Active Duty and Veteran Women: Formative Research Plan

Updated January 20, 2019

Overview

Women are the fastest-growing subpopulation of the military and veteran communities, representing more than 16 percent (1.3 million) of the active duty force in 2018 (U.S. Department of Defense, 2018) and over 9 percent (2 million) of all U.S. veterans in 2015 (National Center for Veterans Analysis and Statistics, 2017). By 2020, the number of veteran women is projected to increase to 10.5 percent of the total veteran population (National Center for Veterans Analysis and Statistics, 2017). From 1973 to 2010, the number of active-duty women in the military has increased seven-fold, from 2% to 14% (Patten and Parker, 2011).

Active duty and veteran women have unique health care needs, conditions, and disease symptoms, compared to active duty and veteran men. For example, active duty and veteran women have unique needs related to obstetric and gynecologic care, domestic violence screening, family planning, pregnancy, postpartum depression, chronic pelvic pain, and menopause (American College of Obstetricians and Gyn., 2012; Washington et al., 2006). Compared with their civilian counterparts, active duty and veteran women have higher rates of some mental health disorders, increased rates of lifetime exposure to interpersonal violence (e.g., sexual assault and intimate partner violence) (Wilson, 2018; National Academies of Sciences, Engineering, and Medicine, 2018), and higher prevalence of post-traumatic stress disorder (PTSD) (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006; Haskell et al., 2011; ACOG, 2012; Harvard Medical School, 2007, Lehavot et al., 2017). Factors such as deployment, combat exposure, and military-specific environmental exposures may also create barriers for seeking and accessing health care. Therefore, it is important for health care providers (HCPs) to understand active duty and veteran women's distinct experiences and health care needs.

The administration of health care for active duty and veteran women is complex, primarily due to a mix of insurance coverage (e.g., TRICARE, U.S. Department of Veterans Affairs (VA), employer-sponsored or private insurance, Medicare, and Medicaid) and care settings. Active duty and veteran women may seek primary and reproductive health care through any one of the following settings or a combination thereof:

- U.S. Department of Defense (DoD) Military Health System (MHS) facilities
  - MHS is a system of 55 hospitals and more than 370 clinics, in addition to the care provided in combat situations and at bases and on ships overseas.
- U.S. Department of Veterans Affairs (VA) Veterans Health Administration (VHA) facilities
  - The VHA is a system of approximately 1,250 medical centers and outpatient clinics that provides care to about 9 million veterans annually.
- Civilian sector (non-military) or other facilities within the community

The number of veteran women using the VA health care system has increased 46 percent over the past decade (National Center for Veterans Analysis and Statistics, 2017). Despite this increase, the majority of veteran women (83 percent) get their health care outside of the VA, at academic centers and private community practices (U.S. Department of Veterans Affairs, 2017). This could be due to a number of reasons, including eligibility to receive care through private insurance, unfamiliarity with the application process for how to receive care through the VA, and inconvenience of VA facility locations (National Center for Veterans Analysis and Statistics, 2017). Researchers have also found that a high proportion of veteran women report receiving dual care, or care obtained from the VA and the private health system (U.S. Department of Veterans Affairs, 2015; Nayar et al., 2013; Schell et al., 2011).

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act ("Choice Act") to allow veterans facing extensive wait times or living more than 40 miles from the nearest VA to seek care in the private sector. In 2017, Congress extended the Choice Act to authorize the VA to cover co-pays and deductibles directly for private care rather than reimbursing veterans afterward and ensure that private sector providers have access to medical records for veterans to enhance the continuity of care.

Given the significant numbers of active duty and veteran women who use non-VHA/MHS sources of care and the broad-ranging health impacts of military service, the research proposed in this plan aims to understand active duty and veteran women's experiences receiving health care in civilian settings, including the facilitators and barriers. It also aims to understand civilian HCPs' experiences delivering care to these women, including the facilitators and barriers. This plan details two components of formative research:

1. In-depth interviews (IDIs) with HCPs
2. Focus groups with active duty and veteran women

Target Audiences

Active Duty Women

The number of active duty women in the military has risen dramatically since the beginning of the all-volunteer force. Compared to 2000, both the percentage of active duty enlisted members and the percentage of active duty officers who are women has increased (from 14.7% and 14.4%, respectively, in 2000 to 15.6% and 17.3%, respectively, in 2016) (U.S. Department of Defense, 2016). As of 2016, the Army had the highest number of active duty women (68,965), while the Marine Corps had the lowest number of active duty women (14,854) (U.S. Department of Defense, 2016).

