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Mental Health Screening Results Associated with Women Veterans' Ratings of Provider Communication, Trust, and Care Quality

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A B S T R A C T

Background: Identifying factors influencing patient experience and communication with their providers is crucial for tailoring comprehensive primary care for women veterans within the Veterans Health Administration. In particular, the impact of mental health (MH) conditions that are highly prevalent among women veterans is unknown.

Methods: From January to March 2015, we conducted a cross-sectional survey of women veterans with three or more primary care and/or women's health visits in the prior year at 12 Veterans Health Administration sites. Patient measures included ratings of provider communication, trust in provider, and care quality; demographics, health status, health care use; and brief screeners for symptoms of depression, anxiety, and posttraumatic stress disorder. We used multivariate models to analyze associations of patient ratings and characteristics.

Results: Among the 1,395 participants, overall communication ratings were high, but significant variations were observed among women screening positive for MH conditions. In multivariate models, high communication ratings were less likely among women screening positive for multiple MH conditions compared with patients screening negative (odds ratio, 0.43; $p < .001$). High trust in their provider and high care ratings were significantly less likely among women with positive MH screens. Controlling for communication, the effect of MH on trust and care ratings became less significant, whereas the effect of communication remained highly significant.

Conclusions: Women veterans screening positive for MH conditions were less likely to give high ratings for provider communication, trust, and care quality. Given the high prevalence of MH comorbidity among women veterans, it is

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important to raise provider awareness about these differences, and to enhance communication with patients with MH symptoms in primary care.

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Effective patient–provider communication contributes to patient trust in their provider and experience with care, both of which have been shown to improve treatment adherence and health outcomes (Anhang Price et al., 2014; Epstein & Street, 2007; Kaplan, Greenfield, & Ware, 1989; Street, 2013; Street, Makoul, Arora, & Epstein, 2009). Taken together, these findings suggest that patient–provider communication may mediate the relationship of patient factors with trust in provider and patient experience. On this basis, identifying patient factors associated with provider communication is an essential step for tailoring care to specific groups of patients, because it may provide guidance to improve care and health outcomes. There is evidence that patient health is a strong determinant of patient–provider communication and that poorer mental health (MH) and physical health (PH) are associated with patient reports of worse provider communication (Hall, Horgan, Stein, & Roter, 2002; Matthias et al., 2010). In contrast, the impact of MH multimorbidity (e.g., the coexistence of MH conditions) has not previously been investigated, to our knowledge, despite how common the co-occurrence of MH conditions is in some patient populations, in particular women veterans (Curry, Aubuchon-Endsley, Brancu, Runnals, & Fairbank, 2014; Davis et al., 2016; Frayne et al., 2014; Stein et al., 2011).

Women veterans constitute the fastest growing segment of new Veterans Health Administration (VA) users (Frayne et al., 2014; Frayne et al., 2007; Yano, Haskell, & Hayes, 2014). Yet they currently represent only 9% of VA users. Delivering high-quality, comprehensive primary care to women veterans may represent a challenge for VA providers who see a low volume of female patients and may be less familiar with women veterans' specific health care needs. Among VA users, women veterans are often younger than men veterans, and more likely to have a health condition (Frayne et al., 2014; Frayne et al., 2007; Yano et al., 2014). In particular, MH conditions are more frequent among women veterans, with depression, posttraumatic stress disorder (PTSD) and anxiety disorders being the most prevalent (Frayne et al., 2008; Frayne et al., 2014). High rates of comorbidity are also observed among those three conditions (Curry et al., 2014; Davis et al., 2016; Stein et al., 2011). VA efforts to improve the delivery of comprehensive primary care for women include tailoring patient-centered approaches based on the recognition that improving quality of care hinges not only on technical skills, but also on how well providers communicate during clinical encounters. Previous studies have identified provider characteristics and organizational factors associated with better communication between women veterans and their providers (Bastian et al., 2014; Bean-Mayberry, Chang, McNeil, & Scholle, 2006a; Mattocks et al., 2011; Mengeling, Sadler, Torner, & Booth, 2011; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano, 2011). In contrast, little is known about the patient factors that shape communication between women veterans and their primary care providers.

In the present study, we evaluated the effect of patient health factors, including overall health, MH, and PH, on communication between women veterans and their VA providers. We hypothesized that, among women veterans who are routine primary care users at VA, patients in worse health and those with a greater burden of PH and MH conditions would be associated with poorer communication. Furthermore, we hypothesized that those patients in worse health and those with greater PH and MH burdens would report lower trust in their provider and lower care ratings, and that communication would mediate the effect of patient health on trust and care ratings.

Methods

Study Design and Sample

We used data collected from the baseline survey wave of a cluster-randomized controlled trial of an evidence-based quality improvement approach to tailoring VA's medical home model (Patient Aligned Care Teams) to the needs of women veterans (Yano et al., 2016). Twelve VA Medical Centers distributed across nine states were recruited through the Women's Health Practice-Based Research Network (Frayne et al., 2013). Using administrative data, we randomly sampled 4,307 women veterans who had three or more primary care or women's health encounters in the prior year (December 1, 2013, to November 30, 2014) within the 12 study sites. Eligibility was confirmed for 3,102 women veterans and 1,395 completed a computer-assisted telephone interview from January to March 2015 (response rate, 45%; Appendix A). Respondents were, on average, older than the nonrespondents (mean age, 52.7 $\pm$ 13.8 years vs. 48.2 $\pm$ 14.7 years, respectively); no difference was observed on other characteristics available for the two groups (marital status, U.S. region, and service-connected disability). The study protocol was approved by the Institutional Review Board at the VA Greater Los Angeles.

Outcome Variables

Our principal outcome measures included patient ratings of provider communication, trust in their provider, and care quality (Appendix B). Questions asking patients to rate provider communication, trust, and care quality were asked in reference to their main VA primary care provider identified using VA administrative data.

We measured patient ratings of provider communication using the Communication scale from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home survey (Cronbach's alpha, 0.88; Agency for Healthcare Research and Quality, 2015). Specifically, patients rated six communication behaviors of their main VA primary care provider on a 4-point Likert scale (always, usually, sometimes, never). To account for a ceiling effect and following standard scoring methods (Agency for Healthcare Research and Quality, 2015), we defined a high communication rating as the selection of always on all items.

Patient trust in provider was measured using the Primary Care Assessment Survey 7-item Trust scale (Cronbach's alpha = 0.91; Safran et al., 1998), expressed as a 0–10 score (higher score indicating higher trust). Patients rated VA care quality for overall care and primary care, respectively, on a scale of 0 (worst possible care) to 10 (best possible care; Agency for Healthcare Research and Quality, 2015; Washington et al., 2011).