HHS Public Access

Author manuscript

Womens Health Issues. Author manuscript; available in PMC 2020 January 01.

Published in final edited form as:

Womens Health Issues. 2019 ; 29(1): 64–71. doi:10.1016/j.whi.2018.10.005.

Local leaders' perspectives on women Veterans' health care: what would ideal look like?

Julian Brunner, PhD, MPH[a], **Cindy L. Cain, PhD**[b], **Elizabeth M. Yano, PhD, MSPH**[a,c], **Alison B. Hamilton, PhD, MPH**[a,d]

[a]VA HSR&D Center for the Study of Healthcare Innovation, Implementation, and Policy, VA Greater Los Angeles Healthcare System, 16111 Plummer Street, Building 25 (Mailcode 152), Sepulveda, CA 91343, USA

[b]Department of Sociology, University of Alabama at Birmingham, Birmingham, LA 35294, USA

[c]Department of Health Policy & Management, UCLA Fielding School of Public Health, 650 Charles E. Young Drive South, Los Angeles, CA 90095-1772, USA

[d]Department of Psychiatry and Biobehavioral Sciences, UCLA Geffen School of Medicine, Los Angeles, CA 90095, USA

Abstract

Background: The Veterans Health Administration (VHA) faces challenges in providing comprehensive, gender-sensitive care for women. National policies have led to important advancements, but local leadership also plays a vital role in implementing changes and operationalizing national priorities. In this paper, we explore notions of ideal women Veterans' health care articulated by women's health leaders at local VHA facilities and regional networks, with the goal of identifying elements that could inform practice and policy.

Methods: We conducted semi-structured interviews with 86 local and regional women's health leaders at 12 VHA medical centers across four regions. At the conclusion of interviews about women's primary care, participants were asked to imagine "ideal care" for women Veterans. Interviews were transcribed and coded using a hybrid inductive/deductive approach.

Main findings: In describing ideal care, participants commonly touched on: whether women Veterans should have separate primary care services from men; the need for childcare, expanded reproductive health services, resources and staffing; geographic accessibility; the value of input from women Veterans; physical appearance of facilities; fostering active interest in women's health across providers and staff; and the relative priority of women's health at the VHA.

Principal conclusions: Policy and practice changes to care for women Veterans must be mindful of key stakeholders' vision for that care. Specific features of that vision include: clinic construction that anticipates a growing patient population; providing childcare and expanded reproductive health services; ensuring adequate support staff; expanding mechanisms to incorporate women Veterans' input; and fostering a culture oriented towards women's health at the organizational level.

Corresponding Author: Julian Brunner, Office: (818) 891-7711 x36062; Mobile: (773) 505-6410, julian.brunner@va.gov.

Introduction

Women Veterans represent the fastest-growing proportion of patients in the Veterans Health Administration (VHA), and are expected to comprise 14% of the Veteran population by the year 2030 (U.S. Department of Veterans Affairs, 2014a). The VHA has established policies and programs to better equip VHA personnel and facilities to meet the demands of this rapid growth. These national efforts have led to important advancements (Yano et al., 2016), but local leadership also plays a vital role in implementing changes and operationalizing goals at the front lines. In this paper, we describe local VHA stakeholders' perspectives about ideal women Veterans' health care.

Evolution of Women's Health at VHA

In the 1990s, comprehensive women's health centers were introduced in response to documented gaps in care for women Veterans. As demand for women's health at VHA grew, the number of women's health centers expanded substantially, though the comprehensiveness of the services offered at these centers varied (Yano 2006). In 2010, VHA policy established standards for "complete primary care" for women Veterans. Acknowledging the heterogeneity of VHA medical centers' needs and capacity, the policy established three models of women's health care for VHA medical centers to choose from: 1) gender-integrated primary care clinics with one or more designated women's health providers, 2) separate but shared space for women's health (within or adjacent to primary care), and 3) entirely separate women's health center with a separate entrance. Across all three models, the policy emphasized attention to gender-sensitive care, i.e. care that includes gender-specific services (e.g. female reproductive health services), is attuned to sex differences in the prevalence, presentation or treatment of conditions, and reflects women's preferences (Yano, Haskell, & Hayes, 2014).

This policy directive was launched alongside the VHA's patient-centered medical home model—Patient Aligned Care Teams (PACT)—that mandated a team-based approach to primary care (Ladebue et al., 2016). The present study takes place in the context of a systematic effort ("Women's Health PACT") to tailor the PACT model to meet the needs of women Veterans (Yano et al., 2016).

Chronic Care Model

The project in which this study is situated was guided by the Chronic Care Model (CCM), which identifies six components of primary care practice transformation and improvement: health care organization, self-management support, delivery system design, decision support, clinical information systems, and community resources and policies (Bodenheimer, Wagner, & Grumbach, 2002). This study offers an opportunity to enrich the application of the CCM to VHA women's health with perspectives from its key stakeholders.