Veteran Women

Veteran women have gaps in their knowledge about services provided by DoD, gaps in knowledge about VA eligibility, and assumptions that VA does not provide unique gender-specific health care services required for women (Washington et al., 2007; U.S. Department of Veterans Affairs, 2015). Only one in six veteran women (15.7 percent) understands their VA health care benefits (Westat, 2010). Among veteran women who do not use VA services, other barriers to VA care include: perceptions of inadequate women's services or provider quality for primary care, perceived stigma when seeking mental health care services, and the location and operating hours of health care facilities (U.S. Department of Veterans Affairs, 2015).

Moreover, researchers have found that some veteran women question their veteran identity and will not readily identify themselves as being veteran. When women talk about their military service, a large number will report that they feel invisible, that their "non-combat" role was less valued than those of the men who served and that they do not identify themselves as veterans (Disabled American Veterans, 2014; American College of Obstetricians and Gyn., 2012). The misperception that a woman who seeks services at the VA is not a veteran herself, but a male veteran's wife, mother, or daughter, also makes it difficult for providers to identify and tailor care based on veteran status (Disabled American Veterans, 2014; American College of Obstetricians and Gyn., 2012).

Health Care Providers

Prior research on providers' experiences in delivering care to veteran women has pointed to potential gaps in primary care provider (PCP) knowledge. Researchers have found that providers outside of the VA are uncertain how to address veterans' needs, citing limited perception of the impact of veteran status on medical care; limited knowledge about medical conditions impacting veterans; lack of comfort discussing health-related exposures and risks veterans might experience; limited knowledge about military stressors;

inconsistent knowledge of military culture; limited knowledge of resources and support services; and challenges coordinating with the VA (Vest et al., 2018; Vest et al., 2018b; Fredricks, 2014). Additionally, in a recent study of non-VA PCPs, most providers asserted that knowing a patient's military status would help them provide better care, yet more than half rarely or never ascertain veteran status (Vest et al., 2018b).

In-Depth Interviews with HCPs

Hager Sharp proposes conducting 16 telephone IDIs among non-VHA/MHS physicians (both Medical Doctors and Doctors of Osteopathic Medicine) and non-physicians (nurse practitioners (NPs) and physician assistants (PAs)), segmented by specialty. We recommend including internal medicine/family practice physicians and non-physicians, as well as obstetrician-gynecologists (OB/GYNs). Because OB/GYNs may be the primary medical providers for active duty and veteran women, they are in a position to interact with these women and intervene early and appropriately with their unique health care needs (American College of Obstetricians and Gyn., 2012).

- Internal medicine/family practice physicians (n = 4) and non-physicians (n = 4)
- OB/GYN physicians (n = 4) and non-physicians (n = 4)

Telephone IDIs are an ideal method for gathering HCP perspectives because they allow flexible, interactive conversations in which the interviewer can adjust to — and probe as necessary on — points raised by participants. There are several methodological advantages of conducting IDIs by telephone, such as perceived anonymity, increased privacy for participants, and the ability for the interviewer to gather information rapidly (Farooq, et al., 2017). This method also offers logistical conveniences, including enhanced access to geographically dispersed interviewees, reduced costs, and greater flexibility for scheduling (Farooq, et al., 2017). Several studies have found telephone interviews to be an effective mechanism for data collection among health care professionals, including in clinical nursing research (Musselwhite, et al. 2017; Mealer, et al., 2014), among nursing and allied health professionals (Law et al., 2011), and among family physicians and gynecologists (Graham, et al., 2003; Hurst, et al., 2005).

The IDIs will have the following objectives:

- Assess providers' knowledge of the unique physical and mental health needs of active duty and veteran women.
- Understand providers' experiences, facilitators for, and barriers to caring for active duty and veteran women.
- Explore providers' informational and training needs related to caring for active duty and veteran women.

Recruitment

All physician and non-physician interviewees will meet the following eligibility criteria:

- Between the ages 25–65
- Mix of race/ethnicity
- See patients at least 75 percent of the time (e.g., 30 hours/week for a full-time HCP)
- At least 40 percent of patients are women ages 18–64
- Practice outside of VHA/MHS
- Regularly screen patients for active duty/veteran status (For those who do not regularly screen patients, the screener questionnaire will include a follow-up question for reasons why before terminating the respondent as ineligible.)
- Mix of practice type, including private practice, group practice, academic/academic teaching hospitals, and community health and public health settings, including at least two providers from a Federally Qualified Health Center (FQHC)
- Mix of practice settings, including rural, suburban and urban.

