

DEPARTMENT OF VETERANS AFFAIRS



Congressionally Mandated Report: Study on Barriers for Women Veterans to Receipt of Health Care from VA September 2024

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INTRODUCTION

As of 2023, there are more women in the United States military as Service Members and Veterans than at any other time in history—both in number and percentage—and their growth in these figures will continue for the foreseeable future. Women now make up the fastest growing cohort within the Veteran community. Over 2 million Veterans in the United States are women. This is up from 4% in 2000 to 10% in 2022. The projected percentage of women Veterans by 2040 is approximately 18%.¹

As more women become Service Members and Veterans, there is an increase in the utilization of VA health care benefits and services. According to the VA Utilization Profile report², over the last decade, the number of women Veterans using VA health care has nearly doubled. Today, more than 800,000 women are enrolled in the Department of Veterans Affairs (VA) health care system. VA strives to honor Veterans and provide exceptional care that is second to none. As such, VA continues to prepare for this increasing demand. Continued effort to understand the unique population dynamics and health care needs for women Veterans is a top priority.

Historically, gender-based disparities were noted in VA care, leading to a decade of innovations and enhancements to the provision of women Veteran's health care in Veterans Health Administration (VHA). This included training over 11,000 VHA clinicians through a women's health mini-residency program; ensuring there are women Veteran program managers at every facility; assignment of women Veterans to specially trained women's health providers, and; expansion of reproductive health services including gynecology, maternity, and fertility care.

In January 2021, the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, P.L. 116-315 § 5402, required the VA to examine potential barriers to accessing and utilizing VA health care services for women Veterans. The legislation specifically identified the following areas of interest:

- (1) The barriers associated with seeking mental health care services, including with respect to provider availability, telehealth access, and family, work, and school obligations;
- (2) The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care;
- (3) The effect of access to care from non-Department providers;
- (4) The availability of childcare;
- (5) The satisfaction of such Veterans with the provision by the Department of integrated primary care, women's health clinics, or both, including perceptions of quality of care, safety, and comfort;

¹ [Women Veterans in Focus \(PDF\)](#)

² [VA Utilization Profile FY2017: Prepared by the National Center for Veterans Analysis and Statistics \(May 2020\) \(PDF\)](#)

- (6) The understanding and perceived accessibility among such Veterans of eligibility requirements for, and the scope of services available under, hospital care and medical services;
- (7) The perception of such Veterans of personal safety and comfort in inpatient, outpatient, and behavioral health facilities;
- (8) The gender sensitivity of health care providers and staff to issues that particularly affect women;
- (9) The effectiveness of outreach for health care services available to women Veterans;
- (10) The location and operating hours of health care facilities that provide services to women Veterans;
- (11) The perception of such Veterans of the motto of the Department; and
- (12) Such other significant barriers as the Secretary considers appropriate.

In order to examine these topics, VA Office of Women's Health (OWH) awarded a contract to Trilogy Federal. Trilogy partnered with Altarum Institute, a non-profit independent health research organization and American Directions Research Group to conduct the survey and report findings. Trilogy conducted a study of the barriers to comprehensive health care for women Veterans using a telephone and online web survey. This study (further referred to as "Barriers to Care Study" or "study") builds upon the 2014 Study of Barriers for Women Veterans to VA Health Care mandated by P.L. 111-163 § 201 and National Survey of Women Veterans in Fiscal Year 2007–2008. This follow-up study included similar questions for comparison, a larger study population and geographic stratification by Veteran Integrated Service Network (VISN).³ The areas of interest were consolidated into nine focus areas or barriers:

- **Barrier 1:** Eligibility Requirements and Scope of Services
- **Barrier 2:** Outreach Efforts for Women Veterans
- **Barrier 3:** Effect of Driving Distance on Access to Care
- **Barrier 4:** Location and Hours
- **Barrier 5:** Childcare
- **Barrier 6:** Acceptability of Integrated Care
- **Barrier 7:** Gender Sensitivity
- **Barrier 8:** Mental Health Access & Stigma
- **Barrier 9:** Safety and Comfort
- **Barrier 10:** Community Care