Evidence about women Veterans' health care needs

Evidence to date about women Veterans' health care and the factors that improve it necessarily comes from many sources, including women Veterans themselves. A 2011 systematic review identified studies employing focus groups and surveys evaluating women

Veterans' perceptions of and satisfaction with VHA health care, as well as studies using administrative or clinical outcomes to evaluate quality measures or test interventions (Bean-Mayberry et al., 2011). This research is complemented by results of a 2012 panel of experts in women's health, who prioritized key aspects of care that most require tailoring to provide gender-sensitive, comprehensive care for women Veterans (deKleijn, Lagro-Janssen, Canelo, & Yano, 2015). The panel made recommendations across domains ranging from the services available in ambulatory settings, to coordination of referrals, to quality improvement capacity. Each of these types of evidence can help inform the design of women Veterans' health care by outlining patient needs and preferences, evaluating specific interventions or programs, and highlighting the aspects of care that might differ for men and for women in the VHA.

However, a growing implementation science literature has repeatedly demonstrated the importance of gathering evidence not only from patients and providers, but also from leaders, i.e., the practitioners and decision-makers who translate policy into practice, who face difficult trade-offs in pursuing improved quality of care (Atkins & Lipson, 2015). The emerging consensus regarding the importance of these perspectives motivated the analysis reported in this study (Bauer et al., 2016; Kirchner et al., 2012; Parker et al., 2009). The purpose of this paper is to present visions for women Veterans' health care as articulated by women's health leaders at VHA facilities and regional networks, with the goal of identifying elements that could inform practice and policy.

Methods

Design and Setting

Within the context of a multisite implementation trial of evidence-based quality improvement for tailoring PACT to women's health (Yano et al., 2016), we conducted semi-structured interviews with leaders of women's health care at 12 VA medical centers (VAMCs), and these VAMCs were selected to span four separate VHA service regions across the United States to increase geographical representativeness. VHA refers to these regions as "Veterans Integrated Services Networks." All participating sites were members of the VHA Women's Health Practice-Based Research Network, a 60-site national network of VHA facilities designed to help ensure that women Veterans are represented in VHA research (Frayne et al., 2013), and leaders from all three models of women's health care delivery (separate, shared, and integrated) were included.

Sample

As shown in Table 1, we interviewed leaders at VAMCs as well those from regional VHA offices. Participants included administrative directors, medical directors, directors of primary care, and directors of women's health. They also included staff responsible for mental health, quality measurement and improvement, health informatics, and clinical research. Some had roles that include care for women Veterans alongside other responsibilities; others had roles devoted to women's health. These roles included Women's Health Medical Director (a clinical supervisory role in women's health, whose relationship to primary care varies by site), Women Veterans Program Manager (a programmatic role which is mandatory

at every VA medical center), as well as regional analogues to both roles. Across the 12 sites, a total of 91 individuals were invited to participate, and 87 (96%) were interviewed, with an average of five participants at each site (range, 3–8 participants per site). Additional information about the sample is available in a previous publication (Hamilton et al., 2017a).

Procedures

Participants were recruited via email, with telephone follow-up as needed. Interviews were conducted between May and December of 2014. All interviews were conducted by phone by the senior author, an anthropologist and expert qualitative methodologist, and at least one team member. On average, interviews lasted between 30–45 minutes. With participants' verbal consent, all interviews were recorded and professionally transcribed. All procedures were reviewed and approved by the Institutional Review Board.

Interview protocol

The semi-structured interview guide included questions about the organization of women's health at the respondent's facility or facilities, the implementation of the VHA's patient-centered medical home model (PACT) within women's health, and quality improvement efforts in women's health. Data in this analysis are drawn from responses to the question, asked at the end of each interview: "If you could design women Veterans' health care in any way you wanted, what would it look like?" We referred to this question as our "queen/king for the day" question, which seemed to foster contemplation among participants.

Analysis

The initial codebook contained deductive codes that pertained to the interview guide questions, e.g., the question of "ideal care" for women Veterans. Two researchers applied the deductive codes to the responses, and then applied additional inductive codes based on the content of the responses that went beyond the original deductive codes. The two researchers met to reconcile the codebook and develop common definitions of inductive codes. Subsequently, both researchers coded the remaining transcripts using the hybrid codebook and met again to resolve discrepancies in coding (Miles & Huberman, 1994). After coding was completed, we aggregated codes to themes, and mapped them onto CCM components (Bodenheimer et al., 2002). We present themes according to CCM to identify the ways in which components were invoked in defining ideal care for women Veterans. ATLAS.ti v.7 (Scientific Software Development GmbH, 2013) was used for data management.