- Mix of patient population socioeconomic status
- Mix of geographic locations with high populations of active duty and veteran women (e.g., Virginia, Texas, California, Florida, Georgia and North Carolina). Appendix A provides a list of the top states for each audience, with citations.

We will work with Medscape market research, a national panel of over a million clinicians across specialties and professional categories. Medscape will:

- Use the approved screening questionnaires and informed consent language
- Distribute dial-in information and instructions to participants as they recruit them
- Remind participants 24 hours in advance of the IDI
- Disburse incentives to participants following the completion of each IDI

Physician interviewees will be offered an honorarium of $180 for a completed interview to reimburse them for their time, and non-physician interviewees will be offered $150.

Logistics
Hager Sharp will conduct the IDIs using a dedicated conference line. OWH will be able to dial in to each IDI to listen to the interview. We estimate that each interview will last approximately 60 minutes.

Analysis and Reporting
Audio from the IDIs will be recorded and submitted to GMR Transcription, a transcription services provider. Transcripts will be labeled by participant category and date of the interview and will not contain any personally identifiable information. The recordings will be destroyed after the report is made final.

We will use the transcripts from the IDIs to code and analyze the data using Dedoose qualitative analysis software. Analysis of the IDIs will focus on specific themes that emerge most frequently from the interviews. The final report will include an executive summary, overview, methodology, detailed findings with verbatim quotations, and recommendations.

Focus Groups with Active Duty and Veteran Women

Hager Sharp proposes conducting 16 focus groups among active duty and veteran women:

- Active duty women (4 groups of 8 participants each, n = 32)
- Veteran women (12 groups of 8 participants each, n = 96)

The focus groups will include a higher sample of veteran women based on OWH preference. Additionally, active duty women are often exposed to conditions during combat that may increase their health risks as they transition to veteran status. Having a larger sample of veteran women will allow us to gather robust feedback on how HCPs can best provide care to women after service.

The focus groups will have the following objectives:

- Understand veteran and active duty women's experiences, facilitators for, and barriers to receiving health care from providers outside of VHA/MHS.
- Determine the health information, online tools, and resources that are most needed to support the physical and mental health of active duty and veteran women.

Recruitment
All focus group participants will meet the following eligibility criteria (further defined in the focus group screener):

- Classify as active duty or veteran women

- Between the ages 18–64
  - Active duty women ages 41–64 are included to ensure representation from careered women in the military.
- Seek health care outside of VHA/MHS
- Mix of education levels
- Mix of income levels
- Mix of race/ethnicity

We will work with focus group facilities in each of the proposed locations to recruit for groups based on the segments below. Locations are based on cities with larger populations of active duty and veteran women, often due to proximity to large military bases. Focus group facility staff will contact active duty and veteran women from their databases to look for respondents who meet the eligibility criteria. A recruitment screener will be administered to ensure that those contacted through databases meet eligibility criteria.

Audience Segment	Age	No. of Groups	Location
Active Duty Women	18–40	1	San Diego, CA
		1	San Antonio, TX
	41–64	1	Virginia Beach, VA
		1	San Diego, CA
Veteran Women	18–40	2	San Antonio, TX
		2	Virginia Beach, VA
		2	San Diego, CA
	41–64	2	San Antonio, TX
		2	Virginia Beach, VA
		2	San Diego, CA

Participants will be offered an honorarium of $75 for completing a 90-minute focus group to reimburse them for their time.

Logistics
Each focus group session will include 8–10 participants — a number that allows for in-depth collection of information. During the focus groups, a moderator will use a guide to lead the participants through a discussion, and Hager Sharp team members will observe and take notes on the participants' comments and suggestions. The session will also be video and audio recorded.

Analysis and Reporting
Audio from the focus groups will be recorded and submitted to GMR for transcription. Transcripts will be labeled by participant category and date of the interview and will not contain any personally identifiable information. The recordings will be destroyed after the report is made final.

We will use the transcripts from the focus groups to code and analyze the data using Dedoose qualitative analysis software. Analysis of the groups will focus on specific themes that emerge most frequently from the focus groups. The final report will include an executive summary, overview, methodology, detailed findings with verbatim quotations, and recommendations.

