Barriers to Accessing Veterans Health Administration Health Care

For Enlisted Women Veterans

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTERS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INTRODUCTION .................................................................1</td>
</tr>
<tr>
<td>Historical Background of Women in the Military ..............................................X</td>
<td></td>
</tr>
<tr>
<td>The Department of Veterans Affairs and Veterans Health Administration .................X</td>
<td></td>
</tr>
<tr>
<td>Women Utilizing VHA Health Care ........................................................................X</td>
<td></td>
</tr>
<tr>
<td>Research Questions ..................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>REVIEW OF THE LITERATURE .....................................................X</td>
</tr>
<tr>
<td>Demographics ........................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Outreach and Communication .................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Institutional Barriers ............................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Geographical Barriers ............................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Discussion and Summary .........................................................................................X</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>METHODS ...................................................................................X</td>
</tr>
<tr>
<td>Rationale for Qualitative Study ............................................................................X</td>
<td></td>
</tr>
<tr>
<td>Study Design ..........................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Methods of Data Collection ...................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Methods of Data Analysis .......................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Limitations of the Study .......................................................................................X</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>PRESENTATION OF FINDINGS .......................................................X</td>
</tr>
<tr>
<td>Demographics ........................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Data Themes ...........................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Common Misperceptions about VHA Health Care Eligibility ....................................X</td>
<td></td>
</tr>
<tr>
<td>Common Misperceptions about VHA Health Care Services .....................................X</td>
<td></td>
</tr>
<tr>
<td>Receiving and Perceiving Information about VHA Health Care .............................X</td>
<td></td>
</tr>
<tr>
<td>Experience While Using VHA Health Care ...........................................................X</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>DISCUSSION AND IMPLICATIONS ...............................................X</td>
</tr>
<tr>
<td>Physical Barriers ....................................................................................................X</td>
<td></td>
</tr>
<tr>
<td>Misperceptions about Eligibility ..........................................................................X</td>
<td></td>
</tr>
<tr>
<td>Information Outside of VA Clinics .........................................................................X</td>
<td></td>
</tr>
<tr>
<td>Information Inside of VA Clinics ..........................................................................X</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>RECOMMENDATIONS ......................................................................X</td>
</tr>
</tbody>
</table>
7 CONCLUSION...................................................................................................................... X

BIBLIOGRAPHY.......................................................................................................................... X

APPENDICES

Appendix A: Glossary of Terms and Acronyms................................................................. X
Appendix B: Interview Guide ............................................................................................ X
Appendix C: Consent Form ............................................................................................... X
CHAPTER 1
INTRODUCTION

In this study, I aim to explore common barriers to receiving health care from the Veterans Health Administration for enlisted women veterans and investigate how enlisted women veterans receive and perceive information about VHA health care. The purpose of this study is to use existing research and qualitative data from in-depth interviews to unravel more of the complex explanations of what has prevented utilization of VHA health care, a free and low-cost benefit available to most veterans who have been discharged from the military under honorable conditions.

**Historical Background of Women in the Military**

Although women have been serving in America’s military since its inception, women’s service was not officially recognized until 1901 when women were permitted to register as Army Nurse Corps.¹ Later in the twentieth century, around the time of the Gulf War, women have entered the armed forces at increasing rates with a current total women veteran population of approximately 10 percent, which is projected to increase to 15 percent by the year 2035,² even though the total population is projected to decline at a steady decrease. Women who served in the most recent military operations—Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND)—are the largest cohort of women directly involved in any combat operations in U.S. history.³ As of December 2015, the Department of Defense announced that all combat positions, without any exceptions, would be open to all

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³ U.S. Department of Veterans Affairs, “America’s Women Veterans,” (see footnote 1).
women, making the future population of women veterans the most mission-diverse than ever before.

The Department of Veterans Affairs and Veterans Health Administration

The Department of Veterans Affairs, also known by its unofficial name of “Veterans Administration,” is the military veteran benefit system with a $87.6 billion budget in 2009 tasked with administering medical, educational, housing and other benefits for veterans, their families and survivors. The headquarters in Washington D.C. is flanked with a pair of metal plaques at the building’s entrance which read “to care for him who shall have borne the battle and for his widow, and his orphan.” Just weeks before the American Civil War ended in 1865, during his inaugural address, President Abraham Lincoln spoke these words upon starting the first government institution to care for honorably discharged soldiers and sailors. After the Department of Veterans Affairs was established 65 years later in 1930, Lincoln’s words became the motto for the department, leaving men as the sole group of service members recognized wherever the official motto is displayed.

Although the Department of Veterans Affairs now acknowledges women as a population in need of care in their mission statement, the predominant recognition of men as service members heedlessly contributed to a number of barriers for women veterans from fully utilizing

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federally-earned benefits through the Veterans Administration. Out of all benefits and services available to veterans, possibly the most prominent is the medical health care program administered by the Veterans Health Administration, which consists of more employees than all other combined divisions of the Department of Veterans Affairs. As one of the largest integrated health care systems in the United States, the Veterans Health Administration (VHA) has a wide range of services for all veterans for free or low-cost including, but not limited to, primary and long-term health care, specialized services, wellness programs, mental health services, dental services, inpatient hospital services and pharmaceutical drugs. Veterans who served a full contracted active duty period or at least 24 consecutive months of active duty are eligible for VHA health care; however, a number of exceptions permitting even more veterans to receive care exist.

Women Utilizing VHA Health Care

Although the amount of women veterans are steadily increasing, U.S. Census Bureau data and the American Community Survey from 2011 reveal women veterans are less likely to be insured than their men veteran counterparts. A 2012 report from the Department of Veterans Affairs revealed that women veterans are still about 30 percent less likely to enroll in VHA than men. Among the total population of veterans, having lower income, a more debilitating health status, having a service-connected disability, and being an ethnic minority all correlate with VA

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use.\textsuperscript{12} Compared to men veterans, women veterans are more likely to have no income or earnings and live in poverty, but despite the increasing rate of women veterans are overall still less likely to use VHA health care.\textsuperscript{13}

The lack of VHA health care use can be seen as especially problematic considering public health research reveals that on average health care expenses for women are approximately a third higher than men throughout their lifetime.\textsuperscript{14} Although the amount of women using VHA health care is increasing, the amount of women veterans eligible to use this benefit is still disproportionate to men veterans, and barriers as to why this gap exists can be explained in part by summarizing government data, peer-reviewed academic research, and investigative reports examining this issue. Aside from reviewing current literature, I aim to explore this issue deeper by synthesizing data from interviews with enlisted women veterans with experience enrolling in VHA health care. I attempt to draw further insight into this issue by identifying common themes and by providing discourse around recent findings.

Research Questions

The primary research questions being addressed are: 1) What are the common institutional barriers to receiving health care for women veterans? 2) How are women veterans receiving and perceiving information about VHA health care? The goal of this research is to: 1) synthesize these findings through research of subjects with direct experience as women veterans and explore the relationship of these data against current literature and 2) offer general policy recommendations to address the gaps in health care utilization of women, assuming that all

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people, regardless of gender, value utilizing a public good in which they may be eligible for. I took the approach of an interpretivist tying in findings from research with multiple methodological approaches ranging from medicine to anthropology. For example, government data, peer-reviewed academic research, and investigative reports were used as sources of data for synthesis. A qualitative approach was used to give a voice to the collective, individual stories that can describe the issue more holistically and add more rich and microcosmical information to larger, macro-level findings that most systematic literature does not include.
CHAPTER 2
REVIEW OF THE LITERATURE

Academic research discussed in this paper has been published in peer-reviewed scholarly journals ranging from the subjects of medicine to anthropology. Research from multiple methodologies has been discussed throughout this paper. Most of the articles discussed were either funded by or published by the Department of Veterans Affairs, although some research institutions have conducted their own research independent of support by the Department of Veterans Affairs. The government publications are primarily provided by a number of divisions affiliated directly or indirectly by the Department of Veterans Affairs, such as the Women Veterans Task Force, Women Veterans Health Strategic Health Care Group, Office of Research and Development of the Veterans Health Administration, and the National Center for Veterans Analysis and Statistics. Reports and findings from federal institutions that are not affiliated with the Department of Veterans Affairs, such as the Government Accountability Office and Congress, are included in this review and were intended to assess systemic issues within the Department of Veterans Affairs.

Evidence has been summarized by categorically grouping themes identified across research accessed. Themes have been grouped into the following two main issue area categories: institutional barriers and outreach and communication. Institutional barriers are defined as “policies, procedures, or situations that systematically disadvantage certain groups of people” and “often feel natural or ‘just the way things are around here.’”\textsuperscript{15} The Outreach and communication research that was evaluated focuses on common misperceptions about VHA health care eligibility and existing types of care and services. Possible connections between these

\textsuperscript{15} “Institutional Barriers & Their Effects: How Can I Talk to Colleagues About These Issues?,” National Center for Women & Information Technology, last modified April 3, 2016, https://www.ncwit.org/resources/institutional-barriers-their-effects-how-can-i-talk-colleagues-about-these-issues.
themes in connection to decision making or lack thereof around using VHA health care are made in this literature review based upon the sources reviewed and analyzed.

Demographics

In 2014, approximately 23.7% of total veterans were enrolled in VHA health care. Only approximately 6% of total veterans using VHA health care were women. As this population of patients continues to grow, the VHA should continue to investigate why women are still less likely to enroll than men while strategizing on ways to improve VHA enrollment of women veterans.

While it is imperative to look across different demographics across women veteran populations, it is difficult to determine how much minority status, age or other factors can explain the differences between health care use among groups without controlling for specific factors. Although some information is known about classifications of women who tend to utilize VHA care more or less across race, age, period of service (which is often, but not always, correlated with age), and geographical location, these factors should be taken into account in attempt to better understand barriers to accessing quality VHA health care.

Determining which age groups of women are more likely to use or not use VHA health care is difficult since available data is typically aggregated by period of service (e.g. by conflict) in connection to age. VA reports show the largest subpopulation of women veterans using VHA health care as of 2012 are women who served during the Vietnam and Gulf War eras aged 45 to

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17 Ibid.
64, which makes up about 44% of women patients.\(^{19}\) Currently, this group is growing at a faster rate than younger women veterans.\(^{20}\)

Whereas 45-64 year olds have increased proportionately compared with other women, among younger women, between 2000 and 2009, the number of women under 45 years old increased; however, the proportion of women using VHA decreased from 51% to 42%.\(^{21}\) \(77.3\%\) of women who served in OEF/OIF/OND are 40 years old or younger.\(^{22}\) Among VHA health care users in this cohort, women are more likely to be younger, single, and black compared to men,\(^{23}\) which is in line with the total population of veterans with lower income, a more debilitating health status, a service-connected disability and being an ethnic minority.\(^{24}\)

Compared to men, women using VHA health care tend to be much younger. 42% of these women are less than 45 years old, compared to men at just 12%.\(^{25}\) Although some research from the Department of Veterans Affairs highlights that OEF/OIF/OND women veterans enrolling in health care are starting to outpace men, women have been entering the service at increasing rates over the last 30 years\(^{26}\) and are still overall under-enrolled compared to men.\(^{27}\)


\(^{20}\) Ibid.