Results

Participants were typically surprised and pleased to have an opportunity to consider and articulate their vision for women Veterans' ideal care. Key inductive themes from interviews mapped to the CCM components of health care organization, self-management support, and delivery system design. The themes and corresponding subthemes are presented in Table 2.

Care Model

The theme that respondents raised most frequently was the question of whether services for women Veterans should be women-only or mixed gender. Respondents voiced a diversity of

views about the ideal model of care for women Veterans: several expressed ambivalence about the ideal model of care, giving examples of the various advantages and disadvantages of each approach. Several suggested that an ideal model would offer both options: a women-only clinic as well as gender-sensitive care in a mixed-gender setting, to meet the needs of women Veterans with different preferences.

A minority of respondents expressed a preference for mixed-gender primary care. These respondents cited factors like the ability to share staff and resources, and enhanced opportunities for providers to interact with and learn from one another. A women's health medical director at a facility with a women-only primary care clinic explained, "We're in a silo and it creates a tough work environment, especially for the providers. There's nobody to talk to, you can't bounce cases off of anyone, and all of the services are in the other area where the other primary care providers are."

In contrast, many described the importance of providing a separate space for women Veterans, and cited many women Veterans' preferences to be treated in a setting that is exclusively or at least primarily reserved for women. A Women Veterans Program Manager explained:

> "I really think that the [ideal] model is the separate women's health clinic with everything co-located, the one-stop shopping. The women that receive their care in those kinds of clinics really, really rave about the care. They rave about the physical setting, the privacy. All of that is just really, really nice for them, but I recognize that that's not going to be possible when you have a storefront [community-based outpatient center] with 200 women involved."

Making clinics feel safe to Veterans who have experienced military sexual trauma was identified as a key factor. A regional network director described,

> "We need to think about a physically separate safe space, because there is a significant cohort of individuals who have been significantly adversely impacted by interaction with individuals of authority, whatever gender. And so, having a safe place that kind of recognizes that is, I think, one of our responsibilities."

Organizational culture

A common thread across many responses was the importance of organizational culture. It was discussed in two ways: first, cultivating a strong interest among providers and staff to work with women Veterans; and second, prioritizing women's health more consistently.

The importance of fostering active interest in women's health was generally raised in the context of a conversation about competency in women's health care. Respondents explained that in addition to training and proficiency in women's health, providers and staff must have an active interest in caring for women Veterans. A regional Women Veterans Program Manager elaborated: "I would want to have all providers… interested in providing comprehensive women's healthcare… hire them with the understanding that that's what they're going to do; that it's part of their job." Some sites described a robust interest, across many providers, in caring for women Veterans, particularly among recent graduates and

among providers who are relatively new to the VHA and want to maintain their skills in women's health. Others noted that some general primary care providers preferred to care primarily for male Veterans, and in some cases, even declined to have female patients on their panel.

Organizational culture was also discussed in the context of how women's health is regarded and prioritized. A Women Veterans Program Manager explained that in some cases, the principle that men and women should be treated equally can have adverse consequences: "All too often we hear, 'Why are we giving our women special treatment; why isn't the healthcare that our men receive good enough?' You know, that's frustrating. There's obvious differences between the healthcare needs of men and women." Another Women Veterans Program Manager emphasized a similar idea and noted substantial recent progress: "I think that the culture change within the hospitals and within VA in general is really, really, really important. I actually see it changed here over the last couple of years. I really feel it from other providers in other areas, like in mental health, that really people get the message of, 'It's everyone's job to take care of women Veterans.'"

Experience of care

Several respondents, in addition to offering their own views, emphasized the importance of eliciting and incorporating the preferences of women Veterans in designing care at an individual and organizational level. At an individual level this entailed engaging women Veterans in choices about their own care, and recognizing and responding to individual preferences and differences across women. At an organizational level, respondents explained that women Veterans need to have a prominent and continuous voice in determining which services are offered and how. Multiple leaders of VHA medical centers described the value of this approach, and one strongly recommend listening sessions with women Veterans for anyone in a leadership role above women's health. One leader explained: "The starting point would be to ensure that we understand what women Veterans want and what's missing: what are the gaps in terms of what they want and what we deliver? [Then we] try to tailor it to close those gaps."

The physical appearance of healthcare facilities was also an area of focus. Respondents suggested that the clinic environments could be more 'pleasant,' 'uplifting,' 'light,' and 'warm.' Several respondents, particularly those in facility leadership roles, noted that the physical environment of a clinic affects whether it is perceived as inviting, and can have an impact on patients' experience of care.