Timeline

Formative Research Activities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Formative research plan development, review, and approval								

OMB package development, review, and approval								
Health care providers IDIs								
Active duty and veteran women focus groups								
Analysis and reporting								

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APPENDIX A: States With Largest Populations of Active Duty and Veteran Populations

Veteran Women

National Center for Veterans Analysis and Statistics, Department of Veterans Affairs. (2016). VetPop2016, Table 6L. Living Veterans by State, Age Group, and Gender, 2015-2045. Retrieved from https://www.va.gov/vetdata/veteran_population.asp.

Veteran women population by state, 2015 – Top 10

State	Total
Texas	168,967
California	142,904
Florida	142,193
Virginia	99,399
Georgia	84,894
North Carolina	78,061
Ohio	61,485
Pennsylvania	60,056
New York	58,453
Washington	55,168

Active Duty Population (not available by just women)

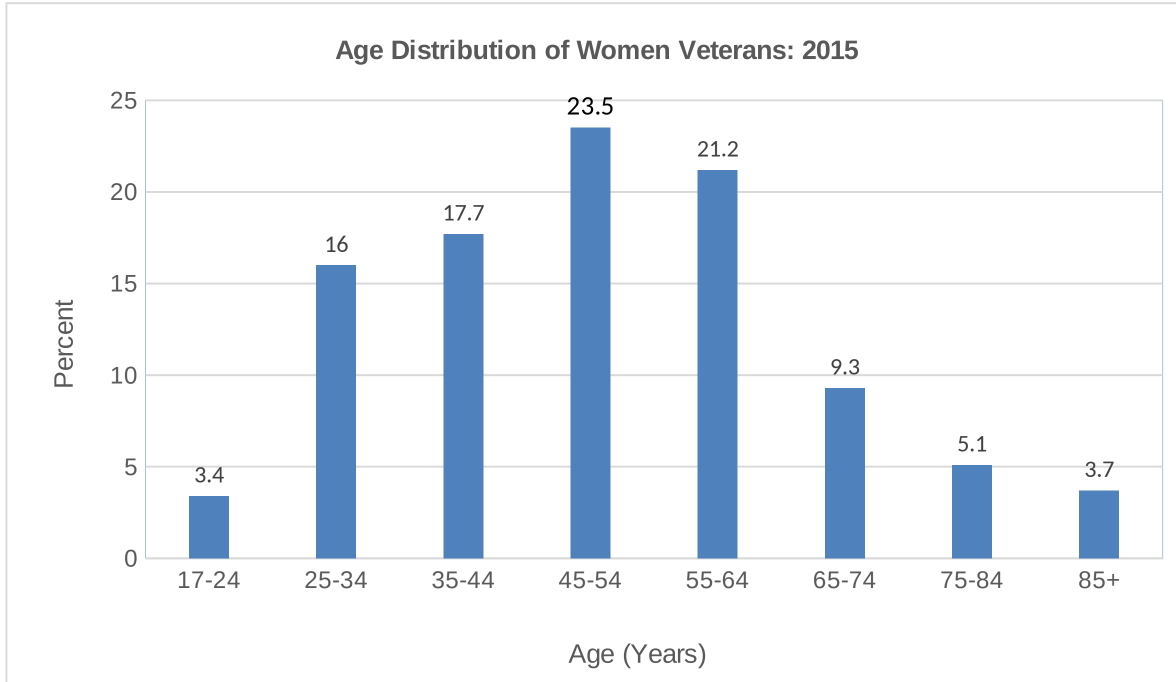
DoD Personnel, Workforce Reports & Publications, Department of Defense. (2018). Military and Civilian Personnel by Service/Agency by State/Country, September 2018. Retrieved from https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp.

Active duty population (men & women) by state, 2018 – Top 10

State	Total
California	158,281
Virginia	126,503
Texas	119,582
North Carolina	100,913
Georgia	65,873
Florida	65,276
Washington	60,153
Hawaii	42,981
South Carolina	40,085
Colorado	35,043

APPENDIX B: Age Distribution of Women Veterans: 2015

U.S. Census Bureau, American Community Survey, Public Use Microdata Sample, 2015
Prepared by the National Center for Veterans Analysis and Statistics
https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf



APPENDIX C: Race/Ethnicity Distribution of Women Veterans: 2015

U.S. Census Bureau, American Community Survey, Public Use Microdata Sample, 2015
Prepared by the National Center for Veterans Analysis and Statistics
https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf