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Women Veterans

Challenges with Implementing a Patient-Centered Medical Home Model for Women Veterans

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A B S T R A C T

Background: The Veterans Health Administration (VA) Patient Aligned Care Team (PACT) initiative aims to ensure that all patients receive care consistent with medical home principles. Women veterans' unique care needs and minority status within the VA pose challenges to delivery of equitable, comprehensive primary care for this population. Currently, little is known about whether and/or how PACT should be tailored to better meet women veterans' needs.
Methods: In 2014, we conducted semistructured interviews with 73 primary care providers and staff to examine facilitators and barriers encountered in providing PACT-principled care to women veterans. Respondents were located in eight VA medical centers in eight different states across the United States.
Results: Respondents perceived PACT as improving continuity of care for patients and as increasing ability of nursing staff to practice at the top of their license. However, the implementation of core medical home features and team huddles was inconsistent and varied both within and across medical centers. Short staffing, inclusion of part-time providers on teams, balancing performance requirements for continuity and same-day access, and space constraints were identified as ongoing barriers to PACT implementation. Challenges unique to care of women veterans included a higher prevalence of psychosocial needs, the need for specialized training of primary care personnel, and short staffing owing to additional sharing of primary care support staff with specialist providers.
Conclusion: Providers and staff face unique challenges in delivering comprehensive primary care to women veterans that may require special policy, practice, and management action if benefits of PACT are to be fully realized for this population.

Women veterans currently comprise only 7% to 9% of Veterans Health Administration (VA) health care users (Frayne et al., 2010). However, their numbers are expected to increase rapidly over the next decade (Frayne et al., 2014). To accommodate this growth and ensure the provision of equitable, high-quality care, VA policy recommends that all women veterans receive comprehensive primary care (i.e., general primary care and gender-specific care) from a designated women's health primary care provider (DWHP) in a single visit (VA, 2010). Comprehensive primary care models have been associated with higher patient satisfaction and quality of care (Bean-Mayberry et al., 2003). Women veterans receiving care from DWHPs also tend to report better experiences of care than those seen by non-DWHPs (Bastian et al., 2014).

Over the last decade, VA recommendations for the care of women veterans have successfully reduced historical gender disparities in care, particularly with regard to screening for mental health conditions such as depression and posttraumatic stress disorder (Whitehead, Czamogorski, Wright, Hayes, & Haskell, 2014). However, in many VA care settings, low numbers of women veterans make it difficult for providers to remain proficient in gender-specific care and pose other

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logistical and fiscal barriers to delivery of care that is sensitive to women veterans' military experiences and health care needs (Bergman, Frankel, Hamilton, & Yano, 2015; Yano et al., 2011). As the VA moves forward with efforts to redesign primary care under its Patient Aligned Care Team (PACT) medical home initiative, research is needed on how changes introduced as a result of PACT may affect the ability of providers and staff to deliver comprehensive care to women veterans.

Women Veterans and the Patient-Centered Medical Home

The VA began implementing PACT as its patient-centered medical home model in 2010. Consistent with other medical home models, PACT relies on primary care teams to provide comprehensive, coordinated, and patient-centered care (Rosland et al., 2013). Under PACT, primary care providers (PCPs) and staff are organized into "teamlets" responsible for all major patient care activities for a dedicated panel of patients (VA, 2014). Ideally, these teamlets are composed of a 1.0 full-time equivalent (FTE) PCP supported by 3.0 FTE staff: a registered nurse (RN) care manager, a clinical associate such as a licensed practical nurse (LPN) or health technician, and an administrative associate such as a clerk or medical support assistant.

When fully staffed and implemented as intended, PACT has been associated with higher quality of care, increased patient satisfaction, and lower emergency department use (Helfrich et al., 2014; Nelson et al., 2014). In practice, however, challenges to implementation remain (Tuepker et al., 2014). Of particular concern is whether and how PACT should be adapted for special patient populations based on criteria such as health condition or complexity of care needs (Yano, Haskell, & Hayes, 2014). Evidence from the broader medical home literature suggests that such adaptations may be critical for achieving positive outcomes among patients with complex care needs (Hollingsworth et al., 2011; Huang & Rosenthal, 2014).