Resources and staff

Addressing resource insufficiencies was a substantial focus of participants' visions for ideal care. Participants noted space constraints – not only as a current barrier but as an increasingly important factor as the population of women Veterans grows. Participants indicated that current construction and remodeling efforts must anticipate this growth so that clinical spaces meet women Veterans' needs for a long time without requiring further construction. A women's health medical director described a renovated space that the women's health clinic would soon be moving to: "We tried to create, as much as possible,

some of the things that we knew that we always wanted in the old clinic that we didn't have. My concern is that we probably are going to be outgrowing the new clinic pretty quickly." Current space constraints were also described as a barrier to providing more services in closer proximity to one another, e.g., mental health services near primary care.

Staffing was also a common theme, with several calling for "at a minimum" a dedicated care coordinator and co-located mental health professional in women's health clinics, and more robust support staff in women's health.

Services

Specific services for Veterans' children and families were mentioned several times within participants' conceptualizations of ideal care. In particular, respondents identified a need for childcare. For example, a nurse executive explained: "With having more women in the system now we're finding that we have little kids showing up during a CT scan or an MRI scan or that sort of thing and we don't have good drop-off care." Other respondents identified much more modest steps that clinics could take (e.g., providing toys in primary care waiting rooms) and some identified more ambitious steps, such as providing drop-in healthcare services for the families of Veterans.

Reproductive health services also featured prominently, with multiple respondents noting that the large numbers of younger Veterans coming to the VHA creates a need for preconception counseling. A director of primary care explained that the cost of over-the-counter emergency contraception can be a barrier for some Veterans, and suggested that access to emergency contraception could be improved. Another director of primary care emphasized unique medical concerns for women of childbearing age: "We still don't advise regularly regarding folic [acid] use and whether some of the anti-seizure medications, anti-psychotic medications should be considered to be relooked at if somebody's trying to get pregnant." This respondent also suggested that the VHA's electronic health record system could be used to address this problem by prompting providers to discuss preconception with women of childbearing age who are not on birth control.

Several respondents described potential improvements to the geographic accessibility of care, suggesting that in an ideal system, a greater range of women's health services would be available at community-based outpatient clinics (i.e., so that women Veterans do not need to travel to a larger VA medical center for care). A regional medical officer explained, "We'd obviously like to be able to deliver the needed care to people in a convenient location when they would like it. And, of course the challenge being is that what we're trying to do obviously is get enough primary care providers so that the convenient location and the expertise is available, at least, at all of our [community-based outpatient clinics], so people don't need to travel all the way to the medical centers."

Discussion

This qualitative study identified prominent features of visions for women Veterans' health care articulated by local and regional leaders of women's health within the VHA. These perspectives encompassed multiple views about how to structure and deliver women's health

care; suggestions for additional high-value services; specific opportunities and potential mechanisms for improving staffing and clinical workspaces; a consistent emphasis on incorporating input from women Veterans; and nuanced recommendations for improving organizational culture with respect to women Veterans. These findings can guide the development of policies and practices that resonate with the key concerns of "implementers" – i.e., policies that reflect the most salient opportunities as defined by the leaders who would play a critical role in implementing those policies.

Our findings also help enrich the CCM by identifying salient themes within the components of health care organization, self-management support, and delivery system design. To best contextualize results, the remainder of our discussion is organized according to the key inductive themes.

Care Model

Participants' responses about optimal women's healthcare models (e.g., women-only, mixed-gender) helped to highlight the considerations that determine the best care model for a given site, and bolstered the case for supporting a diversity of care models (Reddy, Rose, Burgess, Charns, & Yano, 2016). Arguments in favor of greater integration between women's health and general primary care tended to emphasize the impact on providers and staff (e.g., avoiding isolation), while arguments in favor of separation tended to emphasize feedback that respondents had received directly from women Veterans, particularly regarding the impact of the prevalence of military sexual trauma on how women prefer to receive their care (Yano & Hamilton, 2017).

Organizational culture

Previous discussions of organizational culture with respect to women Veterans have emphasized the way that women are treated at VHA facilities (deKleijn et al., 2015). In contrast, our findings about VHA's cultural orientation towards women's health address the way that VHA leadership and employees make structural decisions about care for women Veterans, e.g., recognizing the ways in which women and men have different medical needs, and hiring employees with an active interest in caring for women. This issue in particular exemplifies the importance of organizational culture. The VHA requires sites to designate specific providers who are interested and proficient in caring for women, and holds "mini-residencies" to help train or retrain providers in women's health care (Bastian et al., 2014). These and other training efforts can support the providers who have an interest in women's health, but who may not yet have developed the proficiency. VA medical centers without a pipeline of medical trainees may experience the issue most acutely, and have the greatest opportunity for care to be improved by culture change at the organizational level.

Experience of care

The importance of engaging women Veterans in decisions about VHA overall was a prominent theme, and was one of the only themes that was concentrated among participants from a given role: senior leadership with particularly broad responsibilities (e.g., VA medical center Chiefs of Staff) were consistent in emphasizing the importance of soliciting and incorporating women Veterans' input in decisions about the way that care is organized, and

the experience of care at the VHA. The “listening sessions” that were recommended by a participant represent one promising approach for clinical administrators to better appreciate the concerns and priorities of women Veterans. On a smaller scale, some women’s health teams have conducted focus groups with women Veterans, enabled in large part by training in focus group techniques. Our research team provided this training after our interviews were conducted, as part of the “Evidence-Based Quality Improvement” intervention that forms the context for this study (Yano et al., 2016). These local efforts, focused on women Veterans, complement national initiatives that have collected Veterans’ perspectives to inform program priorities and design (Hamilton et al., 2017; U.S. Department of Veterans Affairs, 2011).

Resources and staff

The space constraints in some women’s health clinics seem to be at least in part attributable to the difficulty of projecting future demands. Even if precise long-term forecasts are infeasible, innovations in population projection and planning may help (Mestre, Oliveira, & Barbosa-Póvoa, 2015), and the ability to include more diverse information sources might improve forecasts’ accuracy. The remaining uncertainty can also be mitigated by using flexible infrastructure design principles to “future-proof” construction where possible (Carthey, Chow, Jung, & Mills, 2011). Finally, the development of regulatory standards for women’s health exam rooms could promote availability of the larger exam rooms needed for women’s care (e.g., for an exam table with stirrups), and this standardization could in fact facilitate increased flexibility (Ahmad, Price, & Demian, 2014).

Concerns about understaffing are common across the healthcare system (Blendon et al., 2002). Our findings help identify the most salient of these concerns within VHA women’s health. Although there is considerable variability in staffing needs across sites, a desire for more support staff (e.g., registered nurses, licensed practical nurses, and clerks) was more common than a desire for additional providers. Respondents at sites without a care coordinator or mental health provider co-located in women’s health viewed the addition of these roles as significant opportunities for improvement.

Services

Respondents highlighted the potential value of providing childcare for patients’ children during healthcare visits. Other studies have found that male Veterans frequently report a lack of childcare as a barrier to care, and that the barrier is even more substantial for women Veterans (Tsai, David, Edens, & Crutchfield, 2013). The VHA ran a pilot program in 2011–13 to offer free drop-in childcare services at three medical centers, but legislative changes would be required for such services to be expanded nationwide (Tsai et al., 2013).

Respondents emphasized provider-level factors that could improve preconception care, e.g., being more consistent and comfortable discussing the initiation and continuation of contraception, and warning about medications that are contraindicated for women who might become pregnant. Major steps toward this goal have already begun, including a validated approach for reproductive life planning (Callegari, Aiken, Dehlendorf, Cason, & Borrero, 2017; Callegari et al., 2015), a prescribing framework for teratogenic medications

(Shroff, McNeil, & Borrero, 2017), and a mobile application to aid providers in preconception counseling (U.S. Department of Veterans Affairs, 2018).

Statements about the geographic accessibility of care helped to highlight areas of concern, and reiterated participants' desire to expand contraceptive services. Hormonal contraception is widely available at VHA clinics (U.S. Department of Veterans Affairs, 2014b), but long-acting reversible contraception is more commonly available in hospital-based clinics than in community-based clinics (Katon et al., 2013). Stakeholders who oversee both of these settings are well positioned to notice the differences between them, and to recognize opportunities to replicate successes.

Limitations

The scope of our analysis was limited to a subset of the many stakeholders in women Veterans' health care. The primary stakeholders are of course women Veterans themselves; researchers and policymakers alike should continue to obtain and act upon women Veterans' perspectives (Kehle-Forbes et al., 2017; Wagner, Dichter, & Mattocks, 2015). Similarly, frontline clinical workers and staff can provide crucial insight into the optimal design of care, which is why these perspectives have been explored in previous studies (Chuang et al., 2017; Tucker, Singer, Hayes, & Falwell, 2008). However, we are unaware of studies that have collected insights from local leadership on the ideal design of women Veterans' health care.

Another limitation is the potential priming effects of other interview questions. Our analysis is based on responses to the final question in interviews that emphasized primary care, the organization of women's health, and quality improvement efforts. These topics may have primed participants to focus on primary care and give less consideration to specialty services. Furthermore, participants were asked to answer an unconstrained, philosophically-oriented question without preparation. Additional time for reflection may have yielded different responses, and indeed, several respondents asked for a few moments to consider their responses.

