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Women Veterans' Pathways to and Perspectives on Veterans Affairs Health Care

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A B S T R A C T

Background: We examined Veterans Affairs (VA) health care experiences among contemporary women veteran patients receiving care at a VA medical center. Specifically, we examined women veteran patients' satisfaction with VA care along dimensions in line with patient-centered medical home (patient-aligned care teams [PACT] in VA) priorities, and pathways through which women initially accessed VA care.
Methods: We used a mixed methods research design. First, 249 racially diverse women (ages 22–64) who were past-year users of primary care at a VA medical center completed interviewer-administered surveys in 2012 assessing ratings of satisfaction with care in the past year. We then conducted in-depth qualitative interviews of a subset of women surveyed ($n = 25$) to gain a deeper understanding of perspectives and experiences that shaped satisfaction with care and to explore women's initial pathways to VA care.
Results: Ratings of satisfaction with VA care were generally high, with some variation by demographic characteristics. Qualitative interviews revealed perceptions of care centered on the following themes: 1) barriers to care delay needed medical care, while innovative care models facilitate access, 2) women value communication and coordination of care, and 3) personalized context of VA care, including gender sensitive care shapes women's perceptions. Pathways to VA care were characterized by initial delays, often attributable to lack of knowledge or negative perceptions of VA care. Informal social networks were instrumental in helping women to overcome barriers.
Conclusions: Findings highlight convergence of women's preferences with PACT priorities of timely access to care, provider communication, and coordination of care, and suggest areas for improvement. Outreach is needed to address gaps in knowledge and negative perceptions. Initiatives to enhance women veterans' social networks may provide an information-sharing resource.

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Women are among the fastest growing segments of new users of VA care (Frayne et al., 2012), making access to high-quality care for women a VA priority. Research has demonstrated barriers to access and utilization of VA care (Washington, Yano, Simon, & Sun, 2006; Washington, Bean-Mayberry, Riopelle, & Yano, 2011b) and risk factors for attrition from VA care (Friedman et al., 2011, 2015; Hamilton, Frayne, Cordasco, & Washington, 2013) for women veterans. The VA has launched initiatives to provide patient-centered, holistic care and to advance women veterans' VA care, including implementation of a patient-centered medical home model through patient-aligned care teams (PACT; Bidassie, Davies, Stark, & Boushon, 2014; U.S. Department of Veterans Affairs, 2014), and the expansion of specialized services for women (Cordasco et al., 2015; Mattocks et al., 2015; Veterans Health Administration, 2010; Yano, Haskell, & Hayes, 2014). The preponderance of research on women veterans' experiences with and perceptions of VA care was conducted before these

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system-wide transformation initiatives, especially the PACT model launched in 2010. In the current study, we examined patients' satisfaction with care along dimensions in line with PACT priorities (access to care, provider communication, shared decision making, and coordination of care), as well as patients' initial pathways into VA care, among a sample of contemporary women veteran patients in the Veterans Health Administration.

Background

Negative perceptions of VA care predict reduced use of VA services (Washington et al., 2006, 2011b; Washington, Farmer, Mor, Canning, & Yano, 2015), as well as attrition from the VA (Hamilton et al., 2013). In prior research, women report barriers to accessing VA care including logistical factors and difficulties with the enrollment process, as well as perceived lack of gender-specific services (Bean-Mayberry et al., 2003; Friedman et al., 2015; Hamilton et al., 2013; Vogt et al., 2006; Washington et al., 2006, 2011b, 2015).

Research examining women veterans' ratings of satisfaction with VA care (for reviews, see Bean-Mayberry et al., 2011; Runnals et al., 2014) has identified differences in satisfaction by patient characteristics. Factors associated with women's lower satisfaction with VA care include younger age, greater social advantage, and worse self-rated health (Bean-Mayberry et al., 2003, 2006a, 2006b; Desai, Stefanovics, & Rosenheck, 2005; Jackson, Chamberlin, & Kroenke, 2001; Kimerling et al., 2011; Washington et al., 2006, 2015). There is inconsistent evidence of racial differences in patient satisfaction in women veterans (Bean-Mayberry, Chang, & Scholle, 2006a; Bean-Mayberry, Chang, McNeil, & Scholle, 2006b; Hausmann, Gao, Mor, Schaefer, & Fine, 2013), with some evidence of varying patterns of satisfaction across racial minority groups and within versus between VA facilities (Hausmann et al., 2013). Organizational features of care, including availability of women's clinics or primary care models tailored to women's needs, female providers, and gender-specific services (Bean-Mayberry et al., 2003, 2006a, 2006b; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano, 2011a) are associated with greater satisfaction among women VA users. More nuanced information about female patient experience within the context and along the aims of new patient care initiatives can serve to better inform VA service delivery for women (Bastian et al., 2015).

Negative perceptions of VA care, coupled with lack of knowledge of both VA services and eligibility are barriers to access for women veterans (Washington et al., 2006, 2011b, 2015; Washington, Kleimann, Michelini, Kleimann, & Canning, 2007), predicting reduced likelihood of use of VA services and increased likelihood of delaying needed care (Washington et al., 2006, 2011b, 2015). Although policy dictates that the Department of Defense provides service members information on their VA benefits before separation from military service (U.S. Code, 2006), it seems that some women veterans who are eligible for VA care are not aware of the potential benefits after their separation. In 2007, a qualitative study examining perceptions of the VA among focus groups of women veterans identified information gaps and noted that women often arrived at the VA by "pure chance," based on informal communication from friends and family (Washington et al., 2007). Women, particularly those of earlier periods of military service, continue to underutilize VA care (Hayes, 2014). Results of a national expert panel recently highlighted the importance of tailoring aspects of first contact with the VA health care system, including outreach policies and practices, to meet the needs of women, to deliver comprehensive, gender-sensitive care (deKleijn, Lagro-Janssen, Canelo, & Yano, 2015). However, little is known about how women veterans learn that they are eligible for VA services and initially access the VA (Hayes, 2014), information that could inform outreach efforts.

Current Study

This mixed-methods study of women veterans' perspectives on VA care sought to fulfill two broad aims. First, we sought to assess women veteran patients' perceptions of and satisfaction with VA care along dimensions of care in line with PACT priorities: access to care, provider communication, shared decision making, and coordination of care (Bidassie et al., 2014; U.S. Department of Veterans Affairs, 2014). The second study aim was to identify pathways through which women veterans from diverse military service periods had initially accessed VA care.

Methods

As part of a larger study on women veterans' experiences with military services, intimate relationships, and VA health care, we conducted a two-phase mixed-methods study employing interviewer-administered surveys and semistructured in-depth interviews with women veterans receiving VA care. Study recruitment and data collection took place at an urban VA Medical Center. This study was approved by the medical center institutional review board.

Phase I: In-Person Patient Surveys (Quantitative)

In phase I, we administered face-to-face surveys to a convenience sample of 249 women veteran patients, ages 22 to 64. Between July and December, 2012, research staff invited patients waiting for primary care appointments in the Women's Health Clinic to participate in a research interview about women's experiences and needs. Participants provided informed consent and survey responses in a private space after their health care encounter. Enrollment continued until a sample size of 250 was reached (one survey was removed because it was a duplicate). Participants were reimbursed $10 for their time.

Participants reported demographic characteristics, self-rated overall health on a 5-point Likert scale (1 [poor] to 5 [excellent]), and number of primary care visits in the past year. Patient satisfaction was measured using 11 items from the Survey of Healthcare Experiences of Patients, a VA initiative that surveys patients on care experiences (Wright, Craig, Campbell, Schaefer, & Humble, 2006). Items measured satisfaction with access (3 items), provider communication (5-item composite), coordination of care (2 items), and shared decision making (1 item) on a 4-point Likert-type scale (0 [never] to 3 [always]), with higher scores indicating greater satisfaction. As low satisfaction ratings were infrequent, item ratings were dichotomized (0 [never, sometimes, or often] and 1 [always]) for single items. We calculated a composite communication score ($\alpha = 0.80$) as the proportion (range, 0–1) of the five dichotomized communication questions with high satisfaction ratings. Outcome variables included this composite and dichotomous items measuring satisfaction with access, coordination, and shared decision making.

We used χ^2 analyses to examine bivariate associations between dichotomous variables, independent samples t tests and one-way analysis of variance to examine associations between categorical and continuous variables, and correlations