforts within and across sites. Team members met weekly to review codes and resolve discrepancies and redundancies. Interview, focus group, and observation data were aggregated for analysis. Two analysts (V.M., K.C.S.) organized the coded data on women veterans' access and women's health care using a priori categories and developed focused themes related to sites' reported access challenges, how sites implemented the initiative, and descriptions of their efforts to improve women veterans' access to care. These steps were repeated through discussion among the larger qualitative analysis team to refine each theme, verify the validity and credibility of themes, and reach consensus. Site-specific contextual factors were evaluated during analysis, including site rurality (i.e., rural, urban) and women's care clinic setting (VHA Handbook 1330.01). Because women's health care access was one of several access-related topics raised during site visits, the data were aggregated across sites and respondent types. Thus, neither site-level nor participant type comparisons were made. Analysis continued until thematic saturation was reached and subsequent data failed to produce new findings (Sandelowski, 1995). The summary of themes was reviewed by the analytic team, including principal investigators (D.A., P.M.H., P.J.K., G.S., S.K.). To ensure rigor and quality assurance, analysts completed a post hoc review and verification of data and findings generated across site characteristics (i.e., rurality and women's care clinic setting).

Results

Of the 25 facilities sampled, 21 site visits were completed (1 site declined, 2 sites did not respond in time to participate, and 1 visit was cancelled owing to a weather emergency). The sites visited included 6 rural and 15 urban medical centers. Women's health care services included primary care clinics (i.e., Patient Aligned Care Team) offered within a setting of gender-integrated clinics (8 sites), separate women's clinics co-located or adjacent to general primary care serving male veterans (1 site), and Comprehensive Women's Health Centers (12 sites). Data collection included semistructured field observations, 127 interviews, and 81 focus groups.

Providers and staff at most participating sites identified women veterans' access as a priority when implementing the initiative. They expressed similar concerns regarding women's access across women's care delivery settings (e.g., gender-integrated clinics, women's health clinics, Comprehensive Women's Health Centers) and site setting (i.e., urban and rural). Analysis and quality assurance review of the data suggested that themes were well distributed across sites. Findings outlining four barriers to women veterans' access to care and seven strategies to improve women veterans' access to care are presented. These barriers, facilitators, and strategies are sequenced for readability and the order is not indicative of relative importance.

Participants' Impressions of Efforts to Improve Women Veterans Access to Care

Participants at most sites reported women veterans' access as a top priority when describing their site's overall challenges and successes in implementing the initiative to improve veterans' access to health care. Increasing recognition and leadership support for addressing women veterans' needs was necessary to support efforts to improve access. One participant explained, "they [site leadership] understand, and they agree that women veterans have often been overlooked and not treated as fairly, just weren't given the focus that they deserved. That in itself has been a real benefit, because I know other sites don't have that level of support" (Women's Health Interview, Urban Site A).

Barriers to Women Veterans' Access

Participants described four main barriers or challenges to women veterans' access to care: 1) limited availability of women's health care services, 2) problems with community care coordination, 3) women veterans' perceptions of VHA medical settings as unwelcoming, or threatening, environments, and 4) psychosocial factors such as competing caregiving responsibilities (Table 1).

Barrier 1: "She can be seen for everything but that"

Participants across most sites described a limited availability of women's health providers and gender-specific services in primary and specialty care, although the availability of facility and community services varied. Many sites reported ongoing challenges to providing comprehensive women's preventive care—specifically breast and cervical cancer screenings—and many basic gender-specific services were outsourced to non-VHA and community providers (Table [T]1, Quotations [Q]1-2). At some sites, participants described some VHA providers as unwilling or lacking the expertise to provide pelvic exams; at these sites, women's preventive services required multiple visits with different providers (T1, Q3).

Barrier 2: "It's a nightmare": Care coordination with community services

Some participants identified poor care coordination with community services as a specific difficulty for women. Issues included inefficiencies in referral processes for women's health care (T1, Q4–5), delayed return of records or test results to the VHA (T1, Q5–7), and veterans receiving bills for covered services (T1, Q8). One participant expressed that it is sometimes unclear whether the community provider or VHA is responsible for notifying patients of abnormal test results when tests are completed in the community (T1, Q7). Breakdowns in care coordination owing to poor communication between VHA and community care delayed action on abnormal preventive breast and cervical cancer screenings, which affected the women's ability to receive timely comprehensive and follow-up care (T1, Q7, Q9). The urgency of time-sensitive conditions, such as maternity care, was also emphasized (T1, Q6).