Implications for Practice and/or Policy

Healthcare systems are increasingly recognizing the ways in which local leadership can make or break attempts at transformation. As systems adapt to changing patient populations, understanding the aspirational visions of local leadership is a crucial step in formulating future policy. Our findings serve as proof-of-concept for an approach to eliciting these ideas, and identify specific and complementary paths toward stakeholders' operational ideals for women Veterans' healthcare delivery: first, projecting and anticipating growth in women's health programs; second, building on the VHA's pilot program to provide child care for patients' children during visits; third, designing a hiring process to more consistently recruit providers with strong interest in caring for women; and fourth, conducting listening sessions and creating other opportunities that allow senior VHA leadership to hear women Veterans' perspectives and preferences directly.

Conclusions

Our study identified several features of local VHA women's health leaders' ideal state of health care for women Veterans. Beyond these individual features, our study helps illustrate the potential value of asking stakeholders to explore "blue sky" solutions to complex challenges, and to concentrate on goals rather than constraints. We hope this approach can elicit stakeholder insight for researchers and administrators alike.

Funding Statement:

The study was conducted in partnership with VA Women's Health Services. This project was funded by the VA HSR&D Service Women Veterans Healthcare CREATE project on Implementation of Women's Health Patient Aligned Care Teams (Project #CRE 12–026), a cluster randomized trial registered in ClinicalTrials.gov . Funding was also provided by VA HSR&D SDR 10–012 (Women's Health Research Network, PIs Yano, Frayne, Hamilton). Dr. Brunner's effort was supported by a predoctoral fellowship awarded by NIH/National Center for Advancing Translational Science (NCATS), UCLA CTSI Grant Numbers TL1TR000121 and TL1TR001883. Dr. Yano's effort was funded by a VHA HSR&D Senior Research Career Scientist Award (Project # RCS 05–195). The views expressed in this study are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

References

Ahmad AM, Price A, & Demian P (2014). Impact of Space Flexibility and Standardisation on Healthcare Delivery. International Journal of Applied Science and Technology, 4(4).

Atkins D, & Lipson L (2015). The role of research in a time of rapid change: lessons from research on women veterans' health. Med Care, 53(4 Suppl 1), S5–7. doi:10.1097/MLR.0000000000000345 [PubMed: 25767976]

ATLAS.ti, v. 7. (2013). Berlin, Germany: Scientific Software Development GmbH.

Bastian LA, Trentalange M, Murphy TE, Brandt C, Bean-Mayberry B, Maisel NC, …Haskell S (2014). Association between women veterans' experiences with VA outpatient health care and designation as a women's health provider in primary care clinics. Womens Health Issues, 24(6), 605–612. doi:10.1016/j.whi.2014.07.005 [PubMed: 25442706]

Bauer MS, Miller C, Kim B, Lew R, Weaver K, Coldwell C, …Kirchner J (2016). Partnering with health system operations leadership to develop a controlled implementation trial. Implement Sci, 11, 22. doi:10.1186/s13012-016-0385-7 [PubMed: 26912342]

Bean-Mayberry B, Yano EM, Washington DL, Goldzweig C, Batuman F, Huang C, …Shekelle PG (2011). Systematic review of women veterans' health: update on successes and gaps. Womens Health Issues, 21(4 Suppl), S84–97. doi:10.1016/j.whi.2011.04.022 [PubMed: 21724149]

Blendon RJ, DesRoches CM, Brodie M, Benson JM, Rosen AB, Schneider E, …Steffenson AE (2002). Views of practicing physicians and the public on medical errors. N Engl J Med, 347(24), 1933–1940. doi:10.1056/NEJMsa022151 [PubMed: 12477944]

Bodenheimer T, Wagner EH, & Grumbach K (2002). Improving primary care for patients with chronic illness. Jama, 288(14), 1775–1779. [PubMed: 12365965]

Callegari LS, Aiken AR, Dehlendorf C, Cason P, & Borrero S (2017). Addressing potential pitfalls of reproductive life planning with patient-centered counseling. Am J Obstet Gynecol, 216(2), 129–134. doi:10.1016/j.ajog.2016.10.004 [PubMed: 27776920]

Callegari LS, Borrero S, Reiber GE, Nelson KM, Zephyrin L, Sayre GG, & Katon JG (2015). Reproductive Life Planning in Primary Care: A Qualitative Study of Women Veterans' Perceptions. Womens Health Issues, 25(5), 548–554. doi:10.1016/j.whi.2015.05.002 [PubMed: 26123640]

Carthey J, Chow V, Jung YM, & Mills S (2011). Flexibility: beyond the buzzword-practical findings from a systematic literature review. HERD, 4(4), 89–108. doi:10.1177/193758671100400407 [PubMed: 21960194]