³ US Department of Veterans Affairs. Office of Research and Development. The National Survey of Women Veterans by Donna Washington. Available at: http://www.research.va.gov/programs/womens_health/conference2010/washington.cfm. Accessed on 10/10/2014

Evaluation of the perception of the motto was omitted from the survey as the motto was updated during survey development. Results of this study assist VA in further understanding the challenges women Veteran's encounter when accessing care, highlight progress made since the original study and examine perceptions that potentially deter the use of VA services. Ultimately, the data collected inform the future planning of services and programming so that VA continues to be a provider of *first* choice among women Veterans. The following provides an overview of the methods, primary findings, and discussion of the study. Data is as of August 2024.

METHODS

Trilogy developed the survey tool in collaboration with the OWH using the 2014 Barriers to Care Survey as a framework, along with input from various subject matter experts. Response scales and questions from existing surveys were used where possible and appropriate. The near-final instrument was pilot tested with 176 eligible women Veterans (58 users of VA health care and 118 non-users). The feedback from these interviews was then used to revise question wording and response options to help make the material more understandable and relevant to the respondents.

The final questionnaire included 91 (some of which were multi-part) questions. One open-ended question allowed women Veterans to report, in their own words, anything they wished to comment upon. The Office of Management and Budget approved the survey tool in January 2023. Internal Review Board approval was received in January 2023.

The study population (also known as the sample) was identified using the Veterans Experience Office (VEO) profile database. The VEO profile data is the most authoritative source of beneficiary address information, as the profile data draws address and contact information from multiple sources. There were 941,488 records representing non-duplicated living women Veterans with a valid address along with reported user status were retained. This data was then stratified by VISN and user status applying a zip code to VISN mapping by person. Strata were then defined as the combination of VISN and user status resulting in a total of 36 strata across 941,488 women Veterans.

Initial sample requirements were derived applying observed response rates from the previous VA Women's Barrier to Care Survey with adjustments. This resulted in a final sample frame of 86,000 women Veterans. To achieve the analytic goals of the study, the sample frame was then stratified by VISN and by those who *had used* VA health services and *had not used* VA's health services in the last 24 months. The goal was to conduct at least 7,200 completed interviews; 400 surveys from each of the VISNs with 200 users and 200 non-users.

Given the complex survey design it was necessary to develop and apply survey weights which when applied resulted in the best available estimates of survey results representing the women Veterans' experience for the entire women Veteran population.

The Barriers to Care survey was conducted utilizing Computer Assisted Telephone Interviewing (CATI), administered by experienced and trained interviewers, and by web survey. A pre-notification letter was mailed at least five-ten days before calls were placed to each woman Veteran. The letter included the link with unique login instructions for women Veterans to access the survey online. The letter also provided details on how to complete the survey over the phone. The survey took about 60 minutes if all questions were applicable to a respondent. Given the sensitive nature of some of the questions in the survey, such as those related to experience of military sexual trauma, only women interviewers were used for CATI. Trilogy conducted the study from April 2023 to December 2023.

The analysis for the Barriers to Care study included basic descriptive statistics as well as bivariate analyses. This type of analysis allowed researchers to compare data between VISNs, and between users and non-user populations. Most importantly, the effect of each of the barriers was evaluated using regression methods which control for relevant known factors that may be related to outcome differences (for example, age, race, service levels). Lastly, qualitative data from the open-ended question was used to help support findings and recommendations.

RESULTS

A total of 7,359 surveys were completed. This response exceeds the original survey target of 7,200 completed surveys. The respondent population of the Barriers to Care survey is drawn from women across all geographic regions and includes responses from both users and non-users of VHA services. Based on this methodology, one can conclude that the results are generalizable to the greater women Veterans population. The following tables highlight the demographics of the study population:

Table 1: Respondent Demographics, Overall and by User Status

Survey Participant Characteristics	Overall Raw Percent	VA User Raw Percent	VA Non-User Raw Percent
Overall	100%	100%	100%
VA Non-User: Non-User in Past 24 Months	49.8%	0%	100%
VA User: User in Past 24 Months	50.2%	100%	0%
Age: 18-34	7.1%	8.0%	6.2%
Age: 35-44	18.4%	19.1%	17.7%
Age: 45-64	46.4%	46.8%	46.0%
Age: 65+	25.2%	23.4%	27.1%
Age: Unanswered	2.9%	2.7%	3.0%
Income: Less than \$20,000	9.6%	10.8%	8.3%
Income: \$20,000-\$49,999	29.5%	34.4%	24.6%
Income: \$50,000-\$99,999	31.4%	29.8%	32.9%

Survey Participant Characteristics	Overall Raw Percent	VA User Raw Percent	VA Non-User Raw Percent
Income: \$100,000 or more	22.5%	17.1%	28.0%
Income: Unanswered	7.1%	7.9%	6.2%
Education: High School or Less	9.8%	8.9%	10.6%
Education: Some College/Vocational/Associates	41.4%	42.0%	40.8%
Education: College Degree	25.2%	25.6%	24.7%
Education: Graduate Degree	23.1%	23.0%	23.2%
Education: Unanswered	0.6%	0.5%	0.7%
Race/Ethnicity: Asian Alone (Non-Hispanic)	1.1%	1.3%	0.8%
Race/Ethnicity: Black Alone (Non-Hispanic)	18.9%	21.3%	16.4%
Race/Ethnicity: Hispanic (Any Race)	8.9%	9.6%	8.3%
Race/Ethnicity: White Alone (Non-Hispanic)	62.7%	59.0%	66.4%
Race/Ethnicity: Multiple/Other/Unanswered	8.4%	8.7%	8.0%
Rural Status: Urban (ZIP code in MSA)	74.1%	69.2%	78.9%
Rural Status: Rural (ZIP code not in MSA)	19.8%	19.1%	20.6%
Rural Status: Unanswered	6.1%	11.7%	0.5%

Table 2: Respondent Service-Related Demographics, Overall and by User Status

Survey Participant Characteristics	Overall Raw Percent	VA User Raw Percent	VA Non-User Raw Percent
Service Era: Up to 1965	0.6%	0.8%	0.46%
Service Era: 1966 to 1989	27.4%	24.8%	30.0%
Service Era: 1990 to 2000	25.1%	23.5%	26.8%
Service Era: 2001 to Present	45.1%	49.4%	40.7%
Service Era: Unanswered	1.7%	1.5%	2.0%
Service-Connected Disability: No Rating	54.6%	28.7%	80.6%
Service-Connected Disability: 0-20%	8.7%	10.4%	7.0%
Service-Connected Disability: 30-60%	11.4%	17.2%	5.6%
Service-Connected Disability: 70-100%	22.8%	41.0%	4.5%
Service-Connected Disability: Unanswered	2.5%	2.7%	2.2%

The following section is a discussion of the major results and findings from the study, organized by the potential barriers:

Barriers 1 and 2: Eligibility Requirements and Scope of Services and Outreach Efforts for Women's Health Services

- The most common source of information among VA users were VA representatives and providers. In comparison, VA non-users cited letters and brochures as the most common source of information.
- The best modes of information about VA eligibility were email (37%), mail (34%), and telephone (26%), with almost no one preferring websites (2%), social media (1%), or newspapers and television (0%). When stratified by users vs. non-users, VA users rated telephone as best (35%), while VA non-users rated mail as best (40%).
- Women Veterans reported receiving more information in 2023 than in 2014, including receiving information about eligibility requirements, available health services, women's health services, and how to receive care.
- Overall, 3 out of 5 (62.3%) VA users said the information they received about women's care was "very helpful" compared to just 37.2% of non-users.
- Those with lower income, higher disability ratings, or who were Black were most likely to report VA communications felt made for them.

Barrier 3: Effect of Driving Distance on Access to Care

- Whether rural or urban and regardless of disability rating, the majority of VA users indicated that finding transportation is not problematic; less than 20% percent indicated that finding transportation is either very hard or somewhat hard.
- Among VA non-users, almost 1 in 4 (22.5%) said VA-sponsored transportation would be helpful to them.
- Distance was the fourth most-cited barrier overall (19.8%). Travel times were much shorter for non-VA care (81% within 30 minutes) than VA care (52% within 30 minutes).

Barrier 4: Location and Hours

- More than half (53%) of VA users said extended hours would be helpful. Users said the most helpful times would be weekends (84%), weekday evenings (80%), and early weekday mornings (55%). The most helpful extended hours would be on weekends and weekday evenings.
- About one in four women Veterans have switched to a non-VA provider because of limited hours of operation at the VA.
- Regarding the convenience of appointment times, 85% of VA users said VA appointment times were convenient compared to 49% of non-users. Women who report convenient appointment times use VA more frequently.

Barrier 5: Childcare

- 14% of women Veterans in this survey cohort had a child that would require care during medical appointments. Less than half (42.9% VA users and 35.9% non-users) reported that it was difficult to find childcare.

- The highest preference for needing childcare was reported for mental health visits (63%) in comparison to other medical appointments among both VA users and non-users.
- Women Veterans were most likely to accept childcare at a VA facility (51%) or reimbursement for their own childcare (50%).

Barrier 6: Acceptability of Integrated Care

- Most women Veterans believed it was important to receive primary care and women's care from the same provider (74%) and have a woman provider (70%).
- About half (53%) of women believed getting primary care from a women's clinic was important.
- The share of women Veterans who value a woman provider increased 6% since the previous study, from 64% to 70%.

Barrier 7: Gender Sensitivity

- Almost 3 in 4 (72.6%) women Veterans who use the VA reported the VA is sensitive to women Veteran's health care needs.
- Approximately half of VA users agreed that the VA provided high quality care for women Veterans.
- Likewise, 53.6% of women Veterans agreed that the VA is welcoming.
- Respect from primary care providers (+4.8%) as well as nursing/office staff (+10.7%) and specialists (+6.2%) all increased over time from the previous study.

Barrier 8: Mental Health Stigma

- Matching national trends, demand for mental health care has increased greatly since 2014, from 41% to 62%.
- Likewise, those who feel hesitant to receive mental health care increased from 24% to 42%. This was due in large part to worry about the medications being prescribed (63%).
- Women Veterans reporting lifetime unwanted sexual attention and sexual assault increased greatly since 2014, with unwanted sexual attention increasing from 44% to 64% and sexual assault increasing from 25% to 37%.
- Of those women who had reported a past sexual assault, 19% reported avoiding the VA because of it in 2023, up from 11% in 2014.

Barrier 9: Safety and Comfort

- Overall, women from all demographic categories felt that the safety and comfort in VA facilities were adequate.
 - 83% of current users feel safe at the VA.
 - 67% of prior users feel safe.
- The aspects of safety and comfort with the lowest scores were check-in area privacy (54%), waiting area welcoming (64%), and caregiver waiting area (67%). These aspects were also highly correlated with overall safety and feeling like they belong at the VA as a woman Veteran.

Barrier 10: Community Care

- 60% of current VA users reported having used Community Care.
 - Community Care was used more by those with lower incomes, in rural areas, and those with disability ratings of 70% to 100%.
- Among those who used Community Care, 69% were satisfied with VA interoperability, and 85% were satisfied with the quality of providers.
- VA users rated community care providers as having better medical knowledge (91%) compared to VA providers (86%) but reported that VA providers had a better understanding of women's health needs (79%) than community care providers (74%), and a better understanding of women Veterans (78%) than community care providers (71%).

Top Barriers for Women Veterans:

- The most frequent barrier to VA care is not understanding their benefits (37%). This was especially true for non-users of the VA (49%). The second biggest barrier was not having information on how to use health care (27%), which was also higher for non-users (40%). The third most frequent barrier to care overall was waiting time for an appointment (23%), but this was the most frequent barrier for current users of the VA (31%).
- Some barriers to care occur with low frequency, such as childcare (4%) and transportation (3%), but these barriers to care can disproportionately affect certain groups. Childcare is a barrier for 17% of women Veterans ages 18 to 34, while transportation is a barrier for 12% of those with an income under \$20,000.
- The top 2 most frequent barriers to care decreased greatly since 2014, with those not understanding their benefits decreasing from 47% to 37% and not having information about how to use care decreasing from 40% to 27%. This suggests communication efforts since 2014 have been effective in reducing these top barriers.

DISCUSSION

The primary aim of the Barriers to Care survey is to measure the effect that barriers to care have had on women Veterans' use of VA health care services. The survey also sought to assess the interval progress in mitigating barriers since the previous study. This section provides a discussion of each of the barriers identified in the Public Law and measured through the survey and highlights comparisons where applicable.

Barrier 1 and 2: Eligibility Requirements and Scope of Services and Outreach Specifically Addressing Women's Health Services

One of the most commonly recognized barriers to VA care for women Veterans is that many women do not know whether or not they are eligible for care. Eligibility is based on a number of factors. For women Veterans without a service-connected disability, eligibility status may change over time as their life circumstances change. As in the

previous study, significantly higher percentages of VA users reported having received information related to eligibility and VA services than did non-users. On average just under 1 in 3 non-users (29.6%) recalled receiving information. Those with service eras after 2001 were more likely to encounter VA information, as were those under 35 or over 65. Receipt of information did not differ based on rural vs. urban status.

Talking to a VA representative or reading a brochure or letter were the most common sources of information overall. VA users were more likely to get their information verbally from a person, such as a VA representative, friend/family, or a health provider. Non-VA users were more likely to get their information in writing from a brochure/letter or a website/blog. As a source of information, email (36.6%), mail (34.4%), and telephone (26.1%) were preferred. VA users preferred telephone while non-users preferred email and mail. Almost 3 out of 4 VA users (73.9%) said VA information feels like it is made for them, compared to just 37.2% of non-users. Those with lower income, higher disability ratings, who were Black, and those with service eras after 2001, were most likely to report that VA communications felt made for them. This suggests VA communications feel inclusive to a wide range of demographics, especially those who have been historically marginalized.

Trends over time show that exposure to all types of information about the VA increased from 2014 to 2023. Information about eligibility requirements increased from 46.2% to 54.2%. Information about VA health services increased from 43.0% to 47.5%, information about women's care increased from 32.5% to 37.2%, and information about getting health care increased from 40.8% to 46.7%. While information exposure increased, the need for additional information also increased. Those who felt they had sufficient information decreased across all information types. Nearly half (47.7%) of respondents reported having enough information specifically regarding services for women Veterans. VA users were more than twice as likely to have said they have enough information compared to non-users.

Women were also asked about a related barrier regarding information and knowledge of the women's health services that VA provides. Most system users (67%) reported having received information on Women's Health Services, compared to only 21% of non-users. The percentage of women who received this information (for both groups) is lower than those having received general VA information.

Across VISNs, there is significant disparity with the percentage of women who reported receiving information specific to women's care. This may reflect variances within each VISN population, but also may be attributed to VISNs having disparate programs for communicating to women Veterans within their boundaries.

Barrier 3: Effect of Driving Distance on Access to Care

In this Barriers to Care survey, both users and non-users of VA health care were asked about their typical drive time to their Primary Care site, as well as other details transportation. Just over half (53.2%) of VA users reported the travel time to their VA primary care provider was less than 30 minutes. This was not significantly different by

service era, age, income, race/ethnicity, or disability rating. Travel time did differ substantially by rural/urban status, with urban women Veterans much more likely to have a VA facility within 30 minutes than those in rural areas. Four out of 5 (80.8%) of VA non-users reported the travel time to their non-VA facility was less than 30 minutes.

Whether rural or urban and regardless of disability rating, the majority of VA users indicated that finding transportation is not problematic; less than 20% percent indicated that finding transportation is either very hard or somewhat hard. Among VA non-users, almost 1 in 4 (22.5%) said VA-sponsored transportation would be helpful to them. Women Veterans who served before 1990 were most likely to have said this would be helpful, though the trend was not clear across age groups. Knowledge of eligibility for travel benefits was also examined. Among VA users, almost 2 out of 3 (64.7%) women Veterans did not know if they were eligible for bene-travel (VA assisted transportation). Those with lower or no disability rating and those living in urban areas were less likely to know if they were eligible for bene-travel services. Seventy-five percent of bene-travel users reported the service was helpful, indicating a relatively high level of value to its users.

Barrier 4: Location and Hours

Women Veterans were asked about the location of their nearest VA as well as their experiences with scheduling an appointment and the convenience of appointment times. All women Veterans were asked about their experiences with scheduling an appointment, convenient appointment times and location of the nearest VA. Overall, 1 in 3 (33.7%) women Veterans said they have switched providers because of the VA location. Those who were multiple/other race/unanswered, and those in rural areas were more likely to switch because of location, as were those with a disability rating. Six out of 7 (84.8%) VA users said the VA had convenient appointment times, though only 1 out of 2 (48.6%) of non-users said appointment times were convenient.

Just under 1 in 4 (23.5%) women Veterans said wait times for an appointment have been a barrier to care. Similarly, 1 in 4 (25.1%) women Veterans said they had switched providers from the VA because of hours of operation. Among VA users, half (49.3%) said extended hours of operations would help them access VA care. Those who served after 1990 were more likely to agree extended hours would be helpful, as were those under the age of 65.

Barrier 5: Childcare

A small percentage of women Veterans in this study (14%) had a child that would require care during a medical appointment. Among those, 42.9% of VA users and 35.9% of non-users reported difficulty finding childcare. Income and disability ratings were both related to difficulty. With lower incomes and higher disability ratings making it more difficult to find childcare. Nearly half (48.5%) reported it was important for the VA to provide childcare during appointments. When queried about the type of childcare assistance preferred, women Veterans reported that on-site VA childcare or reimbursement for their own childcare would be preferred.

Barrier 6: Acceptability of Integrated Care

The integration of VA health care for women Veterans through the implementation of Comprehensive Care was also assessed. For this research, Comprehensive Care was defined as having one provider who can provide all general medical care and all routine women's health care such as Pap smears, contraception, and menopause care. VHA has identified three Comprehensive Primary Care Clinic models which capture the range of settings in which care is provided for women Veterans.

- **Model 1** - General Primary Care Clinics. Comprehensive primary care for the women Veteran is delivered by a Designated Women's Health Provider (DWHP). Women Veterans are seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the Clinic. Referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance.
- **Model 2**- Separate but Shared Space. Comprehensive primary care services for women Veterans are offered by DWHP in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.
- **Model 3**- Comprehensive Women's and Gender Diverse Clinics. Comprehensive primary care is delivered to all Veterans who identify as women as well as Veterans of female birth sex who continue to need reproductive health services by Women's Health Primary Care Providers (WH-PCP) and Women's Health Patient Aligned Care Teams in an exclusive separate space. VHA facilities with larger women Veteran populations are encouraged to create clinics that provide the highest level of coordinated high quality comprehensive care to women Veterans.

Overall, 62.4% of women Veterans reported they have one provider for general care and women's care. VA non-users were slightly more likely (63.5%) to have a single provider than VA users. Almost 1 in 3 (29.5%) VA users received their primary care at a clinic that is just for women patients, compared to just 1 in 10 (9.2%) non-users.

When asked about the importance of receiving care from a clinic just for women, just over half (52.7%) of VA users believe it is important to receive most or all primary care from a clinic that is just for women patients. In comparison just under half (49.3%) of non-users felt this was an important aspect. Those in more recent service eras and those who were younger than 45, and with lower incomes reported receiving care in a clinic just for women as having less importance. Those with higher disability ratings and in urban areas gave more importance to women's clinics. An overwhelming majority (7 out of 10) of women reported receiving primary and women's care from a woman provider as being important regardless of user status. This reflects a significant increase over the 2014 results (70.2% vs. 64.4%).

Barrier 7: Gender Sensitivity

To evaluate gender sensitivity in VA care settings, the study included questions about satisfaction with the relationships with providers and clinic staff and whether the woman felt respected.

Satisfaction with provider, for women receiving comprehensive care remains good. Overall, eight in ten (81.5%) women Veterans were satisfied with their VA providers. Users reported high satisfaction across 5 satisfaction measures: general medical knowledge (85.6%), knowledge of women's health (78.9%), understanding women Veterans (78.4%), spending time with you (83.1%), and the amount of information received (81.9%).