The VA PACT model did not initially include any accommodations for special populations, raising questions about whether it would be equally effective at improving patient satisfaction and care outcomes for all veterans. Research into how the PACT model can be tailored to meet the needs of special populations is underway (Fix et al., 2014; O'Toole, Johnson, Borgia, & Rose, 2015). However, the fit between PACT priorities and provision of comprehensive primary care for women veterans has not been assessed. The current study addresses this gap by drawing on qualitative interviews with providers and staff in VA primary care and women's health clinics to examine experiences of providers and staff caring for women veterans. Of specific interest are barriers encountered in providing care and PACT adaptations that may be needed to better meet women veterans' needs.

Methods

Design, Setting, and Sample

Data for this study are drawn from the evaluation of the Implementation of VA Women's Health Patient Aligned Care Teams (WH-PACT) initiative. The WH-PACT is a cluster randomized, controlled trial of an evidence-based quality improvement approach to tailoring PACT to the needs of women veterans (Yano et al., 2016). The current study utilizes semi-structured interviews with PCPs and staff in general primary care and women's health clinics in eight VA medical centers (VAMCs). These VAMCs represent a range of VA-approved clinic models for how comprehensive primary care for women veterans can be delivered (Yano et al., 2014). In all VAMCs, at least some women veteran patients received care in a mixed-gender primary care clinic. In seven of the eight VAMCs, women veterans also received care in a separate clinic space. Additional information on participating VAMCs is available in Table 1.

Interviews were conducted between July and December 2014, in the fourth year of PACT implementation and in the first year (baseline) of the WH-PACT evaluation. To be eligible for inclusion in the study, providers and staff needed to be part of a PACT teamlet with at least one woman veteran on their patient panel. Initial contact lists were drawn from the Primary Care Management Module in the VA Corporate Data Warehouse. A quota sampling approach (Robinson, 2014) was then used to select individuals from each of the following five strata at each VAMC: PCPs 0.5 FTE or greater; PCPs 0.5 FTE or less; RN care managers; clinical associates (e.g., LPN or health tech); and administrative associates. Full-time and part-time providers were assigned to separate strata based on prior evidence suggesting differing effects of employment status on provider work experiences and patient outcomes under PACT (Mechaber et al., 2008; Panattoni, Stone, Chung, & Tai-Seale, 2015; Rosland et al., 2015). Not all VAMCs used clinical and administrative associates, resulting in no interviews in these strata at those VAMCs.

A total of 97 individuals were invited to participate and 73 were interviewed (response rate, 75%; average of 9–10 respondents per VAMC). The primary reason for not participating was lack of time, often explicitly attributed to short staffing. Interviews were completed with 30 PCPs, 26 RN care managers, 6 clinical associates, and 11 administrative associates. The majority of respondents (84%) were women; approximately 30% were racial/ethnic minorities. All interviews were conducted by phone by at least one trained interviewer following a semistructured interview guide.

Table 1
Organizational Characteristics of Participating VAMCs*

VAMC	Region	Urban/Rural	Total Veteran VA Users (*n*)	Women Veteran Patients (%)	Women's Health Teamlets (*n*/*N*)
1	Northeast	Urban	7,600	10	6/16
2	Northeast	Urban	17,000	6	3/25
3	Northeast	Urban	8,800	13	12/19
4	South	Rural	11,300	7	1/15
5	Midwest	Urban	35,300	6	6/37
6†	Midwest	Urban	27,900	2	0/10
7	Midwest	Urban	13,400	8	5/22
8	Midwest	Urban	16,000	10	3/20

Abbreviations: VAMC, Veterans Affairs Medical Center; VA, Veterans Health Administration.

* Data on total veteran VA users (rounded to nearest hundred) and percent of women veteran patients were drawn from fiscal 2013 data in the Veterans Integrated Service Network Support Services Center Primary Care Almanac. Data on number of teamlets drawn from the Primary Care Management Module in the Veteran's Administration (VA) Corporate Data Warehouse. Data on models of care for women veterans were drawn from the 2015 VA Women's Assessment Tool for Comprehensive Health (WATCH). "Women's Health" teamlets include all teamlets providing care to women veterans in a separate space, rather than in a mixed-gender primary care clinic.

† This VAMC provides care to veterans and Civilian Health and Medical Program of the Veterans Administration patients; however, only numbers for veteran patients are included here.