Chuang E, Brunner J, Mak S, Hamilton AB, Canelo I, Darling J, … Yano EM (2017). Challenges with implementing a patient-centered medical home model for women Veterans. Women's Health Issues, 27(2), 214–220. doi:10.1016/j.whi.2016.11.00 [PubMed: 28063848]

deKleijn M, Lagro-Janssen AL, Canelo I, & Yano EM (2015). Creating a roadmap for delivering gender-sensitive comprehensive care for women Veterans: results of a national expert panel. Med Care, 53(4 Suppl 1), S156–164. doi:10.1097/MLR.0000000000000307 [PubMed: 25767971]

Frayne SM, Carney DV, Bastian L, Bean-Mayberry B, Sadler A, Klap R, … Yee EF (2013). The VA women's health practice-based research network: amplifying women veterans' voices in VA research. Journal of General Internal Medicine, 28(2), 504–509. [PubMed: 23070656]

Hamilton AB, Brunner J, Cain C, Chuang E, Luger TM, Canelo I, & Yano EM (2017a). Engaging multilevel stakeholders in an implementation trial of evidence-based quality improvement in VA women's health primary care. Translational behavioral medicine, 7(3), 478–485. [PubMed: 28585163]

Hamilton AB, Farmer MM, Moin T, Finley EP, Lang AJ, Oishi SM, … Bean-Mayberry B (2017b). Enhancing Mental and Physical Health of Women through Engagement and Retention (EMPOWER): a protocol for a program of research. Implement Sci, 12(1), 127. doi:10.1186/s13012-017-0658-9 [PubMed: 29116022]

Katon J, Reiber G, Rose D, Bean-Mayberry B, Zephyrin L, Washington DL, & Yano EM (2013). VA location and structural factors associated with on-site availability of reproductive health services. J Gen Intern Med, 28 Suppl 2, S591–597. doi:10.1007/s11606-012-2289-9 [PubMed: 23807070]

Kehle-Forbes SM, Harwood EM, Spoont MR, Sayer NA, Gerould H, & Murdoch M (2017). Experiences with VHA care: a qualitative study of U.S. women veterans with self-reported trauma histories. BMC Womens Health, 17(1), 38. doi:10.1186/s12905-017-0395-x [PubMed: 28558740]

Kirchner JE, Parker LE, Bonner LM, Fickel JJ, Yano EM, & Ritchie MJ (2012). Roles of managers, frontline staff and local champions, in implementing quality improvement: stakeholders' perspectives. J Eval Clin Pract, 18(1), 63–69. doi:10.1111/j.1365-2753.2010.01518.x [PubMed: 20738467]

Ladebue AC, Helfrich CD, Gerdes ZT, Fihn SD, Nelson KM, & Sayre GG (2016). The experience of Patient Aligned Care Team (PACT) members. Health Care Manage Rev, 41(1), 2–10. doi:10.1097/HMR.0000000000000048 [PubMed: 25539056]

Mestre AM, Oliveira MD, & Barbosa-Póvoa AP (2015). Location–allocation approaches for hospital network planning under uncertainty. European Journal of Operational Research, 240(3), 791–806. doi:10.1016/j.ejor.2014.07.024

Miles MB, & Huberman AM (1994). Qualitative data analysis: An expanded sourcebook: sage.

Parker LE, Kirchner JE, Bonner LM, Fickel JJ, Ritchie MJ, Simons CE, & Yano EM (2009). Creating a quality-improvement dialogue: utilizing knowledge from frontline staff, managers, and experts to foster health care quality improvement. Qual Health Res, 19(2), 229–242. doi:10.1177/1049732308329481 [PubMed: 19092141]

Reddy SM, Rose DE, Burgess JF Jr., Charns MP, & Yano EM (2016). The Role of Organizational Factors in the Provision of Comprehensive Women's Health in the Veterans Health Administration. Womens Health Issues, 26(6), 648–655. doi:10.1016/j.whi.2016.09.001 [PubMed: 27745998]

Shroff S, McNeil M, & Borrero S (2017). An Innovative Framework to Improve Teratogenic Medication Risk Counseling. J Midwifery Womens Health, 62(3), 353–357. doi:10.1111/jmwh.12604 [PubMed: 28485536]

Tsai J, David DH, Edens EL, & Crutchfield A (2013). Considering child care and parenting needs in Veterans Affairs mental health services. Eval Program Plann, 39, 19–22. doi:10.1016/j.evalprogplan.2013.03.003 [PubMed: 23570988]

Tucker AL, Singer SJ, Hayes JE, & Falwell A (2008). Front-line staff perspectives on opportunities for improving the safety and efficiency of hospital work systems. Health Serv Res, 43(5 Pt 2), 1807–1829. doi:10.1111/j.1475-6773.2008.00868.x [PubMed: 18522667]

