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Women Veterans

Patient-Rated Access to Needed Care: Patient-Centered Medical Home Principles Intertwined

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A B S T R A C T

Background: Primary care teams can facilitate access to care by helping patients to determine whether and when care is needed, and coordinating care across multiple clinicians and settings. Appointment availability metrics may or may not capture these contributions, but patients' own ratings of their access to care provide an important alternative view of access that may be more closely related to these key functions of care teams.
Procedures: We used a 2015 telephone survey of 1,395 women veterans to examine associations between key care team functions and patient-rated access to needed care. The care team functions were care coordination, in-person communication (between patient and care team), and phone communication (timely answers to health questions). We controlled for sociodemographics, health status, care settings, and other experience of care measures.
Key Findings: Overall, 74% of participants reported always or usually being able to see a provider for routine care, and 68% for urgent care. In adjusted analyses, phone communication was associated with better ratings of access to routine care (odds ratio [OR], 4.31; 95% CI, 2.65–6.98) and urgent care (OR, 2.26; 95% CI, 1.23–4.18). Care coordination was also associated with better ratings of access to routine care (OR, 1.66; 95% CI, 1.01–2.74) and urgent care (OR, 2.26; 95% CI, 1.23–4.18). Associations with in-person communication were not significant.
Conclusions: Access, communication, and care coordination are interrelated. Approaches to improving access may prove counterproductive if they compromise the team's ability to coordinate care, or diminish the team's role as a primary point of contact for patients.

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Improving access to care is one of the central goals of the patient-centered medical home (PCMH) model. The model recommends access-related changes aimed at improving appointment availability; accordingly, much research on access and PCMH has focused on administrative indicators of the availability of appointments (Aysola, Rhodes, & Polsky, 2015; Leroux, Cote, Kum, Dabney, & Wells, 2017). However, the patient-centered care team—a core part of the PCMH—plays an important role in access to care beyond improving appointment availability: the care team helps patients to determine whether and when care is needed, and manages the scheduling of different services, in some cases across several clinicians and settings. Indeed, qualitative research has identified these care team functions among patients' top priorities for what PCMH should deliver (Van Berckelaer et al., 2012).

Although administrative measures may be well-suited to evaluating appointment availability, patients' own ratings of their access to needed care provide an important alternative view that better captures key functions of care teams in directing patients to care. Patients' ratings provide an important, patient-centered view of access, which is why a 2015 Institute of Medicine report urged organizations to assess patient ratings of access as a vital part of transforming access to care (Institute of Medicine, 2015). Patient ratings are especially valuable in a PCMH context because the principle of patient-centeredness encourages success to be defined in a way that is recognizable and meaningful to patients (Aysola, Werner, Keddem, SoRelle, & Shea, 2015; Barksdale, Newhouse, & Miller, 2014).

In 2010, the Veterans Health Administration (VA) implemented a version of PCMH called Patient-Aligned Care Teams (Rosland et al., 2013). Recent implementation efforts have focused on tailoring the Patient-Aligned Care Teams model to better meet the needs of special populations within the VA (Yano et al., 2016; Yano, Haskell, & Hayes, 2014). Women veterans are a particularly fast-growing special population with unique needs that necessitate additional attention to their access to needed care (Washington, Farmer, Mor, Canning, & Yano, 2015). Because women veterans are a numerical minority in the VA, some VA providers may lack sufficient recent experience treating women, and may be unaccustomed or unable to provide gender-specific services (Yano, Hayes, et al., 2010). Women veterans are also exposed to military sexual trauma at higher levels, which requires providers to be proficient and comfortable in providing trauma-sensitive primary care, and demands particular attention to the safety and security of clinic environments (deKleijn, Lagro-Janssen, Canelo, & Yano, 2015). The coordination of women veterans' care is also more complex; for example, reproductive health needs often require additional visits within and outside of the VA (Yano, Rose, Bean-Mayberry, Canelo, & Washington, 2010).

Studies have examined various aspects of women veterans' access to care, including the geographic accessibility of care (Friedman et al., 2015), availability of mental health care (Kimerling et al., 2015), and extent of unmet health care need (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). These studies identified ways that women veterans' access to care could be improved, for example, by offering broader services at community-based facilities, by expanding telemedicine, by providing designated women's mental health treatment settings, and by providing more opportunities for care outside of regular clinic hours. However, factors associated with women veterans' ratings of access to needed care have been underexplored, and important questions remain: What aspects of PCMH might contribute to ratings of access? And how do women veterans perceive their access to needed care? We sought to answer these questions by drawing on data from a multiregion telephone survey of women veterans to examine the association between key care team functions and ratings of access to needed routine and urgent care. We examined the potential role of three functions played by care teams, as rated by patients: care coordination, in-person communication, and phone communication.

Methods

Study Design and Sample

Data in this study are drawn from a cross-sectional survey of women veteran patients ($n = 1,395$) conducted between January and March 2015 at 12 VA medical centers participating in a Practice-Based Research Network for women veterans (Frayne et al., 2013). We used data from the baseline wave of a survey conducted as part of a cluster-randomized controlled trial, Implementation of Women's Health Patient Aligned Care Teams Study (Yano et al., 2016). To study factors related to care team functions in a population of active VA users, the survey sampled women veterans with at least three primary care and/or women's health visits at a participating medical center in the last 12 months. Veterans who were found to be deceased or with invalid or missing contact information were excluded. The study was reviewed and approved by the Institutional Review Board at VA Greater Los Angeles.

Analyses of access to routine care excluded 14 respondents who were unsure of their routine access and 3 respondents who declined to answer the routine care access question. For analyses of access to urgent care, of 852 respondents who indicated having a health problem warranting immediate attention, we excluded 25 who were unsure of their urgent access. Listwise deletion owing to missing covariates reduced the final analytic samples to 1,333 for routine care and 723 for urgent care. Participants in the analytic samples were younger and more likely to have seen a specialist compared with those excluded because of missing data. Participants in the routine access analytic sample had fewer comorbidities than those in the full sample. The two groups did not differ on any of the other characteristics we tested (ratings of care coordination, in-person communication, or phone communication; age, race/ethnicity, marital status, employment status, insurance status, children in household, education, overall rating of VA, mental or behavioral care, care outside VA, overall health, anxiety and depression, posttraumatic stress disorder, or military sexual trauma).

Data Collection and Measures

We used survey recruitment best practices (Dillman, Smyth, & Christian, 2014), which included sending potential participants an advance information packet with an introductory letter, leadership endorsements, a magnet, and a brochure with the elements of informed consent. Interviewers made up to 12 attempts to contact each potential participant using a computer-assisted telephone interviewing system. The survey response rate was 46%. Among eligible individuals, 30% could not be contacted within the survey period, 22% declined participation, and 2% began but did not complete the interview. Survey respondents were on average older than nonrespondents, but did not differ significantly by the other observable characteristics (marital status and geographic region).