Table 1
Barriers to Women Veterans' Access to Health Care Illustrative Quotations

Barrier	Illustrative Quotations
1: "She can be seen for everything but that"	(1) Another big access issue with—related to women's health, is inability to provide mammograms within facility… We have non-VA care that has a lot of challenges, but there have been many efforts to try to figure out a more practical solution that makes it easier for our vets that are female veterans to get screened and to get follow up if they screen positively for breast lesion. -Patient-Centered Care Committee Focus Group, Urban Site H (2) … they're sent out for a lot of their stuff… cause we don't have those providers within our facility… if we had them, then that would help probably a lot more of our females instead of having to CHOICE them out … -Medical Support Assistants Focus Group, Urban Site B (3) … one thing that's unique to the VA, is historically they wrote the Handbook for Women's Health that said providers who are knowledgeable and interested in providing women's health … they left this loophole where you could refuse to do comprehensive care for women. You could treat 80%, deal with their diabetes and osteoporosis and whatever, but "I'm not going to do any sort of pelvic exams." I've got guys [providers] downstairs who are still practicing that way. But, Dr. [name] has said, "no, we're doctors, you are trained, you are competent." I'm not advocating that we force some of the, I call them, "old dogs," if you will, to start doing this. If they really haven't had training in 20 years, you have no business performing those exams if you really don't want to be doing it. I'm not going to subject a woman to that …. Before, it was kind of an up-road hill, because we're short of physicians, so a doctor is better than no doctor. And even if a doctor is going to do 80%, there's workarounds. So that's been probably one of my larger challenges, and that directly goes to access to care. That she can be seen for everything but that, and now she has to go to another provider. -Women's Health Interview, Urban Site A
2: "It's a nightmare": Care coordination with community services	(4) … women veterans are referred outside, but then they come back for a Pap smear. So somehow, Primary Care on the outside don't do Pap smears, so they'll be referred back to our Women's Health. That in itself to me isn't very efficient as far as taking care of veterans as a whole. -Patient Aligned Care Team Focus Group, Urban Site A (5) … it's been a nightmare… We do the best we can, we go of course through the [third party administrator]. We lost control of what happens at some point with the patient's access. The patient may get a 41-day access? The patient may get a 90-day access and then we find out about it at 120 days… -Women's Health Focus Group, Urban Site D (6) … The problem is when we have to send them out for specialty care. And that is really where we end up with a lot of issues in terms of coordination of care. Number one, timeliness of care delivery; number two…women's service as we move out from primary care to more specialized care, are for the most part, time limited, if you're pregnant … you don't have any wait times or anything you know and when the baby's trying to come out, that's about it! Or if you have … an acute complaint, the service has to be provided right now… there are special problems that providing women's services entails. -Women's Health Focus Group, Urban Site D (7) … the scariest thing I saw with this was patient finds out they have breast cancer when they went out for a mammogram, who tells them? The other outside center should by ACR standards, but how long did it take the records to get back, then they had to farm them back to us, then OK, well we started out in this, like a mammo[gram] going out versus breast cancer care is two hugely different things, they can't plan, so it's just the communication case management aspect. -Medical-Surgical Administration Focus Group, Urban Site I (8) ... in women's health we use it [CHOICE] a little bit more cause obviously a lot of the women's health services aren't provided in the VA … like infertility treatments, genetic counseling, and ultrasound … breast biopsies, those are all going through CHOICE and … our nurses and care coordinators had difficulty with getting people scheduled, which those are all things … that you want to get seen for in a timely manner … there is a whole kind of process it has to go through for that to be authorized and then so a veteran will just go, schedule an appointment, and be seen and then they end up with a bill for it… -Primary Care and Women's Health Social Work Focus Group, Urban Site C (9) … there are a lot of CHOICE problems even if people get an appointment. We don't get consult notes back. We don't get abnormal results … sometimes it takes months to get mammogram results. We had some abnormal mammogram results that came back significantly delayed and that delays care. And a lot of times, people will go get an initial appointment approved, but they cannot go for follow up… there has to be a way to get the records within 24 hours, just like we require to put our notes within 24 hours. We should get records within three business days at least, because as a primary care provider I could not act on an abnormal result if I don't know it's abnormal. -Patient-Centered Care Committee Focus Group, Urban Site H
3: Some women veterans are not comfortable coming to the VA	(10) … a lot of women find VA … not the most welcoming place … So a little bit of a generalization, but women do find the VA nationally less of a welcoming environment and are very open to alternative ways of getting care. -Primary Care Leadership and Administration Focus Group, Urban Site E (11) I know that women's health had tried to roll it out [extended hours] … they tried it, and the feedback they had received was that some female veterans were not comfortable coming into [VHA facility city location] early morning or late at night. -Medical Support Assistants Focus Group, Urban Site C
4: "Women come in with the world"	(12) … there's evidence-based research that shows that, it takes a little longer, not a whole lot, but a little longer, to see women because of the extra issues that women have. There's no accommodation for that with a PACT team; you have so many women, you're still seeing the same amount of patients. You're still having the same access … -Primary Care Leadership and Group Practice Manager Focus Group, Urban Site D (13) I think one of the interesting things about women is first of all, they need more outpatient visits … so it's much more challenging to reduce the return rate because their baseline return rate is higher. -Primary Care Leadership and Administration Focus Group, Urban Site E (14) … with a new patient with 20 meds, there's no way you can go through and interview that patient, go through all their past medical history, past social history, past mental history, past everything, and get that all done. And in a female, do a Pap and pelvic, all in that hour at the same time. No way you're going to get that done. -Community-Based Outpatient Clinic Primary Care Leadership Focus Group, Urban Site R (15) … women often, not always, are more likely to be caregivers. There are plenty of families where that's not true, but women tend to be more likely to be caring for young children, caring for parents … lately I have two patients, who haven't been seen in over a year, and both are caring for elderly parents and they keep cancelling their appointments. So some of it is caring for others. -Primary Care Leadership and Administration Focus Group, Urban Site E

Abbreviation: PACT, Patient Aligned Care Team.

Barrier 3: Some women veterans are not comfortable coming to the VA

Some participants reported women veterans felt unwelcome at VHA facilities owing to ongoing or anticipated harassment from male veterans (T1, Q10). A few participants reported women veterans feeling uncomfortable attending appointments during extended hours, making extended evening hours ineffective in improving access for women in these cases (T1, Q11).

Barrier 4: "Women come in with the world"

Psychosocial factors and perceptions of VHA were recognized as critical to providing effective care and improving women veterans' experiences. One women's health nurse expressed that women veterans present more issues during a visit compared with male veterans, who often focus on single issues. Participants reported longer, more frequent appointments to address women veterans' unique care needs, placing additional pressure on what can be accomplished during time-limited appointments (T1, Q12–14). Participants also perceived women in parenting or caregiving roles as facing additional barriers to attending and scheduling appointments (T1, Q15). Staff emphasized the necessity to address these psychosocial needs to effectively meet women's medical needs.

Strategies for Improving Women Veterans' Access

Participants described seven strategies used to improve women's access. These were focused on efforts to increase internal capacity for women's health care services and improve processes for utilizing non-VHA and community providers to fill gaps (Table 2).

Strategy 1: Women veterans' program's administration

Women veterans' program managers and women's health committees were tasked to identify women veterans' access issues and focus on developing solutions to improve access (T2, Q16).

Strategy 2: Assembling women's primary care teams

Some participants described "juggling" staff to provide gap coverage for women's primary care (T2, Q17), and others developed a designated women's health "team" that consisted of one clinician in the absence of a fully dedicated women's primary care team (T2, Q18). Inefficient credentialing processes for primary care providers to obtain women's health privileges were streamlined at the local site level to increase availability of women's health providers (T2, Q19).

Many sites responded to the increasing demand for women's health providers by training their staff and providers in gender-specific care to ensure the competency of available providers and increase capacity for essential women's health care services (T2, Q17). "Women's health champion providers" also served as local resources and mentored new providers (T2, Q20).

Strategy 3: Increasing gender-specific specialty care

A few participants reported increasing the availability of on-site gender-specific services, such as reproductive and gynecological specialty services and gender-sensitive mental health. For example, one site's women's health center provided prepregnancy planning and maternity care through the first trimester (opportunistic observation, Urban Site J). This site also had on-site specialty gynecology staff to provide expanded services, for example, hysterectomies, and accepted women veterans from out of state for these services. Participants discussed contracting community providers to deliver on-site services at VHA locations (e.g., gynecologist) (T2, Q21), which increased women's access to gender-specific specialty care at their facilities, and in some cases increased staffing available to provide comprehensive women's care.

Strategy 4: Using telehealth to address barriers to women's access

Sites used telehealth to increase access to primary and specialty care. A few participants described offering gender-specific mental health programs for military sexual trauma and postpartum depression via telehealth (T2, Q22–23). Sites used telehealth to facilitate patient-centered strategies (strategy 5) and address concerns for privacy and safety while improving flexibility. For example, when women did not like going to VHA facilities in person, telephone care and secure messaging were utilized (T2, 24). Telehealth also enabled providers and staff to better manage limited appointment availability.

Strategy 5: Patient-centered strategies for supporting women's psychosocial needs

When women veterans presented multiple concerns during visits, one women's health nurse asked veterans to identify their top three concerns for the visit. This strategy helped providers to address the concerns most important to the veteran within the limited appointment time. Patient-centered strategies were especially important for supporting survivors of military sexual trauma. Some participants reported referring women veterans to community care to offer more privacy (T2, Q25).

Sites used flexible scheduling to accommodate women in caregiver roles, particularly parenting women. Participants highlighted "being mindful" of how efforts to accommodate scheduling needs were reflected in clinic data and performance measures (T2, Q26). Another participant from a women's residential post-traumatic stress disorder program reported changing the admissions process to improve access for parenting women (T2, Q27).

Although some participants identified parenting as a women's access issue, analyses identified efforts to support parenting veterans that were not explicitly aimed at women veterans, though they may have benefitted from them. Observations during site visits identified children's play spaces in general, non–gender-specific primary care clinic waiting areas. For example, one site developed a dedicated family waiting room central to outpatient waiting areas for primary care and specialties (guided tour, Rural Site G). Another site arranged child-care services for veterans to use during their VHA appointments (T2, Q28).

Strategy 6: A dedicated space for women veterans

Participants highlighted the importance of offering more privacy and security, providing a safe and comfortable environment for women veterans to access care. Many sites with separate spaces and established women's health centers offered enhanced conditions for privacy, security, and comfort (T2, Q29). These centers also supported co-located comprehensive primary care and gender-specific specialty care services, making it easier for women veterans to get a range of services in one location (T2, Q30). Participants at one site described including women veterans in designing their site's new women's health center (opportunistic observation, Urban Site J). This included making the space "*aesthetically pleasing*" and enhance privacy in care processes designed so veterans did not have to leave the exam

room in a gown. The design incorporated women veterans' desire for child-friendly waiting rooms, where they didn't have to listen to war stories. The waiting room space included a dedicated child's play area, a lactation room, and a bathroom with a shower for homeless women veterans. To help women feel more comfortable during exams, robes replaced traditional paper gowns, and cloth sheets were used instead of paper sheets for privacy.

Strategy 7: Improving community care access

Many participants shared that leveraging non-VHA providers and community care is necessary to improve women's access to care. Despite challenges, coordination with non-VHA providers continued to be an integral component of providing comprehensive care when on-site resources were limited (e.g., gynecology, maternity care, reproductive health). Specialized committees and staff were implemented to provide dedicated coordination of women's services, including women's diagnostic coordinators and maternity care coordinators. A few participants established direct communication with outside facilities to increase access (T2, Q31). One site partnered with a local military station to identify women transitioning from military service to enroll in VHA care to facilitate access (T2, Q32) and viewed this as especially critical for pregnant veterans to facilitate timely maternity care access. During a guided facility tour (Urban Site A), staff reported that their facility partnered with the local military health care facility perinatal unit for labor and delivery care to improve continuity of care.

Discussion

Although MyVA Access improved access across a number of areas (Pringle et al., 2019), the impact of the initiative on women veterans has been unreported to date. Our evaluation extends our understanding of challenges providing women veterans' care as well as responses to these challenges to improve women's access. Although the literature predicts differences between sites offering more women's health care services (e.g., women's health centers) compared with sites with limited services (e.g., gender-mixed primary care clinics) (Katon et al., 2012; Oishi et al., 2011; Yano, Haskell, & Hayes, 2014), participants across settings identified similar issues despite these differences in available resources. Participants reported that ensuring adequate access to women's comprehensive primary care and specialty care was both an increasing challenge and greater priority owing to the growing number of women veterans using VHA health care. Implementation efforts included increasing VHA capacity and availability of women's health care services, increasing gender-specific services, and developing more gender-sensitive services for women. However, participants described multiple ongoing challenges and barriers to women veterans' access, such as perceptions of VHA as an unwelcoming environment for women veterans and limited VHA and community care options.

Attending to women's psychosocial needs was cited as integral to effective medical care and overall access. Participants' perspectives reinforced findings describing women veterans' preferences about care environments and perceptions about VHA facilities associated with VHA use and attrition (Evans, Tennenbaum, Washington, & Hamilton, 2019; Hamilton, Frayne, Cordasco, & Washington, 2013; Kehle-Forbes et al., 2017; Klap et al., 2019; Mengeling, Sadler, Torner, & Booth, 2011). Participants perceived that some VHA facilities were unwelcoming, hostile, or unsafe for women veterans, as reported in other studies (Dyer et al., 2019; Evans et al., 2019; Kehle-Forbes et al., 2017; Klap et al., 2019; Washington, Yano, & Simon, 2006). Our evaluation highlights staff and providers' efforts to address access barriers, including increasing provider training in gender-sensitive care, developing more private clinic spaces for on-site care, and offering alternative options to receive care (e.g., telehealth, community care). However, efforts to address gender-sensitive needs (e.g., longer or more frequent appointments) compete with other demands for clinic time and resources.

Although men and women veterans have reported lack of childcare as an access barrier (Tsai, David, Edens, & Crutchfield, 2013), participants in our evaluation identified childcare and caregiving as specific challenges for women's access. Our analysis showed that facilities used multiple efforts to support parenting veterans, including developing agreements with community childcare providers and providing on-site family-friendly spaces. National efforts to reduce childcare-related access barriers are reflected in the Veterans' Access to Child Care Act (2019–2020) and the funding of a childcare pilot program at select VHA facilities (VA Office of Public and Intergovernmental Affairs, 2011).

Finally, the use of community providers continues to be an integral, but challenging, component of access. These issues may disproportionately affect women veterans' access to care owing to a necessary reliance on non-VHA care for gender-specific services. Our finding that access to appropriate community care services is critical to women echoes previous research findings (Mattocks, Mengeling, Sadler, Baldor, & Bastian, 2017; Mattocks et al., 2018; Sayre et al., 2018), and ongoing issues with integrating community care under the Choice Act (Department of Veterans Affairs, 2018), including addressing the limited availability of community care options. As in past studies on women's health access in the VA, participants reported persistent challenges with community care services: confusion about eligibility, difficulty scheduling appointments, delayed reporting of testing results to VHA for follow-up, and concerns regarding management of unpaid bills. These issues emerged as a significant barrier to care under the Choice Act in our evaluation, and our findings confirm earlier findings that these challenges pose particular barriers for women veterans (Mattocks et al., 2017; Mattocks et al., 2018). A lack of clarity on whether community providers or VHA are responsible for notifying patients of abnormal test results when testing was completed by community providers is concerning. These issues delay action and threaten continuity of care and timely access to appropriate care (e.g., abnormal breast and cervical cancer screenings, time-sensitive specialty care such as maternity and cancer care).

Implications for Practice and/or Policy

Since the completion of our evaluation, the VHA has made changes to address challenges identified. For example, although most of the sites we visited made changes to panel management to allow more frequent and longer visits for women veterans, and updated security and privacy standards, changes to VHA policies now make these a requirement for women's health care services (VHA Handbook 1330.01(2)). Further, changes to community care policies mandated by the VA MISSION Act of 2018 (2017–2018) provide veterans with more choices for accessing community care and aims to streamline VHA's community care programs. However, researchers have yet to uncover the law's impacts, including any changes to the availability of providers in underserved communities. VHA should continue to support

Table 2
Strategies to Improve Women Veterans' Access to Health Care Illustrative Quotations

Strategy	Illustrative Quotations
1: Women veterans programs administration	(16) Each month we [Women's Health Care Committee] look at data. So we're looking at the [report] for patient satisfaction by gender… I call it the gender equity report, for things like smoking cessation, diabetes… We look at how many women are assigned to a designated comprehensive Women's Health Provider…We're looking at how many consults we're sending out to the community, why, and how many we can recapture. -Women's Health Interview, Urban Site A
2: Assembling women's primary care teams	(17) I closely coordinate with our women's coordinator in terms of ensuring that I think over 90% of our primary care providers are women's health trained, and that helps us ensure that there should be access to women's services. We don't have separate women's health providers, they are all primary care providers… A number of our providers are male providers … but there are plenty of times that women would prefer a woman provider, and we only have a few women providers in our primary care teams. So we have designated some of [woman provider's] time to catch those patients who might just want to see a [woman] provider … because [the woman provider] also maintains a primary care panel who, there are male patients, and some of the female patients that she sees in the women's health clinic may not really be her primary care patient as well, you know so she just provides women's services … So, yeah there's a lot of juggling around as far as women's services … -Women's Health Focus Group, Urban Site D (18) … I've got a Nurse Practitioner downstairs… it's not an official PACT, but it's a Women's Health Team. Because we don't have enough women to make a full PACT. It's a gender-integrated Primary Care Clinic … assigned to her. Previously it was just one morning a week, but we've expanded that now to one morning and one afternoon. -Women's Health Interview, Urban Site A (19) … our credentialing process was unnecessarily tedious. So you would apply for your Primary Care privileges, but then you'd have to go back and reapply for Women's Health privileges. Well, a basic annual exam is Primary Care. So we decided we were going to move that piece and roll it into the overall Primary Care credentialing package. So that if you apply for it, you're automatically designated, capable, you can go forth and start … Now for higher level interventions, IUDs, Colpos … that would still be separate. But at least taking a roadblock out … that one highlighted that we need to change our thinking. -Women's Health Interview, Urban Site A (20) … [champion providers] these are providers who kind of go the extra mile if we call them … Also any new provider they kind of champion under their wing even though the new providers go through this training and I go out to the satellites as well and work with the nurses and providers. -Women's Health Focus Group, Urban Site D
3: Increasing gender-specific specialty care.	(21) They actually have contracted with the [community] Medical Center here and they're bringing one [gynecologist] over once a week I think now… [the] Women's Clinic here. -Medical Support Assistants Focus Group, Urban Site B
4: Using telehealth to address barriers to women's access	(22) … because Women's Health is not just Primary Care. It's everything. So, one example is that I applied for and got a grant for telehealth for MST-identified veterans in rural [site]… giving them that external, but convenient, way to access that care. -Women's Health Interview, Urban Site A (23) I also regularly send out information on the online Mom Mood Booster Program … it's an online postpartum depression therapy program … and it's free of charge to women veterans, and it's a partnership with the VA and the [university]. -Women's Health Interview, Urban Site A (24) … women actually really often don't like coming to VA. So we rely very heavily on telephone care, on secure messaging. I think last year my data for virtual care was well over 100% in my visits. -Primary Care Leadership and Administration Focus Group, Urban Site E
5: Patient-centered strategies for supporting women's psychosocial needs	(25) If she was assigned and served here in [state], and she was traumatized here in [state], most will not come over here [VHA facility] because they're worried that they're going to run into their attacker. And that's valid … then I really push CHOICE Program … it's in a more private means, that they don't even have to step foot on the campus. -Women's Health Interview, Urban Site A (26) … one of my patients, she likes to see me without her children, so it's whenever she can get a babysitter … I wanted to make sure that I got this clinic open, because Friday happened to be a time when grandma was available to watch her kids. But that's hard, you want to be available, and we do make it work. The patient is going to be seen regardless, but I'm just trying to be mindful of how they collect the data so that it doesn't look like … we're hiding clinic slots… -Community-Based Outpatient Clinic Primary Care-Mental Health Integration and Mental Health Focus Group, Rural Site G (27) We have specialty here [mental health residential treatment], but for PTSD and substance abuse… in terms of initiatives for access … what we've really focused on is making sure that prescreening process is as quick and agile as possible … We used to have from a clinical perspective, track treatment, so meaning they come in cohorts, which was really beneficial for the community, terrible for access … so we did a lot you know working with our veteran consumers to try to change that so now we no longer have cohorts, we do have rolling admissions … just for somebody to kind of step out of their life for 12 weeks, right, we want to make sure that we're as available as we can be of when they're able to make that happen, particularly with the women, I mean some of the men are primary caretakers for children, but a higher percentage of our women are primary caretakers so that plays a really huge role for them in terms of when they are able to get care cause we don't take the children into treatment … so those are some significant changes we've made, we went from cohorts to rolling admission and now we're in the process of making our rolling admission hopefully a four, possibly five day week, as opposed to just two days a week. -Primary Care-Mental Health Integration and Women's Health Focus Group, Urban Site F (28) If we're looking at barriers of care for women, childcare is a real issue. We're really fortunate that the [non-VHA facility] runs a free childcare service ... We went over, asked them if they would extend that to veterans … So now there's up to two hours of free childcare if you have an appointment … That was one thing that we did to try to increase access. -Women's Health Interview, Urban Site A
6: A dedicated space for women veterans	(29) We have a separate women's waiting room, it's locked. So the doorbell rings and you have to go out and let them in. -Patient Aligned Care Team Focus Group, Rural Site G (30) Yeah, it's quieter up there, it's nice … and also for female veterans you can get all of your care in one place instead of having to come for a primary care and come for like a women's health visit separately … you see a comprehensive provider and get all of that in one so I think that helps, too … if you can just get everything done in one fell swoop. -Primary Care and Women's Health Social Work Focus Group, Urban Site C

(*continued on next page*)

Table 2 (*continued*)

Strategy	Illustrative Quotations
7: Improving community care access	(31) … I am the mammogram coordinator … and I have a good rapport with the outside facilities that our people go to. … I'm calling the facility, and we are getting that patient in … -Primary Care and Ancillary Providers Focus Group, Urban Site B (32) … I sit on the team who works with all the transitioning service members. So we have weekly meetings… and they're aware of veterans who are discharging from the military and gonna start their veteran status, so I can help be a liaison between them and women's health to make sure that they can get scheduled … so that helps with access too, particularly we've had a couple of veterans who discharged from the military while they are pregnant, so they need to get seen pretty quickly so we can provide their care … -Primary Care and Women's Health Social Work Focus Group, Urban Site C

Abbreviations: MST, military sexual trauma; PACT, Patient Aligned Care Team; PTSD, post-traumatic stress disorder.

VHA-based women's services, including telehealth modalities, to ensure that women in areas with limited medical services can access care. VHA access measures, performance ratings, and some VHA initiatives focused on improving veterans' access (such as decreasing return to clinic intervals or standards for care delivery) can pose barriers to gender-sensitive care. Lastly, VHA policies and practices outlining women's health care services (VHA Handbook 1330.01(2)) require ongoing review by the VHA Women's Health Services national program office and implementation by local VHA women's health clinics, leadership, and dedicated women's health staff to ensure compatibility with women veterans' unique care needs.

Study Limitations

The limitations of this work include that we did not apply criteria for women's health care services when sampling. However, data collected include a heterogenous sample of facilities with a range of women's health care services. Social desirability bias (Hewitt, 2007) may have also influenced some participants' responses, and we attempted to minimize bias by using participant-engagement methods during recruitment. Data collection methods used prompts and probes grounded in participants' words and examples, and we ensured confidentiality of responses. Detailed demographics were not available for opportunistic interviews and some focus group participants, thus participant-level analysis based on respondent roles or demographics was limited. In addition, because sites identified a divergent range of site-specific access efforts reflecting unique patient population needs, site valid comparisons were not possible. Last, this work does not include women veterans' perspectives of access, the efforts to improve access, or women's experiences with their care.

This study's overall strengths include a large dataset with a diverse representation of providers and staff from a variety of roles and settings, as well as the inclusion of observations, interviews, and focus group data capturing experiences and perspectives of providers and staff tasked with implementing a large-scale initiative to improve veterans' access to care. Although women's health was not an explicit focus of the evaluation, participants made clear that providers, staff, and leadership considered improving women veterans' access a critical component of their access improvement efforts. The validity of our findings is strengthened by the consistency of our findings on challenges and barriers to veterans' access with findings reported in other studies.

Conclusions

Understanding staff and providers' experiences with improving access can inform future initiatives to effectively address barriers to women veterans' health care access. Policies affecting community care programs may disproportionately affect women veterans owing to a necessary reliance on community care for gender-specific services. Further study is needed to describe impacts on access to care and related health outcomes for women veterans, including social determinant factors, the effectiveness of specific innovations, and the effectiveness of community care in improving access to health care for women veterans.

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Supplementary Data

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