Similarly, women reported that provider and staff respect was high. Overall, 8 in 10 (81.4%) women Veterans felt respected by VA providers and staff. All three measures of respect from VA providers and staff increased over time. Respect from primary care providers increased from 78.5% in 2014 to 83.3% in 2023. Respect from specialists increased from 74.7% in 2014 to 80.9% in 2023. Respect from nursing and office staff increased from 69.2% in 2014 to 79.9% in 2023.

Four questions assessed satisfaction with VA quality of care for women. This includes agreement with statements that the VA provides quality healthcare (56.3%), the VA is welcoming to women Veterans (53.6%), VA care is equal to private care (43.2%), and the VA provides specialized care for women (44.4%).

Barrier 8: Mental Health Stigma

Mental health self-ratings were significantly better for non-users than users. Less than 2 out of 3 VA users (63.9%) rated their overall mental health as "good, very good, or excellent" compared to almost 4 out of 5 (78.1%) non-users. Women who reported higher ratings of their mental health were more likely to be older, have lower or no disability rating, or be in a higher income group. Those in rural areas reported higher self-ratings about their mental health than urban areas. The share of women Veterans who felt the need for mental health care increased from 40.6% in 2014 to 61.7% in 2023.

Overall, 41.5% of women Veterans have felt hesitant to seek mental health care services. VA users were significantly more likely to be hesitant to seek mental health care than non-users. Those in more recent service eras and younger women Veterans were also more likely to be hesitant. Those with higher disability ratings were more likely to be hesitant to seek mental health care. There was no significant difference by income level or urban/rural status. When asked why women Veterans felt hesitant, respondents expressed greatest concerns with worry about medications (62.9%). The share who were hesitant to seek mental health care increased from 24.4% to 41.5%.

Overall, 2 out of 3 women Veterans reported unwanted sexual attention, such as touching, cornering, or pressure for sex during their lifetime (65.7%). In all cases, VA users reported higher rates of unwanted sexual attention than VA non-users. When comparing results from 2014 with the current study, rates of unwanted sexual attention

increased substantially for all questions. These increases may reflect greater public awareness and likelihood to report sexual harassment and assault over time. The share of women Veterans reporting unwanted forced sex during their lifetime increased from 25.3% in 2014 to 37.4% in 2023. Of those who had ever received unwanted sexual attention or forced sex in their lifetime, 1 in 5 (21.8%) VA users reported they had avoided the VA because of that experience, compared to about 1 in 6 (15.6%) non-users.

Barrier 9: Safety and Comfort

VA users were asked if they agree with eight aspects of safety and comfort at their VA facility. The lowest ratings (although still positive) were for “check-in privacy” (53%). The highest ratings (70% or higher) were received in the categories of exam room privacy (86.9%), availability of women’s or unisex restrooms (82.5%), the facility was clean and well-equipped (79.6%) and parking was safe (79.1%) All participants were asked if they felt they belonged at the VA as women Veterans. Three out of 4 users felt they “almost always” or “often” felt they belonged at the VA (74.1%) however, only 1 in 3 (34.9%) non-users felt they belonged. There was no difference by service era, but those over 45 were more likely to feel they belong. The top predictors of overall safety at the VA are feeling safe with other vets (16.6%), exam room privacy (15.4%), belonging at the VA as a woman vet (15.3%), feeling safe with VA staff (15.0%), and a welcoming waiting room (13.5%).

Since 2014, 5 measures of overall safety and comfort have improved. Measures that improved include clean and well-equipped facility, accessible parking, safe parking, check-in privacy, and a welcoming waiting area. Measures that remained statistically the same include exam room privacy and the availability of women’s or unisex bathroom. Having a place for caregivers to wait (72.7% to 67.3%) was the only measure with a slight decline since the prior study was conducted.

Barrier 10: Community Care

One in three women reported receiving VA care through a community provider. Among those, 70% reported being satisfied with coordination of care and the quality of care received. VA users rated community care providers as having better medical knowledge (91%) compared to VA providers (86%), but VA providers had a better understanding of women’s health needs (79%) than community care providers (74%), and a better understanding of women Veterans (78%) than community care providers (71%).

RECOMMENDATIONS FROM THE REPORT

Significant improvement in communication and education for women Veterans has occurred since the 2014 survey. The share of current VA users and non-users having received information on VA eligibility and services increased. This suggests the VA has improved at reaching more women Veterans. However, the need for additional for information has also increased. Overall satisfaction with the level of detail in this communication has decreased, especially among non-users. Preferences on the type of communication differed among users (telephone) and non-users (mail). Outreach efforts need to be developed based on these preferences and ensure that communication is

inclusive and tailored to the audience. A comparison of all barriers found not understanding benefits (36.6%) and not being given info about how to use VA care (27.0%) were the most frequently cited barriers and were much more common among VA non-users than users. Clear options to access additional information when needed must be provided.

Women in all demographic categories showed a preference for women-only settings. The preference for receiving comprehensive care from one single provider remained significant in the current study, underscoring the importance of VA's policy of assigning women to designated WH-PCPs who provide comprehensive primary care including gender specific care. Women Veterans also preferred women providers. That preference, increased for women Veterans under the age of 35, with 4 out of 5 responding that it is important to have a woman provider. VA must continue to prioritize efforts to recruit and retain women's health providers and explore opportunities to provide more women-only care settings. Veteran satisfaction with regard to general medical knowledge, knowledge of women's health and understanding women Veterans all increased in the current study, demonstrating that VA's national educational trainings and hands on workshops to educate and prepare women's health providers has been helpful and necessary.

Matching private sector trends, the demand for mental health care services has increased since the prior study. The share of women Veterans reporting "fair" or "poor" mental health was especially high among VA users ages 18-34 (43%). Unfortunately, the stigma surrounding seeking mental health care remains high. The top concern about receiving mental health care was reported as worry about medications. Increasing awareness about the range of mental health treatment options available, including non-medication treatments, may be warranted. The share of women Veterans reporting unwanted sexual attention and sexual assault over their lifetime increased greatly since 2014, with unwanted sexual attention increasing from 44% to 65% and sexual assault increasing from 25% to 37%. Of those who had been assaulted, the share who reported it occurred while in the military also increased. VA should continue to address the perceived stigma around mental health care and continue support and services for Veterans with sexual trauma.

Lack of childcare did not emerge as a significant barrier for women Veterans in this study. In fact, it was one of the least cited barriers. However, for those with children needing care, they reported preferring childcare at a VA facility or accepting reimbursement for their own childcare arrangements. VA childcare offsite and non-VA childcare offsite were not desirable options for this cohort.

Likewise, travel distance and transportation were not found to be significant deterrents to VA care in this study. Most users reported travel time to their primary care provider was less than 30 minutes. Four out of five VA users indicated that finding transportation was easy. Among VA non-users, only one in four reported that VA transportation would help them choose VA care. However, when asked about bene-travel most respondents did indicate that they were unsure of eligibility. Those who served more recently and

younger women Veterans were less likely to know if they were eligible. VA should explore opportunities to provide additional information about this resource; especially among those women Veterans recently separated from service.

CONCLUSION

It is clear through the results of the 2024 Barriers to Care Study that VA has made significant progress since the 2014 Study of Barriers for Women Veterans to VA Health Care in addressing women Veterans healthcare. Many barriers to care for women Veterans have improved. Widespread improvement in outreach for women Veterans to provide information on VA eligibility and services, coordination of care and a focus on safety and comfort at VA facilities have reduced barriers and improved Veteran satisfaction. Additionally, efforts to address culture and ensure that the delivery of care meets or exceeds women Veteran expectations has resulted in an overall improvement in patient experience.

However, as VA continues to respond to the increasing demand, ongoing examination of the gaps and challenges that influence women Veterans' decisions to seek care through VA remains paramount. This study has provided an even greater understanding of the women Veteran experience. Continued work in the area of recruitment and retention of women's health providers and equipping staff with tools to support women with a history of sexual trauma and mental health conditions will continue to be critical to best serve women Veterans. VA will focus future efforts and resources on several of these key findings in addition to leveraging the study to guide future research that can inform policy and practice decisions for providing comprehensive health care to women Veterans.

Department of Veterans Affairs
September 2024