U.S. Department of Veterans Affairs. (2011). Voice of the veteran survey. Retrieved from https://mobile.va.gov/sites/default/files/files/VoiceofVeteranOPCCCTReport.pdf

U.S. Department of Veterans Affairs. (2014a). Profile of women veterans. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2014.pdf

U.S. Department of Veterans Affairs. (2014b). The State of Reproductive Health in Women Veterans. Retrieved from https://www.womenshealth.va.gov/WOMENSHEALTH/docs/SRH_FINAL.pdf

U.S. Department of Veterans Affairs. (2018). Preconception Care App. Retrieved from https://mobile.va.gov/app/preconception-care

Wagner C, Dichter ME, & Mattocks K (2015). Women Veterans' Pathways to and Perspectives on Veterans Affairs Health Care. Womens Health Issues, 25(6), 658–665. doi:10.1016/j.whi.2015.06.009 [PubMed: 26341566]

Yano EM, Bastian LA, Frayne SM, Howell AL, Lipson LR, McGlynn G, & Fihn SD (2006). Toward a VA women's health research agenda: Setting evidence-based priorities to improve the health and health care of women veterans. Journal of General Internal Medicine, 21(3), S93–S101. [PubMed: 16637953]

Yano EM, Darling JE, Hamilton AB, Canelo I, Chuang E, Meredith LS, & Rubenstein LV (2016). Cluster randomized trial of a multilevel evidence-based quality improvement approach to tailoring VA Patient Aligned Care Teams to the needs of women Veterans. Implement Sci, 11(1), 101. doi:10.1186/s13012-016-0461-z [PubMed: 27435723]

Yano EM, & Hamilton AB (2017). Accelerating delivery of trauma-sensitive care: Using multilevel stakeholder engagement to improve care for women veterans. Fam Syst Health, 35(3), 373–375. doi:10.1037/fsh0000288 [PubMed: 28945449]

Yano EM, Haskell S, & Hayes P (2014). Delivery of gender-sensitive comprehensive primary care to women veterans: implications for VA Patient Aligned Care Teams. J Gen Intern Med, 29 Suppl 2, S703–707. doi:10.1007/s11606-013-2699-3 [PubMed: 24715395]

Table 1.

Sample characteristics

Feature	N
Number of sites	12
Number of key stakeholders	87
Regional stakeholders	26
Local stakeholders	61

Table 2.

Themes regarding the ideal design of care for women Veterans

Chronic Care Model Component	Theme / Subtheme	Illustrative Quotes
Health care organization	Care model	"Well I think [ideal care] would involve a great deal of choice for women Veterans… … I am of two minds with this because I've had women Veterans tell me both sides of the coin. Some say hey I served… …I don't need anything special, I don't want my care separate… …Then we talk to other women Veterans that say, 'I really want my own clinic; I want it to be separate."
		"We've made a focus on this, all of our medical centers have separate women's clinics… …Many of the women like that arrangement and so we've made sure that we've built that. It's something that meets a need… …I think particularly in the VA which tends to be more male oriented, that the women Veterans appreciate having this kind of space"
	Organizational culture	
	Active interest in women's health	"I hope that… …that we have people in all of our primary care clinics who are doing women's health and feel confident in doing women's health and have teams, you know, nursing staff who enjoy and are confident in doing women's health."
	Relative priority of women's health	"If I had my wish… …the medical center directors would be required to make [women's health] a priority and not the stepchild. My biggest complaint is that whenever primary care staff are down, they pull people who work in women's health clinic to fill in in primary care."
Self-management support	Experience of care	
	Input from women Veterans	"I think this whole effort to change the conversation and return the focus to patients and what's important to them in their lives is really the direction that we want to go not only with women's health, but with all of the healthcare that we deliver."
	Facility appearance	"When you walk into the building or to the service area, the department, it's warm, it's inviting… …some place where a woman can go and feel comfortable, relaxed, and have her health needs addressed."
Delivery system design	Resources and staff	
	Workspace	"I would like to see… …some more defined space, with some co-located services… …It seems like in most of our main facilities, there's women's primary care, but then all the services are spread out throughout the hospital."
	Staffing	"We still don't have adequate resources primarily around support staff and care coordination. So from my perspective here where we have plenty of designated women's health providers, we still have issues with, number one, we need more co-located mental health; number two, we need greater resources for care coordination."
	Services	
	Childcare	"I'd love to see Congress approve childcare for patients in our facilities. We have been asking for a long time for that."
	Reproductive health	"As we get younger and younger Vets coming in… …we need to get more comfortable with family planning issues, contraception and how to be very women-centered in terms of how we administer, initiate and continue contraception,"
	Geographic accessibility	"We have certain things at one campus and maybe a lack of a particular service at another campus. I would like to see it to be uniform across all campuses and [community-based outpatient clinics]."