\(^{23}\) Ibid.

\(^{24}\) Donna Washington et al., “To Use or Not to Use: What Influences Why Women Veterans Choose VA Health Care,” (see footnote 12).


\(^{26}\) U.S. Department of Veterans Affairs, “America’s Women Veterans,” (see footnote 1).

In regards to race, according to a 2011 National Center for Veterans Analysis and Statistics report on minority veterans, Asian veterans were the least likely to use VHA health care and the percentage of VA utilization between Black and American Indian and Alaska Native Veterans was not statistically different. While more research is needed to understand this gap, it can be difficult to draw conclusions about VHA health care users based on a single isolated demographic.

**Outreach and Communication**

*Misperceptions about VHA Health Care Eligibility*

As the old saying goes, “sometimes you do not know what is missing until you find it.” Institutional barriers aside, a consistent barrier to care, identified by government and nonprofit researchers alike, is the lack of knowledge about VA eligibility and available services. Arguably, the Department of Veterans Affairs and Department of Defense’s shortcomings of making former service members aware of accurate information regarding VHA health care benefits can be defined as an institutional barrier, however, even though these outreach failures are systematic, they deserve individual attention since strategic marketing and communication is verifiably an ongoing issue and from the perspective of many communications scholars, a “low-hanging fruit” solution to getting more women veterans enrolled in VHA health care. A 2010 National Survey of Women Veterans revealed 39% of women veterans had either “zero or almost no knowledge” about VA services. In addition, across all groups of women veterans studied, there were several misperceptions about who is eligible for VA care. During a focus

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group study, a woman who used VA health care captured the essence of this issue by solemnly referring to women’s health care benefits as “the best kept secret in the whole VA.”

Consistent across several data sets, women non-VA users reported having little to no information they would need to determine their eligibility about health care benefits. For example, research found many women veterans believe eligibility for VHA health care is solely for veterans with service-connected disabilities. In particular, younger women non-VA users were more likely to have less accurate information regarding eligibility.

Although some non-veterans are eligible for VHA health care, one of the most obvious criteria for eligibility for VHA health care is being a veteran of the U.S. Armed Forces. Interestingly, many women who served in the armed forces are not self-identifying as veterans and therefore do not think to utilize VA benefits or think they are eligible. In response to women’s lack of understanding about what constitutes an eligible service member, the VA has launched a variety of “culture change campaigns” in recent years for Women Veterans Program Managers, Public Affairs Officers, and others in the field that work with women veterans. What is likely the largest external outreach campaign with a women’s health focus is the launch of a two-year hotline campaign contacting women veterans to inform them of their benefits. Irene Trowell-Harris, director of VA’s Center for Women Veterans (CWV), stated a core

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35 Ibid.
component of this call center is to address “correct existing misinformation and misperceptions so we can provide more women veterans with the benefits they’ve earned.” Although the VA cites over 183,000 women veterans were contacted by the Call Center during this campaign, no known formal assessments or research were conducted about the effects of the VA’s outreach campaign.

Requirement to Buy Coverage Under the Affordable Care Act. Under the Affordable Care Act, most U.S. citizens are legally required to have a health insurance plan. When choosing a health care plan, multiple research studies found women did not have the information to simply decide whether or not they should use VHA health care. Information aside, before the implementation of the Affordable Care Act (ACA), a 2009 National Survey of Women Veterans unveiled many women were unfamiliar with the VHA application process. However, the implementation of the new health care law requiring most to apply for coverage may have a positive effect of familiarizing women veterans with the VHA application process since information about VHA health care is available through the U.S. Centers for Medicare & Medicaid Services. More research is needed on the effects of ACA implementation and VHA health care application familiarization and enrollment.

Common Misperceptions about VHA Health Care Services

In regards to both primary care services and gender-responsive care, such as cervical cancer screenings, breast examinations, and menopause management, research has found that

there are misperceptions among non-VA users about programs and services available. Additionally, some women veteran VHA health care users are unaware of all programs and services available through the VA. Services that are more specialized, such as women-only residential mental health programs, vary by service and facility and do not have information on the VA’s external websites. Most literature around women’s awareness of VHA health care focuses on primarily on eligibility, but more research is needed to identify specific programs and services women are aware of. In addition, due to the growing amount of medical research around women veteran’s specialized health care needs, research should also explore the correlations and gaps in beliefs and perceptions about women veterans health needs and what current medical research has identified as their actual health care needs.

**Institutional Barriers**

Unsurprisingly, knowing one’s eligibility for benefits does not imply an automatic intention to enroll in or let alone utilize VHA health care. Women veterans who are enrolled in VHA health care may also decide to not use their benefits for similar reasons as women who chose not to enroll. Furthermore, some women veterans may not have enough knowledge, resources and agency to make a choice about their health care needs, and are forced to navigate services perceived as available or the most convenient to them.

Audits and evaluations of women’s access to VHA care shed light on a number of environmental barriers. Below are the most consistent findings found among various research

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investigating the impact of service availability at VA facilities, challenges around accessing available services, and how the VA are implementing and adhering to policies for providing health care for women veterans. These findings include inconsistent gender-specific and primary health care services and care environments, varying models of care, inconsistent coordination of care, and other barriers that effect utilizing VHA health care.

**Inconsistent Care Services and Environments**

The VA operates 152 medical centers, approximately 1400 community-based outpatient clinics, domiciliaries, Vet Centers, and community living centers. Out of all of the VA facilities, only 9 locations have women-only residential mental health programs or have dedicated cohorts for women, limiting the access to care in gender-exclusive environments. Considering there are a limited number of these sites, information about all of these programs are not listed on VA’s external websites. The need for more preceptorship and support for women’s health care providers, especially in smaller community-based outpatient clinics, is made evident, along with a need to measure proficiency in women’s health. Due to the lack of access to, and knowledge of, gender-specific care, studies have found there is an increased reliance on non-VA community-based providers for primary and gender-specific services.

To better synthesize standards of care, in 2010, the VA implemented a new policy per the VHA Handbook 1330.01 requiring “system-wide achievement of patient-centered comprehensive [primary care] PC for women,” with standards for primary care physicians in

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47 Ibid.
both integrated and women-only facilities.\textsuperscript{48} However, despite the implementation of this new policy, access to women’s health care providers and female chaperones for gender-specific exams vary, along with access to patient-aligned care teams in women’s clinics.

\textit{Varying Models of Care}

The VA policy requirements for women’s health requires one of three comprehensive primary care clinic “models” for women veterans including:

1. General primary care clinic (gender neutral) with one or more designated women’s health providers, co-located mental health care, efficient referral to specialty gynecology care;
2. Designated women’s health providers deliver primary care in separate but shared space (within or adjacent to primary care clinic) with readily available, co-located gynecological and mental health care; and
3. Women’s health center, with separate, exclusive use space with separate entrance, comprised of designated women’s health providers; co-located specialty gynecological, mental health and social work services; other sub-specialty services (e.g., breast care, endocrinology, rheumatology) may also be provided in same location.\textsuperscript{49}

Deciding which and how many models to adapt, how to procedurally adhere to a model or models, the competition for resources for primary care, and varying levels of proficiency and interest in women’s health have led to evidence for needing greater guidance, primary care performance measures, and gender-specific integration for VA facilities. The shaky adaptation of these models highlight how the standards for primary care physicians in both integrated and women-only facilities translates into unclear implementation and adherence of policies centered around providing health care for women veterans.

\textit{Coordination of Care}

The coordination of care essential to women’s health ranging from care around military sexual trauma (MST), gynecology and substance abuse vary in not just availability depending on

\textsuperscript{48} Ibid.
\textsuperscript{49} Ibid.
the VA medical facility, but in coordination of service. To illustrate, one-third of VA medical centers do not have a gynecologist on staff, which will leave women in need to gynecological care to either obtain a referral to a non-VA provider.\textsuperscript{50} Several VA facilities do not have enough knowledge about women’s health and may refer women to a non-VA provider that is unaware of issues unique to women veterans.\textsuperscript{51} In addition, referrals may be too distant or out of reach for women, which will be discussed with physical (geographic) boundaries later in this paper.

Considering that the number of young women enrolled in the VHA is significantly increasing, clinical services essential for reproductive health will consequently only continue to increase. Although the demand for gender-specific reproductive care for prenatal and infertility is increasing, regardless of the facility, legislative authority prohibits the VA from providing full, comprehensive reproductive health care for women such as in-vitro fertilization and abortion services.\textsuperscript{52} Not providing these services can be detrimental for women’s health and impact their decision-making of when or whether or not to use VHA health care, considering in-vitro fertilization is the most effective and most common form of assisted reproductive technology and among women in general, 13.2 legal abortions per 1,000 women aged 15–44 years were performed in 2012 according to the Center of Disease Control.\textsuperscript{53}

\textit{Post-traumatic Stress Disorder (PTSD).} Women in the military are at a higher risk of developing post-traumatic stress disorder (PTSD), combat-related disorders and depression


\textsuperscript{51} Ibid.


compared to men who served in the military.\textsuperscript{54} However, coordination of mental health care has been noted as a crucial lapse for women’s health care needs. Aside from inconsistent care available at VA facilities, a lack of female mental health providers has created a shortage for women veterans seeking specific mental health services.\textsuperscript{55}

\textit{Military Sexual Trauma (MST).} Women are also at a much higher risk of experiencing military sexual assault (MST), which can carry long-lasting effects on women’s mental health and overall well-being.\textsuperscript{56} Approximately one out of every five women veterans who use VHA health care screen positive for MST.\textsuperscript{57} This is especially true for women who are enlisted, which make up the majority of VHA health care users.\textsuperscript{58} Younger women are more susceptible to screening positive for MST, especially compared to their men veteran counterparts.\textsuperscript{59} In 2011, 19.4 percent of OEF/OIF/OND women veterans screened positive for MST compared with just 0.9 percent of OEF/OIF/OND men veterans.\textsuperscript{60} Although women veterans are disproportionately more likely to experience MST, mental health care for MST are only available at select VA sites. Mental health care aside, other deliberating effects of MST, such as physical injury, may not be appropriately addressed due to the lack of access to gender-specific health care providers and specialists within all VA facilities.

MST is associated with an increase of PTSD, depression, and substance abuse.\textsuperscript{61} Furthermore, women with cases of MST are “more than four times more likely to have PTSD

\textsuperscript{54} U.S. Congress, House, Committee on Veterans Affairs, \textit{Eliminating the Gaps: Examining Women Veterans’ Issues}, 111\textsuperscript{th} Cong., 1\textsuperscript{st} sess., 2009.
\textsuperscript{55} Ibid.
\textsuperscript{56} Ibid.
\textsuperscript{57} U.S. Department of Veterans Affairs, “Strategies for Serving Our Women Veterans,” (see footnote 11).
\textsuperscript{58} Ibid.
\textsuperscript{59} Ibid.
\textsuperscript{60} Ibid.
\textsuperscript{61} Ibid.
and are at six-fold increased risk for having three or more mental health conditions.”

Furthermore, substance abuse may be more prevalent among women veterans than women non-veterans and men veterans. Although each VA medical center has a trained specialist in substance abuse, PTSD, and MST, other VA facilities such as Vet Centers and outpatient clinics do not have a trained specialist in at least one of these areas.

Although women veterans with histories of MST tended to report positive perceptions of VHA health care overall, women veterans using VHA health care with histories of MST are substantially less satisfied with coordination and patient-provider interactions. Women veterans with histories of MST have a poor perception of patient and provider interactions because they are often forced to deal with the lack of concentrated gender-specific care.

Recently, programs and services specifically meant to support women with histories of MST have been established, including the possibility of receiving “free, confidential treatment for mental and physical health conditions related to MST” even for veterans not eligible for other VA services, veterans without a VA service-connected disability rating, veterans who did not report any incidents when they happened, and those without any documentation that any related incidents occurred. However, obvious social barriers beg the question of whether or not women veterans with histories of MST have more negative safety perceptions around VA services.
Social constructs of gender and violence entrenched deep within military and veteran culture, explained through anthropological frameworks, exist within military and veteran institutions tasked with supporting women veterans. Limited research on best practices for treating women veterans with MST, along with data revealing a strong dissatisfaction for patient-provider interactions, reveal a need for more sensitivity training about ways hegemonic power works against women veterans, more discussions around what components are essential for gender-sensitive models, and how to address the dynamics of the social constructions of gender and its impact for delivery of health care for women veterans. Despite underlying challenges of social stigma in the VHA health care system, data showing a positive perception of VHA health care overall is possibly indicative of using VHA as a potential for delivering quality health care. However, it is very important to note women in the military are at higher risk for experiencing sexual trauma than their civilian peers, and since the VA offers services and support to women veterans not utilizing VHA health care who may have experienced MST, they should coordinate every effort possible to understand residual stigma and triggers which prevents some women from using VA services.

Sexual Harassment. Few studies have examined linking sexual harassment and VHA health care use among women veterans. However, one study revealed women veterans who did not use VHA health care were more likely to disagree that women can feel safe from sexual

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68 Ann Cheney, “The Intersections of Gender and Power in Women Veterans’ Experiences of Substance Use and VA Care,” (see footnote 84).
harassment at VHA facilities than current women veteran VHA users.\textsuperscript{69} Among the population studied, the non-VA users were younger, married and were less likely to report current mental health issues such as PTSD.\textsuperscript{70} Based upon these demographics, researchers may be able to draw conclusions based upon demographics and perception. Interestingly, this group of women veterans are less likely to need to utilize VHA health care, as they are “are more likely to have options for health care through employment and insurance.”\textsuperscript{71} As studies consistently find non-VHA users tend to carry more negative perceptions of VHA care, demographics of non-users should be accounted for and examined, as they may account for varying levels of exposure to other VA services, social services in general, and veteran-influenced social networks (for example, by learning about details of support and services via word-of-mouth).

\textit{Post Traumatic Stress Disorder (PTSD).} Studies show that although women veterans are twice more likely to experience PTSD than men,\textsuperscript{72} OEF/OIF/OND women veterans are less likely to have received a mental health diagnosis and be diagnosed with PTSD.\textsuperscript{73} Furthermore, women are less likely to be granted a service-connection for PTSD, which may prevent them from obtaining treatment at VHA facilities.\textsuperscript{74} Without qualifying for a service-connected disability, women are may not be eligible for other types of VA assistance such as housing and

\begin{itemize}
\item \textsuperscript{69} Michelle Mengeling et al., “Evolving Comprehensive VA Women’s Health Care: Patient Characteristics, Needs, and Preferences,” (see footnote 75).
\item \textsuperscript{70} Michelle Mengeling et al., “Evolving Comprehensive VA Women’s Health Care: Patient Characteristics, Needs, and Preferences,” (see footnote 75).
\item \textsuperscript{71} Ibid.
\item \textsuperscript{73} U.S. Department of Veterans Affairs, “Systematic Review of Women Veterans’ Unique Mental Health Needs,” (see footnote 87).
\item \textsuperscript{74} U.S. Congress, House, Committee on Veterans Affairs, \textit{Eliminating the Gaps: Examining Women Veterans’ Issues}, (see footnote 55).
\end{itemize}
employment services, which could likely exacerbate symptoms connected to PTSD. In discourse about perception of VHA health care users and non-VHA health care users, women who do not qualify for VHA health care and are not granted an exception due to a service-connection for PTSD, would likely hold a negative perception on the VA’s ability to meet the health care needs of women veterans.

Other Considerations with Barriers

Other barriers to care that may effect decision making around best utilizing VHA health care for women veterans may not be directly embedded within the level of quality of types of care available. For example, a women veteran’s parental status and status of homelessness may bear weight in accessing VHA health care.

Even though the number of homeless veterans is declining, the number of homeless women veterans is increasing and are the fastest growing cohort of the homeless population. In addition, women veterans in poverty are more than three times more likely to be homeless than women non-veterans in poverty. Considering that women are still overall less likely to utilize VHA health care, this is especially problematic.

Unless a veteran is rated permanently and totally disabled due to a service-connected disability or qualifies for a special program, such as the Spina Bifida Health Care Program, children are not typically covered for health care through the VHA. Little information has been found about whether or not the VA’s coverage of children’s health care deters women veterans from using VHA health care. More research and data should be gathered about this potential barrier.

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75 Ibid.
77 Ibid.
However, research does show women needing child care due to employment or other reasons can be problematic, especially considering that multiple visits may be needed since most VA health care facilities do not have comprehensive services for women veterans.\textsuperscript{78} In response, in 2010, the Caregivers and Veterans Omnibus Health Services Act was passed requiring the VA provide childcare options in a two-year pilot program to facilitate their access to quality health care services.\textsuperscript{79} Since women often are associated as the primary caretakers for young children and more than ten percent of veterans have reported needing to cancel or reschedule VA medical appointments because of child care issues, the law’s intent was meant to remove barriers for veterans needing medical care.\textsuperscript{80} The pilot program’s intent was to assess the “feasibility and advisability of providing assistance for childcare to qualified veterans” and more information on the program’s success and policy plans is needed regarding preventing child care as a barrier to accessing health care.\textsuperscript{81}

\textit{Geographical Barriers}

According to U.S. Census data from 2010, 36\% of the total veteran population are considered rural veterans. Since those living in rural areas are traditionally underserved by the VA, the VHA Office of Rural Health was developed to address issues preventing access to care.\textsuperscript{82} Although reasons for this are “multiple and varied,” barriers identified through research include a lack of specialized care and needing to travel longer distances to obtain care.\textsuperscript{83} In addition, it is assumed that specific regions may have experienced varying numbers of women

\textsuperscript{78} U.S. Government Accountability Office, \textit{VA Health Care}, (see footnote 9).
\textsuperscript{79} U.S. Department of Veterans Affairs, “Strategies for Serving Our Women Veterans,” (see footnote 11).
\textsuperscript{80} Ibid.
\textsuperscript{81} Ibid.
\textsuperscript{83} Ibid.
veteran patients, and it may benefit regions and individual facilities to examine reasons for their enrollment numbers by gender and other demographics.

Specialized Care

Many studies note the consistent findings that rural women veterans are less likely to visit the VA for gender-specific care and seek mental health care, especially in highly rural areas. Although studies have shown women veterans in rural areas utilize primary care more than urban women veterans, this could be due to the absence of gender-specific services for women and mental health care services. 30% of OEF/OIF/OND veterans are rural veterans enrolled in VHA health care which include the largest group of women directly involved in any combat operations in U.S. history and are more prone to having issues connected to PTSD and MST compared to their men veteran counterparts. Also in regards to PTSD and specialized care, women veterans living in rural and highly rural areas are older than urban women veterans and older women veterans are likely at a greater risk for both PTSD and depression compared to younger women.

Distance

The inconvenience of VA facility locations cause more issue for rural veterans in accessing care. This is especially problematic considering that women veterans living in rural and highly rural areas are older than urban women veterans and the need for transportation to

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84 Ibid.
86 Ibid.
87 U.S. Department of Veterans Affairs, “America’s Women Veterans,” (see footnote 1).
distant appointments is likely to increase for older women veterans. Furthermore, in general, as health declines with age, women veterans who are older may need more access to transportation in order to receive care. For example, Women 65 years and older were more likely to report difficulties with transportation as a reason for delaying or foregoing health care.

**Discussion and Summary**

Why or why not a person, let alone a classification of people based on a gendered social identity, accesses a particular type of health care is an extensive and complex question with multifaceted and varied possible explanations. Even though it is not possible to provide conclusive explanations about the decision making of U.S. women veterans and their use of VHA health care, themes have been identified across academic research, medical research, internal VA audits and reports, and government publications using multiple research methodologies. Although gaps in research have been identified by conducting a systematic literature review, women’s lack of knowledge about VHA health care eligibility, social stigma and perceptions concerning the VA’s ability to meet the needs unique to women veterans, institutional barriers concerning gender-specific services available and varying qualities of care, and geographical distances that can prevent rural and elderly veterans from using VHA care, have been recognized as consistent factors preventing women veterans from utilizing care.

While it is important to look across different demographics across women veteran populations, it is difficult to determine how much minority status, age or another factor can

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explain the differences between health care use among groups without controlling for specific factors. Although some information is known about classifications of women who tend to utilize VHA care more or less across race, age, period of service (which is often, but not always, correlated with age), and geographical location, these factors should be taken into account in attempt to better determine barriers to accessing quality VHA health care. A significant finding regarding age groups between gender and period of service are OEF/OIF/OND women veterans, who tend to be younger, and are enrolling in health care at a rate that has begun to outpace men. Also, regarding age, women over 45 years old use health care less than men, however, compared to other age groups of women, women between 45 and 64 use VHA health care the most.

Among VA users, recent data from 2002-2008 reveals that OEF/OIF/OND women veterans are more likely than men to be young and black. Although it is understood that outreach and communication campaign efforts are still needed, quality of care should be monitored and evaluated since people from these populations may be especially vulnerable. In addition, since women centers tend to have more young, minority patients, a group known to rate satisfaction lower in other VA studies, found that “women veterans who receive care in specialized women's clinics are more satisfied with their care than their counterparts in traditional primary care clinics.” This response may point that young, minority women veterans

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“may be better served in gender-specific VA settings” which reveal the need for more consistent and quality gender-specific care.96

Another study revealed that the entire sample population of women veterans disagreed with the statement that “VA health care facilities serve the needs of men and women veterans equally well.”97 Although VHA health care users were less likely to agree, agreeing less with this statement across all three groups reveal the consensus for more equitable care.

Important factors to acknowledge are that not all women who attempt to enroll in VHA health care will be determined eligible to receive these benefits and not all women who enroll in VHA health care actually end up using the system. Studies which compare the amount of health care applicants compared to enrolled patients and patients who utilize VHA care, should be conducted if possible. It is fortunate veterans who are lower income, such as women compared to men, have priority when determining requirements for eligibility.98

It is evident from multiple sources of data that one common reason why women are not signing up for VHA health care because they simply are not aware of their eligibility. This could be due to the fact that they do not identify as a veteran or do not believe their time in the service merits free or low-cost health care through the VHA. In attempt to curb these myths, in 2012, the VA’s Center for Women Veterans (CWV) has launched a series of campaigns centered on women’s health hoping to educate women about health benefits and services.99 In addition, the VA’s Women Veteran Coordinators (WVC) are working specifically on ensuring women use VA benefits and assisting women with claims, especially among vulnerable groups, such as

96 Ibid.
98 U.S. Department of Veterans Affairs, “America’s Women Veterans,” (see footnote 1).
women with histories of MST. Comprehensive evaluations should be conducted on the effectiveness of these coordinators in hopes of expediting the amount of women enrolled in VHA health care and in effort to not waste valuable government resources.

Women who do not know they are eligible for VHA health care do not have the ability to identify internal barriers to care because they have not actually used VHA health care. Perceptions about their eligibility and the quality of care from VA facilities likely prevent them from accessing a potential federally-granted benefit at a low-cost or free of cost. Consistent research highlighting that women who receive VHA health care have a more favorable view of the VHA overall reveal a strong distinction between perception and actual use.

Fortunately, the Department of Veterans Affairs have provided a number of reports investigating the impact of service availability at VA facilities in addition to identifying challenges around accessing available services and how their own implementation and adherence to procedures and policies may be lacking. A variety of procedural recommendations have been put forth by other government entities such as the Government Accountability Office, legislation has been successfully passed by Congress, and leadership within the Department of Veterans Affairs has spearheaded a variety of initiatives for women veterans. Although one or more of these approaches to the numerous issues preventing women from enrolling and utilizing VHA health care have helped curb women’s enrollment, not all proposed fixes have been implemented accordingly, or worked as planned, and contribute to why women are still under-enrolled compared to men.

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100 Ibid.
CHAPTER 3
METHODS

Rationale for Qualitative Study

Although research from multiple methodologies have been presented and critically evaluated in the systematic literature review, very little research specifically examines how women veterans are receiving information about VHA healthcare and how this shapes their perceptions and beliefs about health care eligibility, care and services. Most research studies are in the form of government publications that present summaries of survey findings, with little attention to collective, individual stories that can add more rich information to larger, macro-level findings.

Ethnographic methods, such as in-depth interviews with participants, have the advantage of processes that pay more attention to things that are either not measured or are difficult to measure.\(^{101}\) Qualitative research has the ability to dig more into \textit{how} something occurred, and attempts to go beyond quantitative relationships between fixed variables by providing the opportunity for researchers to understand a phenomenon by using the lexicon of a female veteran’s own experience.\(^{102}\) By using an interpretivist approach, this study attempts to bring to light some of the unrecognized and unacknowledged pieces to the multifaceted issues surrounding perceptions about health care eligibility, care and services in addition to the actual institutional barriers preventing women from accessing VHA health care. In addition, the military’s full integration of women since December of 2015 coupled with the highest entrance rates of women into the armed forces make strong cases for having the stories of women veterans.


be presented with the goal of improving their transition to civilian life and care post-military service.

**Study Design**

This study was conducted using twelve in-depth interviews that were held either via telephone or in-person. Participants were all enlisted veterans who identified as women. All participants were asked questions about their service-related background, how and when they received messages about VHA programs and services, and their experiences using VHA health care. A full interview guide can be found in the appendices of this paper (see Appendix B).

**Recruitment of Prospective Subjects**

All participants recruited for this study were enlisted veterans who identified as women. For the purposes of VA health benefits and services, “a person who served in the active military service and who was discharged or released under conditions other than dishonorable is a veteran.” Participants were recruited from all five branches of service including the Air Force, Army, Coast Guard, Navy, and Marines. Prior enlisted service members were sought out since they 1) vastly outweigh the number of commissioned veterans and 2) typically are associated with more underrepresented categories such as race and educational attainment. Although studying men-identified veterans could provide for a rich analysis around the central research questions for this study, this study intentionally focuses on the experience of women-identified veterans in order to isolate their perspectives rather than compare them to another gendered category.

In order to collect a sample, I used “chain referral sampling” or “snowball sampling” by reaching out to possible participants within my own social network of friends, colleagues,

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103 U.S. Department of Veterans Affairs, “Health Benefits,” (see footnote 52).
veterans organizations and groups. Chain referral sampling is a type of purposive sampling, which “groups participants according to preselected criteria relevant to a particular research question.”

Although it was simple to put out a call for “enlisted women veterans who have had experience enrolling in Veterans Health Administration health care,” only twelve total participants were derived by using the snowball method. As all researchers in search of participants understand, some participants will reach out after communication is initiated by I through a call for participants, however not all participants follow through with interviews. However, twelve participants were enough to provide this study with a rich data synthesis between data analysis and data collection since theoretical saturation was reached. Participant feedback was becoming iterative and themes were already well-developed.

**Methods of Data Collection**

In total, 12 participants were interviewed. All participants interviewed had four criteria in common. First, all participants were former enlisted service members, who fit the legal definition of a veteran according to Title 38 of the Code of Federal Regulations.

Second, women veterans were chosen because they have been found to be under-enrolled in VHA health care compared to their veteran men counterparts. Any participant who identified as a “woman” were eligible and all participants self-identified their gender as a woman.

Third, former enlisted service members were chosen because the minimum level of education required to enlist is a high school diploma. To become a commissioned officer,
specific educational, leadership and management skills are required. Therefore, the military experiences of enlisted service members and commissioned officers may very greatly, and because all branches of the armed services were welcome to participate, I aimed to frame uniformity through types of responsibility while serving.

Lastly, all participants were enrolled in VHA health care. All but one participant have used VHA health care at some point. The one participant who has not yet used VHA health care has recently been enrolled in VHA health care and has future plans to use VHA health care in some capacity. Women enrolled in VHA health care were chosen because they have insider knowledge on how they overcame the barriers. By narrowing the scope of the sample to enrolled former enlisted women veterans, I was able to learn about how they overcame institutional barriers, their experience actually using VHA health care, and receive their recommendations for how to approach anything barring access from using VHA health care.

Initially, participants were invited via email to participate in the study explaining what the study is about, what I will be asking them to do, and contact information of I. This study was determined to be an exemption through the Institutional Review Board (IRB) at Cornell University and did not require that I obtain signatures through a consent form. A consent form was still created and given to participants before the study took place to give participants the option to learn more about the research study, risks and benefits, the voluntary nature of the study, compensation for participation, IRB contact information, a statement about consent to record conversations and information regarding privacy, data and security.

Interviews were transcribed by I after each recording. All but one interview was recorded since one participant did not consent to being recorded. For this participant, I took very thorough notes. All recordings and transcriptions were kept confidential in a secured data storage site.
through Cornell University. After each interview, a pseudonym was immediately assigned to the participant.

**Methods of Data Analysis**

The primary research questions being addressed are: 1) What are the common institutional barriers to receiving health care for women veterans? 2) How are women veterans receiving and perceiving information about VHA health care? The goal of this research is to: 1) synthesize these findings through research of subjects with direct experience as women veterans and explore the relationship of these data against current literature and 2) offer general policy recommendations to address the gaps in health care utilization of women, assuming that all people, regardless of gender, value utilizing a public good in which they may be eligible for.

My analysis of qualitative findings was a very iterative process. After each transcription, I would conduct my analysis in two ways: first, I would make connections between other interviews by noting emerging themes and patterns. Second, I would make connections between interviews against current literature. While conducting my analysis, I used Wolcott’s two out of three “major ways to ‘do something’ with descriptive data.”

First, I attempted to consistently stay as close to the original data as possible, meaning I tried to use the same terminology and honor participant’s words as fact by letting the data “speak for themselves.” Second, I aimed to “extend beyond a purely descriptive account with an analysis that proceeds in some careful, systematic way to identify key factors and relationships among them” by reading through all of the interview transcriptions and making notes to

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109 Ibid.
identifying common categories and data themes.\textsuperscript{110} Using a thematic analysis approach, I developed themes through phrases or codes that appeared “causally related.”\textsuperscript{111} Boyatzis defends that thematic analysis is flexible and “may be a list of themes, a complex model with themes, indicators, and qualifications that are causally related; or something in between these two forms.”\textsuperscript{112} Though this method, I was able to both identify new themes that has not been covered in any of the research which I reviewed while also making connections to findings from prior research.

While conducting my research, I logged a series of memos about my reflections about what participants seemed to focus on or address multiple times throughout the interviews. As Charmaz suggests, “memo-writing consists of taking your categories apart by breaking them into their components.”\textsuperscript{113} For example, I identified my main categories of how women receive information about VHA health care, perceptions and beliefs about health care eligibility, and behaviors around actual use of VHA health care. In regards to the category of how women receive information about VHA health care, I broke it down into components of information inside VA clinics and outside clinics. I kept breaking each category down, as Charmaz suggests to “look for its underlying assumptions and show how and when the category develops and changes.”\textsuperscript{114} For example, outside of VA clinics, I examined how women received information about VHA health care post-discharge and came up with more categories such as finding out

\begin{footnotes}
\item[110] H. Wolcott, \textit{Transforming Qualitative Data: Description, Analysis, & Interpretation}, 10 (see footnote 108).
\item[112] Ibid.
\end{footnotes}
through a male spouse or partner, sought out care when looking for maternity care and through
having to sign up for health care through the Affordable Care Act. I recorded how each category
would be maintained or changed depending on circumstance or other factors.

**Limitations of the Study**

*Validity Issues*

Fred Hess makes the brilliant distinction that “validity in qualitative research is not the
result of indifference, but of integrity.” 115 Going off of this distinction, I own the lens at which I
view my research through by acknowledging my possible biases, while attempting to adjust my
vision by explaining how I have dealt with these.116

To ensure the themes identified were accurately depicting the data I gathered, I would
conduct member-checks after data was transcribed. In a few instances, I member-checked the
data after drawing comparisons between themes, so ensure I was making connections in
accordance with the data participants were initially relaying. The themes used for this research
were kept fairly much in line with the same terminology to honor participant’s own words and
again, letting the data “speak for themselves.” 117

*Researcher’s Status as an Insider and Outsider*

As an enlisted veteran, I have an “insider” status connecting with other veterans about
our prior experiences serving in the armed forces. In regards to being a veteran, I am able to don
a “badge of membership” when conducting intensive interviews with both personal and

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116 Ibid.
117 H. Wolcott, *Transforming Qualitative Data: Description, Analysis, & Interpretation*, 10, (see footnote 108).
professional informants.\textsuperscript{118} It should also be noted that I have never enrolled or used VHA health care although I have considered checking my eligibility as a veteran.

An additional point to consider, is that although I am a veteran, I am not a woman. Thus, based upon the criteria for my informants (veterans who identify as women), I am not a complete “insider” participant researcher. Depending on who the informant is that I am interviewing, I may be seen as an “outsider;” thus, maybe a more appropriate label for me would be a quasi-“insider” participant researcher.

Although I am a man, during my time in service and for a short period afterwards as a veteran, I was perceived solely as a woman by my entire personal and military network. I believe this unique perspective has been hugely beneficial to understanding some of the institutional and social nuances that women encounter as both a service member and veteran. However, having a period of time where my institutional and sociological frameworks were gendered as a woman does not allot me a complete, holistic understanding of all women veterans.

More importantly, when taking intersectionality into account, my status as a white, heterosexual, college-educated, and middle-class person awards me unearned privileges and access which the participants of this study are not privy to some or all of these categorical licenses of advantages. All but one participant in this study identified as “white” and all of the participants in this study identified as heterosexual. Quota sampling would have provided intentional racial, ethnic and sexual diversity among participants, ultimately providing a more rich and inclusive discussion and rounded set of findings. I take responsibility for working with time and resource constraints which prevented me from being able to reach out to more diverse populations. I primarily reached out to veteran organizations-- I am not sure if this sample is

\textsuperscript{118} John Lofland, \textit{Analyzing Social Settings: A Guide to Qualitative Observation and Analysis} (Victoria [u.a.]: Thomson, Wadsworth, 2006), 66.
reflexive of the lack of diverse racial, ethnic and sexual representation within these organizations, but nonetheless it is an important question to raise. In addition, not only should future research be inclusive of underrepresented participants, but the lack of inclusive representation calls for studies which specifically look at these vulnerable populations.

Although I recognize my experiences are not that same as all U.S. women veterans, I can only hope that my social positioning as a person who has a shared experience as an enlisted woman service member and veteran affords me more insight and profound respect for the experiences of former and current enlisted women veterans. My hope is that my acknowledgement and consistent reflexivity enhanced my credibility by interpreting my “own behavior and experiences within the research context.”

Lastly, data on income, educational level, ability or other defining characteristics were not collected. However, gender identity and age questions were presented as demographic questions to all participants, allowing participants to describe their own demographic characteristics in accordance to their own definitions (see Appendix B).

Ethical Issues

This research protocol was submitted to the Institutional Review Board at Cornell University in October of 2015. This project was deemed as exempt from IRB (Committee) review, according to Cornell IRB Policy #2 and under paragraph 2 of the Department of Health and Human Services Code of Federal Regulations 45CFR 46.101(b). Although this project classifies as an exemption, participants were still given consent forms with information about the

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entire study including what participants are being asked to do, risks and benefits, voluntary
nature of the study, compensation for participation, a section about audio recording,
privacy/confidentiality/data security information, and contact information for further questions
(see Appendix C).

Beyond the formality of having a consent form, voluntary informed consent was taken
into consideration while interviews were being conducted as an “ongoing, two-way
communication process between research participants and the investigator.” 121 I attempted to
keep communication two-way open by consistently asking participants if they have any
questions about anything we are discussing. Consent was inferred throughout every interview.

Although my research project received an exemption from IRB and I did not anticipate
participation presented greater risk than everyday use of the Internet, I needed to consider all of
the possible risks about women veterans talking about their health care use. However, while I do
not explicitly ask any personal questions about participant’s health-related issues, participants
may volunteer some personal information about their health. Since discussing deeply personal
health-related issues could bring stress to the participant, I had crisis hotline phone numbers
ready in case participants may want to use them. Fortunately, during instances where participants
disclosed personal information related to their health, I have not identified a circumstance where
participants have communicated a sense of discomfort.

121 Sieber, J. “Planning Ethically Responsible Research.” In L. Bickman & D. J. Bog (Eds.), Handbook of applied
CHAPTER 4
PRESENTATION OF FINDINGS

The purpose of this chapter is to let the data “speak for themselves” as much as possible by providing content from the 12 interviews conducted and describe how connections were made and themes emerged (Wolcott article from class, p. 10). Saturation was reached through 12 interviews, as Guest et al. asserts “if the goal is to describe a shared perception, belief, or behavior among a relatively homogeneous group, then a sample of twelve will likely be sufficient.”

First, I will provide demographic characteristics among participants. Second, I will present the themes that emerged through repetition in content and shared experiences.

Demographics

All twelve respondents were enlisted veterans who identified as women. For the purposes of VA health benefits and services, “a person who served in the active military service and who was discharged or released under conditions other than dishonorable is a veteran” (U.S. Department of Veterans Affairs, “Health Benefits,” June 19, 2015. Five participants served in the Navy, four participants served in the Army and three served in the Air Force. All participants served on active duty. Time in service ranged from 6 months to 17 years. Period of service ranged from starting active duty service in post-Vietnam era from 1974 to well into the Global War on Terrorism in 2010. Correlating with period of service, ages of participants ranged from 29 to 59. None of the women were currently serving in an active duty or reserve capacity when they were interviewed.

Participants were located in many different parts across the United States and were in both highly rural and urban locations. For example, some participants lived in small towns while others were in large metropolitan cities. In regards to race and ethnicity, all but one participant

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123 U.S. Department of Veterans Affairs, “Health Benefits,” (see footnote 52).
identified as “white.” This is very unfortunate as research in this area should strive for equitable representation in race and ethnicity, especially considering that research shows that some minority groups, such as blacks, are overrepresented in the Armed Forces.\textsuperscript{124} Below is a graphical representation of participant demographics:

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Branch of Service</th>
<th>Dates of Active Duty</th>
<th>Age During Interview</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emmry</td>
<td>Navy</td>
<td>2003 - 2007</td>
<td>32</td>
<td>White</td>
</tr>
<tr>
<td>Raquel</td>
<td>Navy</td>
<td>1988 - 1992</td>
<td>46</td>
<td>White</td>
</tr>
<tr>
<td>Helen</td>
<td>Navy</td>
<td>1994 - 2011</td>
<td>46</td>
<td>White</td>
</tr>
<tr>
<td>Rachu</td>
<td>Army</td>
<td>1974 - 1976</td>
<td>59</td>
<td>White</td>
</tr>
<tr>
<td>Tandy</td>
<td>Navy</td>
<td>2004 - 2006</td>
<td>30</td>
<td>White</td>
</tr>
<tr>
<td>Clare</td>
<td>Navy</td>
<td>2004 - 2010</td>
<td>29</td>
<td>White</td>
</tr>
<tr>
<td>Victoria</td>
<td>Army</td>
<td>1990 (6 months of service)</td>
<td>53</td>
<td>Black</td>
</tr>
<tr>
<td>Sammy</td>
<td>Air Force</td>
<td>1985 - 1994</td>
<td>51</td>
<td>White</td>
</tr>
<tr>
<td>Ruth</td>
<td>Army</td>
<td>1988 - 1991</td>
<td>50</td>
<td>White</td>
</tr>
<tr>
<td>Adele</td>
<td>Army</td>
<td>1982 - 1986</td>
<td>54</td>
<td>White</td>
</tr>
<tr>
<td>Nancy</td>
<td>Air Force</td>
<td>2000 - 2004</td>
<td>36</td>
<td>White</td>
</tr>
<tr>
<td>Flora</td>
<td>Air Force</td>
<td>2005 - 2010</td>
<td>29</td>
<td>White</td>
</tr>
</tbody>
</table>

\textbf{Data Themes}

Data themes have been identified within three categories drawing distinctions between beliefs and attitudes about VHA health care; receiving and perceiving information about VHA health care; and behaviors around use of VHA health care. The categories are intended to parse out when, where and how perceptions emerge about VHA health care and their correlation to utilization of VHA health care.

Beliefs and Attitudes about VHA Health Care Eligibility and Services

Interestingly, all but one participant reported to have previously used or is currently using health care through the VHA. The other participant recently completed enrollment into VHA health care. Although all participants are enrolled, at minimum, in the VHA health care system, all of the participants in this study were not made aware of VHA health care services until years after their discharge from military service. Once processed out of the military, participants took anywhere from 4 to 37 years to enroll for VHA health care. The mean number of years it took for participants to enroll in VHA health care was 15.7 years. Most of the findings in this study have been included in existing research identified by government and nonprofit researchers alike around the lack of knowledge about VA eligibility and available services, especially among women veterans.125 126

Common Misperceptions about VHA Health Care Eligibility

In regards to information around eligibility, pre-existing research has identified some common misperceptions among women veterans. The most common misperception was that only veterans with service-connected disabilities qualify for VHA health care. In this study, all but one participant were at one point under the impression that only veterans with service-
connected disabilities qualified for VHA health care. A service-connected disability is anyone determined by the VA “to be disabled by an injury or illness that was incurred or aggravated during active military service.”

Ruth stated:

When I think of the VA health care, I think of injured men— guys with missing limbs. I knew that wasn’t me so I never thought about using their health care.

When probed why participants carried this perception, participants asserted that they had associated terms such as “disabled” and “wounded” were associated with VHA health care. However, veterans do not need to have a service-connected disability in order to enroll in health care and there are a number of criteria which may make veterans eligible for care. A few participants applied for a service-connected disability when applying for VHA health care and became enrolled after determining they have a disability. When participants discussed how they learned that the VA has different priority groups based upon factors such as disability and income, they understood that VHA health care is tiered, but more inclusive and comprehensive than previously perceived.

Another common misperception carried by participants was around length of time in service. Four participants mentioned they thought their period of service was not long enough. The participants who mentioned this served anywhere from two to six years. When participants were probed about how long they thought they would have to serve in order to qualify for VHA health care, none of them had a definitive answer, although two mentioned that they may have thought they would have to retire from military service in order to be eligible. Although the VA does have an eligibility prerequisite around time of service, the time in service requirement may

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not apply to all veterans depending on other circumstances such as place of duty, hardship or disability. Due to the exceptions around requirements and ambiguity around qualifiers for VHA health care, the VHA has posted on their website: “Since there are a number of other exceptions to the minimum duty requirements, VA encourages all veterans to apply so that we may determine their enrollment eligibility.”

Common Misperceptions about VHA Health Care Services

One misperception across most participants about VHA health care services was carrying the belief that on-going primary and preventative care for women did not exist. Most participants reported knowing that maternity care existed, but was unaware that women could receive primary and preventative care which included health care services specifically for women’s needs such as mammograms and gynecological care. Not every VA medical center offers the same services, including on-going primary and preventative care for women’s health, which was believed by some participants to be the cause for women not being aware of this.

Participants had their misperceptions about eligibility and services debunked through interpersonal conversations with men enrolled in VHA health care who did not have a service-connected disability, when seeking health care options as a result of the Affordable Care Act, or when they were exploring maternity care options.

Receiving and Perceiving Information about VHA Health Care

Information Outside VA Clinics

Processing out of the Military: Department of Defense Transitional Assistance Programs. When processing out of the military, depending on the branch of service, military

\[128\] U.S. Department of Veterans Affairs, “Health Benefits,” (see footnote 52).

\[129\] Ibid.
members transitioning out of the service may participate in a transitional program meant to equip military members with information and resources meant to prepare them for civilian life. All five branches of the military have transition counselors intended to implement these programs and provide services. Only one branch of service, the Marine Corps, requires transitioning members to attend a briefing on VA benefits prior to separation.130

While it is not clear whether or not former Marines, let alone female Marines, enroll in the VA at greater rates than their counterparts from other branches, several participants mentioned they did not receive any information about benefits when they were being processed out of the military, including undergoing transitional assistance programs. When asked about whether or not they received pamphlets or information when processing out, none of the participants reported receiving any pamphlets or informational literature on VA health care services. All participants who did recall hearing about VHA health care through a processing out program was that veterans can become eligible for VHA health care if a successful claim for service-connected disability is filed. As mentioned previously, veterans do not need to have a service-connected disability in order to qualify for VHA health care use.

When discussing the transitional process, participants discussed how they felt processing was overwhelming considering the outpour of information related to the legal and medical separation from service. A few participants mentioned that it would be helpful to receive hard copy information about VA medical care as they processed out in order to revisit it later and have available for reference. Helen mentioned that learning about VHA health care during the

Navy’s transitional program would have impacted her decision making around utilizing VHA health care more soon:

I experienced an extreme amount of relief when I found out about health care through the VA. I wish I would have known earlier… I wish they would have gone through it in TAPS class. I would have signed up for VA care right away.

Post-Discharge from the Military

VHA Health Care Through Marketing. Once service members are separated from service, the Department of Veterans Affairs is responsible for providing vital services to veterans and in some cases, their families. As the self-proclaimed “most comprehensive system of assistance for Veterans of any nation in the world,” the VA is responsible for administering health, education, housing, and other benefits. However, enrolling women veterans in comprehensive VA health care is a known issue.

All but three participants said they have not seen any marketing materials about VHA health care in-person nor online. Participants who have not seen any materials did not have a recollection of noticing anything about the VA with the exception of educational benefits. Of the three participants who noticed advertising from the VA, one participant reported spotting a billboard advertisement for VA health care as she was driving down the highway. Raquel reported that the advertisement is what propelled her to sign up for VHA health care:

I was driving down the highway and I remember I had a really bad cold. I looked up and saw a billboard that said something about veterans and health. I believe it was from the VA. I work for a veterans organization, so I thought, ‘Hey, I’m a veteran’ and decided to give them a call.

131 U.S. Department of Veterans Affairs, “About VA,” (see footnote 6).
Interpersonal Conversations with Men Veterans. Through interpersonal conversations with other veterans, participants acknowledged they found out information about enrolling in VHA health care and some of the services provided. Interestingly, all four participants who discussed learning information about VHA health care through interpersonal relationships were all through interactions with men veterans. Three participants discussed VHA health care with men veterans who were romantic partners at the time of their discussions. One participant had a conversation about VHA health care eligibility requirements and services with a man veteran colleague.

Requirement to Buy Coverage Under the Affordable Care Act. Due to the implementation of the Affordable Care Act in 2010, two participants who were not enrolled in health care before were made aware of health care through the Veterans Administration. Due to the health care law standards mandating insurance coverage, veterans may be prompted to sign up for health care coverage through the VA if they acknowledge their status as a veteran. The two participants who were made aware of VHA health care as a possibility mentioned they were told by speaking with a representative over the phone from the Obamacare line. Both participants were middle-aged and mentioned they were more comfortable accessing information via the phone than online.

Seeking Maternity Care. Four participants mentioned they sought out VHA health care for the first time when they were expecting a child. When each participant with this response was asked why they thought of the VHA, two participants responded that their spouse was also formerly in the service or currently serving during the time of the pregnancy and the other two respondents were not specifically certain what made them think to use VHA health care. One respondent who wasn’t certain how she thought of going to the VHA for her maternity needs, Nancy, responded:
It was my first ever pregnancy and I remember I just wanted to keep costs low. So, I was thinking about low-cost care and remembered the VA. They did an excellent job in providing care all of the way through the pregnancy.

*Information Inside VA Clinics*

All but one participant has visited a VHA medical facility. All of these participants were asked to describe the messaging they witnessed while inside a facility; this could include brochures, pamphlets, posters or any materials or literature witnessed. It should be noted that one of the twelve participants were currently working for a Veterans Health Administration clinic. No other participants have ever worked for a Veterans Health Administration clinic, however, two other participants were working for an advocacy organization for homeless veterans.

The eleven participants who have visited VHA health care facilities reported witnessing brochures and/or posters for issues that have been determined to be of significance to women veterans either because women are adversely impacted or gender-specific issues within care have been identified. Participants reported information covering the following topics: Post-traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), substance abuse, and possible care options for family members of veterans (such as a child or spouse). These materials were reported to be made available in waiting rooms of clinics, including women’s clinics. All five of the participants who have used VHA health care for 10 years or more reported seeing an increase in materials including health concerns specific to women’s care and the presence of images of women in brochures. Although every participant were asked about what materials they have seen or noticed, no specific questions were asked about a change in the mention or presence of women or women’s health care.
When probed about what witnessing these types of messages mean to participants and other women veterans, participants responded that the witnessed representation and inclusion of women and women’s health care were positive. All participants that were middle-aged (above the age of 46 years old) made mentions about observing the changes in having materials specifically for women’s care available. Aside from having access to more medical information, all of these participants mentioned witnessing the change in visual representations of women in advertising in VHA health care. Sammy shared:

Now I think the general public is recognizing us. We are now featured on posters and it’s a new thing. Not acknowledging us before was kind of degrading. The visual is important. If we don’t see a woman on a poster, then it’s just for men. We look at these visuals with a quick glance for that instant gratification thing.

**Experience While Using VHA Health Care**

All but one participant reported to have previously used or is currently using health care through the VHA. While most participants do currently use VHA health care, two participants do not currently use VHA health care. One participant does not use VHA health care because they were not satisfied with the quality of care and as a Federal employee utilizes the Federal Employees Health Benefits (FEHB) Program. When asked why the participant was dissatisfied, she mentioned a couple of bad experiences she has had with doctors giving a misdiagnosis and having to deal with long wait times for appointments for non-specialized care.

The other participant who does not use VHA health care said that the VA clinics were not accessible enough and were at located at an inconvenient distance from her home. The participant said the nearest VHA medical clinic was one hour away from her home. Among participants that did use VHA health care at the time, four other participants mentioned VA
clinics were too far away when asked about how satisfied they were with VA facilities or when
asked about how they utilized VHA health care. One participant, Rachu, mentioned that her
participation in the Veterans Choice Program, a program which allows VHA users to receive
care within their community if they live more than 40 miles from a VA medical care facility or
have been waiting for more than 30 days for care, has enabled her to receive accessible care.
This was especially helpful for Rachu since she mentioned she cannot drive far distances and at
night due to vision issues. Mentions of the lack of VA facilities and lack of consistent care were
not surprising because it is reflected throughout previous literature and acknowledged as a
critical problem by the VA.¹³²

With instances where VA medical facilities were near participants, not all facilities had
women’s clinics. Many participants expressed concern about the inconsistency in care and
mentioned that there were not enough women’s centers. In addition to a lack of women’s centers,
many participants mentioned that there are not enough women physicians and therapists. Helen
reported that she feels that women need to have other women physicians for varying levels of
care:

Sometimes I just need another woman who is taking care of my medical needs. I need
someone who isn’t going to just think I’m complaining when I am reporting a medical
concern. I need someone to listen and who understands as a woman.

CHAPTER 5
DISCUSSION AND IMPLICATIONS

The primary research questions being addressed are: 1) What are the barriers to receiving health care for women veterans? 2) How are women veterans receiving and perceiving information about VHA care? The goal of this research is to: 1) synthesize these findings through research of subjects with direct experience as women veterans and explore the relationship of these data against current literature and 2) offer general policy recommendations to address the gaps in health care utilization of women, assuming that all people, regardless of gender, value utilizing a public good in which they may be eligible for. I took the approach of an interpretivist tying in findings from research ranging from medicine to anthropology with multiple methodological approaches. Government data, peer-reviewed academic research, and investigative reports were used as sources of data for synthesis.

Bearing in mind this study connects data from interviews with 12 participants to a variety of research with various approaches, it is acknowledged that the analysis and implications are inherent from the sample of participants. Although every individual has their own unique representation of their perceptions, beliefs, behaviors and ultimately, experiences, data saturation was reached among this sample. Participant feedback was becoming iterative and themes were already well-developed.133

Data Synthesis: Review of Research Questions with Themes

Research Question I: What are the institutional barriers to receiving health care for women veterans?

This research question was intentionally crafted to allow participants in this study to identify numerous ways women veterans are deterred from using VHA health care services. Participants were asked a variety of questions related to possible institutional hurdles.

133 Morse, J., “Theoretical Saturation,” The SAGE Encyclopedia of Social Science Research Methods, (see footnote 105).
Institutional Barriers

As recognized in the literature review, audits and evaluations of women’s access to VHA care identified a number of institutional barriers. From the literature, these findings include inconsistent gender-specific and primary health care services and care environments, varying models of care, inconsistent coordination of care, and other barriers that affect decision-making. Participants in this study drew connections to most of the findings discussed in the literature review.

With instances where VA medical facilities were near participants, not all facilities offered comprehensive gender-specific care for women, including but not limited to cervical cancer screens, birth control, reproductive health care, and confidential counseling and treatment for mental and physical health conditions related to MST. Many participants expressed concern about the inconsistency in care and mentioned that there were not enough women’s centers. This would make sense considering out of 152 medical centers, approximately 1400 community-based outpatient clinics, domiciliaries, Vet Centers, and community living centers, only 9 locations have comprehensive care for women, including women-only residential mental health programs and dedicated cohorts for women, limiting the access to care in gender-exclusive environments. Participants who visited multiple VA health facilities discussed varying levels of care and remarked about inconsistencies with services provided and varying levels of proficiency. When participants were probed about their thoughts and feelings around this, the participants used terms such as “frustrating” and “irritating” but still use health care through the VHA. Some participants mentioned being referred to non-VA medical providers for

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134 U.S. Department of Veterans Affairs, “Fact Sheet,” Women Veterans Health Care, (see footnote 19).
135 U.S. Department of Veterans Affairs. “Veterans Health Administration.” Where do I get the care I need?, (see footnote 43).
“specialized” issues. Participants were not probed further to respect not asking for personal health information. In addition, participants voluntarily shared information about their health and questions about specific conditions such as PTSD and MST were not asked. Four participants discussed their histories with PTSD and MST, and made terse mentions that they were satisfied with their level of care when they sought treatment for these issues.

Physical Barriers

Aside from inconsistencies from clinic to clinic, five participants total mentioned having the belief that VA clinics were located too far from them. All five participants described their location as “rural” or “not urban.” Rural health research discusses how the inconvenience of VA facility locations cause more issue for rural veterans to access care. Although this is recognized by the VA as a critical issue, it still needs to be completely addressed by the Department of Veterans Affairs; two participants mentioned they believe they would utilize health care more if it were more physically accessible.

Research Question II: How are women veterans receiving and perceiving information about VHA care?

Misperceptions about eligibility and health care services have been identified through existing research and echoed by participants in this study. A couple new themes have emerged that have no mention in the literature discussed in this paper, but merit validity through data synthesis.

Misperceptions about Eligibility

It is evident through literature and throughout the duration of this study that a few common misperceptions about VHA health care eligibility and services have been identified. Women veterans not being made aware of their eligibility has been determined as a core issue
barring women veterans from accessing VHA health care by the Department of Veterans. The data found in this research study confirms that all but one participant were at one point under the impression that only veterans with service-connected disabilities qualified for VHA health care. The most common misperception found in both a variety of literature about women veterans and in this study was that only veterans with service-connected disabilities qualify for VHA health care. In this study, all but one participant once carried the belief that only veterans with service-connected disabilities qualified for VHA health care. In addition, another common misperception participants carried was that they believed they did not serve long enough to be eligible for benefits. Research regarding this belief has not been found in former research covered in the literature review. Further research should examine if this belief is shared among veterans, especially women veterans who carry misperceptions more than veteran men.

**Information Outside of VA Clinics**

Participants recall receiving information about VHA health care eligibility and services through a variety of common means including from signing up for health insurance due to interpersonal conversations with veteran men, having to sign up for insurance due to the Affordable Care Act mandate, and when they were seeking maternity care. Although none of these means of receiving information has been directly addressed in the literature covered in this paper, the findings were consistent across multiple participants in this study.

the number of veterans overall, although it is noteworthy that women did not report having these discussions with other women veterans. Overall, women are less likely to enroll in VHA health care and identify as a veteran.137 138

If women do acknowledge their status as a veteran, if women veterans find themselves prompted to elect a health care plan through the new Health Insurance Marketplace via website or phone, veterans may be prompted to sign up for health care coverage through the VA if they acknowledge their status as a veteran. Future research should examine the amount of women veterans who utilize the new Health Insurance Marketplace for exploring options for health care.

Four women participants who underwent pregnancy used the VHA for the first time when seeking out maternity care. Two participants reported men service members or veterans led them to choose VHA health care. As noted above, the dialogue from men veterans to women has been noted as a venue for women receiving information about VHA health care services. In addition, future research should examine why women veterans opt to choose VHA maternity care and how their experiences may or may not encourage them to continue to utilize VHA health care.

**Information Inside of VA Clinics**

All participants in the study have noted that the representation and inclusion of women and women’s health care were positive. Participants who noticed an increase in both information about women-specific health issues and women being featured on materials featured within the VA clinic were well-received by these participants. Although it is safe to assume the inclusion of

women on materials and content about women-specific health issues likely motivates women veterans to utilize health services once enrolled, more research is needed in order to substantiate this claim. Further studies should explore how information made available to women veterans at VHA clinics impact the decision making about utilizing specific services and VHA health care overall.

**Recommendations**

A moment of both pride and perplexion occurred at the beginning of every interview with almost every participant. At some point during the interview I would be thanked for taking the time to conduct in-depth research and express concern for issues faced by women veterans. Arguably, there was a unified call to action for reform of bureaucracy often in charge of administering benefits and services to U.S. veterans. A primary goal of this research is to synthesize the findings from all twelve participants and literature reviewed to offer general policy recommendations to address the gaps in health care utilization of women, assuming that all people, regardless of gender, value utilizing a public good in which they may be eligible for.

Both research questions focused on 1) institutional and physical barriers preventing women veterans from accessing VHA health care and 2) outreach and marketing efforts by the Department of Defense during transition from military service and the Department of Veterans Affairs upon complete separation of the military. Extrapolating from these findings, a list of prevalent recommendations are offered:

*Processing out of the Military: Department of Defense Transitional Assistance Programs*

As previously discussed, the military does not have uniform standards for providing service members transitioning out of service with benefit information from the Department of Veterans Affairs. In addition, every branch of the military does not require service members to
undergo a transitional assistance program upon transition. Based upon participant feedback regarding a lack of consistent and clear information about VHA health care, having a uniform policy mandating all five branches of service undergo similar transitional assistance programs could provide for an equitable experience for service members preparing for discharge. Considering that findings reveal across varying groups of women studied, there are misperceptions about eligibility, providing accurate and uniform information about VHA health care benefits and services before service members actually separate from service could close the gap in the amount of time it takes for women veterans to enroll in VHA health care.

VHA Health Care Through Marketing

In addition, participants mentioned feeling overwhelming from the outpour of information related to the legal and medical separation from service. A few participants recommended receiving hard copy information about VA medical care to revisit later and have available for reference. Furthermore, information could be passed on additionally via email with links to information about VHA health care, including eBenefits, a service of the Department of Veterans Affairs and Department of Defense, where veterans can sign up for a number of Federal benefits including benefits such as VHA health care, disability compensation and educational benefits.

Even with policies in place for uniform and mandatory transitional assistance programs, as administers of the VHA health care services, the Department of Veterans Affairs should still vigorously conduct outreach about available VHA programs and services. A VHA marketing plan should be implemented to increase awareness among enlisted women veterans regarding the types of care offered, highlighting the levels of the most patient satisfaction. However, the strategic plan can only be successfully implemented with a laid out sustainable groundwork if
Congress continues to increase allocated funding to the VHA. This groundwork should include a dedicated engagement from Congress to 1) “commit to a dramatic increase in money for marketing, communications, and community relations” and 2) carefully consider budgetary items for these relations by understanding that costs associated with marketing are considered administrative costs which are “usually the focus of budget cuts in a financially constrained environment.”

Despite current efforts made by the Department of Veterans Affairs to increase outreach, such as the implementation of the Call Center, all but three participants said they have not seen any marketing materials about VHA health care in-person nor online. A marketing analysis should be conducted on all promotion and outreach efforts, in addition to a cost-benefit analysis in order to ensure health care that is both high quality and low-cost. These reports would be beneficial when proposing the VHA’s budget to Congress. The VHA has faced challenges in strengthening their marketing efforts since these costs are considered administrative and “are usually the focus of budget cuts in a financially constrained environment.” Lastly, if marketing efforts are proven effective, government spending on television and social media sites for the VA should continue to be supported.

**Experience While Using VHA Healthcare**

*Institutional Barriers*

Many participants expressed concern about inconsistency in care within each center and around the lack of gender-specific care for women. An independent review mandated by

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140 Ibid.
Congress in 2014 revealed the inconsistencies in care and policy makers should work to address identified incongruences in standards of care and services available.\textsuperscript{142} As women are the fastest growing group in the veterans population, consistent gender-specific care will need to be integrated into the VHA.\textsuperscript{143}

In addition to implementing standards and policies to increase the amount of consistent gender-specific care, many participants believed there were not enough women medical physicians and therapists. Information about the distribution of physicians and therapists by gender in the VA was not found, however, the VA should ensure they are actively recruiting women physicians and therapists and consider developing an initiative to hire more women.

\textit{Physical Barriers}

Although a veteran may be enrolled in VHA health care, physically and geographically accessing care may be difficult. Five participants participants total mentioned VA clinics were too far away when asked about how satisfied they were with VA facilities or when asked about how they utilized VHA health care. It is known that those living in rural areas are traditionally underserved by the VA and programs such as Veterans Choice Program, which allows VHA users to receive care within their community if they live more than 40 miles from a VA medical care facility or have been waiting for more than 30 days for care, can assist veterans in receiving accessible care. One participant mentioned using the Veterans Choice Program and was very satisfied with the service. When the other four participants were asked about whether or not they use Veterans Choice, they said they were not sure if they were eligible. Two of these participants who were unsure about their eligibility through Veterans Choice Program suggested that the VA


\textsuperscript{143} U.S. Department of Veterans Affairs, “Fact Sheet,” Women Veterans Health Care, (see footnote 19).
should automatically let participants know whether or not they are eligible and update participants on their eligibility as they move. To make the Veterans Choice program even more accessible, upon being enrolled in the program, the VA should send a list of participating providers to newly enrolled patients. Currently, patients have to take it upon themselves to look up information about participating providers. Lastly, the office that implements Veterans Choice Program, the VHA Office of Rural Health, should continually assess the rationale for the spatial requirements for the program. For example, in 2015, the VA changed the distance calculation from the straight line distance to a driving distance between a veteran’s home and the closest VA medical facility.\textsuperscript{144}

**Future Research Opportunities**

This research examined enlisted women veterans who were already enrolled in VHA health care to gain an understanding about how they overcame institutional barriers, their experience actually using VHA health care, and receive their recommendations for how to approach anything barring access from using VHA health care. Interviewing enlisted women veterans who have never enrolled in VHA health care would be extremely valuable in understanding they have not enrolled for VHA health care benefits. In addition, although research around Military Sexual Trauma and Posttraumatic Stress Disorder addresses and evaluates the patient experience through the VHA including gender-differences in experience and triaging of care, research should continue to critically evaluate the VHA’s role in the treatment of women veterans.

Most notably, evaluations on the VA’s former and current marketing efforts should be met with a critical eye to gain understanding about their possible impacts. The VA has implemented a handful of known communication campaigns and has adopted a recent strategic plan, however, no research has been found assessing the outcomes, consequences and effects of these efforts.

**Conclusion**

As of December 2015, the Department of Defense announced that all combat positions, without any exceptions, would be open to all women\(^{145}\) making the future population of women veterans the most mission-diverse than ever before. The announcement makes the military the most equitable and integrated between men and women more than ever before in U.S. history. Women have been entering the armed forces at increasing rates despite the steady decrease of the total population decrease, and projections show both trends will continue. Recent reports revealing that women veterans are still less likely to enroll in VHA than men have led to many studies as to why women are not utilizing VHA health care– often a free or very low-cost benefit for veterans.

Without surprise, most of the findings from this qualitative study are directly correlated with the research, reports and evaluations on issues with accessing VHA health care services. Rather than just solidify existing research through personal accounts from in-depth interviews, these findings are unique in that they 1) through ethnographic methods explore known institutional barriers in more details based on personal accounts and 2) uncover more intricate

and detailed reasons on how women veterans are getting information about VHA health care and what is prompting them to decide to enroll and utilize VHA health care.

Answering the second research question of how women veterans receive and perceive information about VHA care offered new insights to information about health care services inside VHA health care facilities and information about eligibility outside of facilities. Through a synthesis of findings, recommendations that emerged include forming uniform policies across branches of services that delivers accurate information about VHA enrollment and eligibility, developing a targeted strategic marketing plan with precise goals of increasing women’s enrollment, and providing more research and inclusion of women and issues pertaining to their health care needs within information provided by and disseminated within the VHA. In addition, there is an insufficient amount of research on how women veterans are getting information about VHA health care and what is prompting them to decide to enroll and utilize VHA health care, which begs for more attention to this issue area.

Fortunately, the research that does exist has propelled the VA to put many recent efforts underway in attempt to get more women enrolled in VHA health care. The begging question remains of how effective these efforts have been, how to put these efforts to better use, and how the VA can better communicate past, ongoing and planned future efforts to stakeholders. Again, more research is needed in this topic to adequately address ongoing, systemic issues within the Veterans Health Administration.


 (accessed November 30, 2015).


National Center for Women & Information Technology. "Institutional Barriers & Their Effects: How Can I Talk to Colleagues About These Issues?," National Center for Women & Information Technology, last modified April 3, 2016,


http://vapha.org/Resources/Documents/Programs/Health%20on%20the%20Homefront/session%2027%20updated.pdf


(accessed November 12, 2015).

(accessed November 30, 2015).


(accessed November 15, 2015).

U.S. Department of Veterans Affairs. “Strategies for Serving Our Women Veterans.” Current
Status of Women Veterans.


U.S. Department of Veterans Administration. "VA Works to Expand Choice Program Eligibility." Office of Public Affairs and Media Relations.


Center for Women Veterans (CWV): Established by Congress in 1994 with a mission of “monitoring and coordinating VA’s administration of health care and benefits services, and programs for women Veterans, serving as an advocate for a cultural transformation (both within VA and in the general public) in recognizing the service and contributions of women Veterans and women in the military, and raising awareness of the responsibility to treat women Veterans with dignity and respect.”

Department of Defense (DOD): America's oldest and largest government agency in charge of the U.S. Armed Forces and a civilian force concerned with national security.

Military Sexual Trauma (MST): The definition of MST used by the VA is given by U.S. Code (1720D of Title 38): “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training.” MST includes any sexual activity where someone is involved against his or her will—he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or implied faster promotions or better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. MST includes unwanted sexual activities.

touching or grabbing; threatening, offensive remarks about a person’s body or sexual activities; and threatening and unwelcome sexual advances.”\textsuperscript{148}

- **Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/and Operation New Dawn (OND):** Operations under the international military campaign known as the Global War on Terrorism (GWOT) and the War on Terror (WoT).

- **Post Traumatic Stress Disorder (PTSD):** “a condition that can occur after have been through a traumatic event.” A traumatic event is “something terrible and scary that you see, hear about, or that happens to you. For veterans, posttraumatic stress disorder (PTSD) can occur after someone goes through a traumatic event like combat, assault, or disaster in the military.”\textsuperscript{149}

- **Veterans Administration or officially “The Department of Veterans Affairs” (VA):** a military veteran benefit system administering medical, educational, housing and other benefits for veterans, their families and survivors. The VA’s total 2009 budget was approximately $87.6 billion USD.\textsuperscript{150}

- **Veteran:** For the purposes of VA health benefits and services, “a person who served in the active military service and who was discharged or released under conditions other than dishonorable is a veteran.”\textsuperscript{151}

- **Veteran Health Administration (VHA):** The Veterans Health Administration has the “United States’ largest integrated health care system consisting of 150 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers

\textsuperscript{148} U.S. Department of Veterans Affairs, “Strategies for Serving Our Women Veterans,” (see footnote 11).
\textsuperscript{149} U.S. Department of Veterans Affairs, “PTSD: National Center for PTSD,” (see footnote 91).
\textsuperscript{150} U.S. Department of Veterans Affairs, “Fact Sheet,” (see footnote 5).
\textsuperscript{151} U.S. Department of Veterans Affairs, “Health Benefits,” (see footnote 53).
and domiciliaries. Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide comprehensive care to more than 8.3 million* Veterans each year.”

- **Woman/Women:** Mentions of “women” or “woman” in this paper are in referenced to anyone identified as such. In regards to the studies referenced throughout this paper, it is assumed that gender identity is congruent with respondents’ own affiliation with their gender. However, while gender refers to the “socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women,” it is possible that other gender identities other than woman/women may have reported across these studies.

- **Women Veteran Coordinators (WVC):** provide specific information and comprehensive assistance to women Veterans, their dependents, and beneficiaries concerning VA benefits and related non-VA benefits. They may assist in the claims intake, development, and processing of military sexual and personal trauma claims.

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APPENDIX B:
INTERVIEW GUIDE

Interview Guide for Participants

1) Service Related Background
   a) Branch(es) of service
   b) Enlisted/Commissioned
   c) Rate/Rank
   d) Occupational specialty (MOS or job description)
   e) Length of time(s) in service
   f) Retired/Separated/Reservist status
   g) Discharge/Separation date(s)

2) Messaging
   a) Tell me about a time you’ve seen or noticed any materials discussing VA health information, programs and services. When and where have you seen these materials? How much does this matter to you?
      i) Have you seen any in your processing center as you were preparing to be discharged or separated?
      ii) How about online through an official military or VA website?
      iii) How about online through a non-official military or VA website?
      iv) How about through email from the military or VA?
      If “YES” to any of the above
          v) Please describe what messaging you witnessed.
          vi) What did it mean to you (i.e. How do you think this messaging affected you)?
      If “NO” to any of the above
          v) Do you believe it would have motivated you to use VA care more quickly or at all?
   b) Tell me about a time you’ve seen or noticed any materials discussing VA care specifically for women’s needs (e.g. substance abuse, OBGYN care). When and where have you seen these materials? How much does this matter to you?
      i) Have you seen any in your processing center as you were preparing to be discharged or separated?
      ii) How about online through an official military or VA website?
      iii) How about online through a non-official military or VA website?
      iv) How about through email from the military or VA?
      If “YES” to any of the above
          v) Please describe what messaging you witnessed.
          vi) What did it mean to you (i.e. How do you think this messaging affected you)?
      If “NO” to any of the above
          v) Do you believe it would have motivated you to use VA care more quickly or at all?

3) Health Care Use – Participants must be enrolled in VHA health care
   a) Have you ever or do you currently use health care through the Veterans Healthcare Administration since separating from the military?
      *Try just starting with: Do you use VA Healthcare?
      If “YES”
         i) Utilization
            A. Are you currently using healthcare through the VA?
               NO: Why are you no longer using VA health care?
            B. How long have you used healthcare through the VA for?
APPENDIX B:
INTERVIEW GUIDE

Have you used VA care since you separated from the military?
C. What services do (or did) you use?
D. Do (or did) your dependents or immediate family members use VA healthcare?
   YES: Who is using it? How long have they used VA care for?
   THEY DID BUT ARE NO LONGER: Why are they no longer using VA health care?
E. When did you find out you were eligible for VA care?
F. How did you find out you were eligible for VA care?

ii) Satisfaction
   *Try just starting with: Tell me about your level of satisfaction with VA care.
   A. How easy is it (or was it) for you to make a timely and convenient healthcare appointment?
   B. How helpful and knowledgeable has VA physicians and staff been who you have interacted with?
   C. How satisfied are you with VA facilities?
   D. Communication
      1. How accessible have physicians and staff been when asking for advice or help during business hours? How much does this matter to you?
      2. How well have physicians and staff explained procedures and test results? How much does this matter to you?
      3. How effective do you believe the health information materials they gave you or had available are? (e.g. brochure in a VA Medical Center about a specific health condition). How much does this matter to you?
      4. How effective do you believe the health information materials they gave you or had available are regarding care specifically for women’s needs (e.g. substance abuse, OB/GYN care)? When and where have you seen these materials? How much does this matter to you?

4) Optional Demographics
   *Do not give participants categories (unless they ask). Give them a chance to describe responses using their own words— e.g. Please describe your ____.
   a) How do you identify your sex?
      • Male
      • Female
      • Intersex
      • Additional category that fits you better (please specify):
      • Prefer not to respond
   b) How do you identify your gender (Please select all that apply)?
      • Man
      • Woman
      • Transgender
      • Gender non-conforming
      • Additional category that fits you better (please specify):
      • Prefer not to respond
   c) How do you identify your sexual orientation (Please select all that apply)?
      • Heterosexual
      • Gay or Lesbian
      • Bisexual
      • Queer
      • Pansexual
APPENDIX B:
INTERVIEW GUIDE

- Additional category that fits you better (please specify):
- Prefer not to respond
d) What is your ethnicity (Please select all that apply)?
  - Hispanic or Latino
  - Black or African American
  - Native American or American Indian
  - Asian or Pacific Islander
  - White
  - Additional category that fits you better (please specify):
  - Prefer not to respond
e) What is your age?
  - [Fill in blank]
  - Prefer not to respond

5) Closing
   a) Do you have anything else you would like to share with me?
   b) Do you have any questions for me?
   c) Would it be okay if I follow up with you again if I come up with any more questions?
   d) THANK YOU!
APPENDIX C:
CONSENT FORM

Consent Form

I am asking you to participate in a research study titled “The Promotion and Outreach of the Department of Veterans Affairs for Women’s Healthcare.” You have been asked to participate because you are a woman veteran. I will describe this study to you and answer any of your questions. This study is being led by Hill Wolfe, Cornell Institute for Public Affairs at Cornell University. The Faculty Advisor for this study is Dr. Sahara Byrne, Department of Communication at Cornell University. Both the Lead Researcher and Faculty Advisor are not affiliated in any way with the Department of Veterans Affairs.

**What the study is about**
The purpose of this research is to uncover why health care is underutilized for women veterans and to identify the barriers to accessing services. I would like to understand where the healthcare needs of women veterans are not being met and what services the Department of Veterans Affairs are lacking, and how the VA may improve their communication about available health care services and health-related benefits for women veterans.

**What we will ask you to do**
I will be asking you a series of questions about why or why not you utilize VA healthcare. I will not be asking you to share any personal issues related to your health. If you choose to share any information about your health, it is completely voluntary and will be kept confidential. The interview will take about 45 to 60 minutes to complete. With your permission, we would also like to tape-record the interview.

**Risks and benefits**
There are no anticipated risks to participation other than those encountered in day-to-day life. There are no direct benefits for participating in this study.

**Taking part is voluntary:** Your participation is completely voluntary. You may decide not to participate or to withdraw from the study at any time.

**Compensation for participation**
There is no payment or course credit for taking part in the study.

**Audio/Video Recording**
Please sign below if you are willing to have the audio from this interview recorded. The audio is used for interview transcriptions and will only be kept for no longer than 6 months after the initial interview. You may still participate in this study if you are not willing to have the interview recorded.

I do not want to have this interview recorded.
I am willing to have this interview recorded:

Signed: ____________________________________________

Date: ____________________________________________

**Privacy/Confidentiality/Data Security**
Your responses will not be connected to your name, nor will we report your responses in a way that could allow anyone to identify you. Identifying information will be kept separate from the survey data and the two will not be connected. Only I will have access to identifying
information. Data will be stored in Qualtrics or Cornell Box. We anticipate that your participation in this survey presents no greater risk than everyday use of the Internet.

Also please note that email communication is neither private nor secure. Though I am taking precautions to protect your privacy, you should be aware that information sent through e-mail could be read by a third party.

If you have questions
The main researcher conducting this study Hill Wolfe, a Graduate Fellow at the Cornell Institute for Public Affairs at Cornell University. Please ask any questions you have now. You may also ask any questions about the research at any time. If you have questions about the research after you leave today, you should contact the Principal Investigator, Hill Wolfe (206-419-0994; hlw64@cornell.edu). If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) for Human Participants at 607-255-6182 or access their website at http://www.irb.cornell.edu. You may also report your concerns or complaints anonymously through Ethicspoint online at www.hotline.cornell.edu or by calling toll free at 1-866-293-3077. Ethicspoint is an independent organization that serves as a liaison between the University and the person bringing the complaint so that anonymity can be ensured.

Statement of Consent

I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature_____________________________________________ Date_______
_______

Your Name (printed)__________________________________________
_______

Signature of person obtaining consent___________________________ Date_______
_______

Printed name of person obtaining consent________________________
_______

This consent form will be kept by the researcher for five years beyond the end of the study.