Journey to a Medical Home for Women Veterans

By

JULIE ELIZABETH LISS

Submitted in partial fulfillment of

the requirements for the degree of

MASTER IN NURSING

WASHINGTON STATE UNIVERSITY
College of Nursing

MAY 2011
To the Faculty of Washington State University:

The members of the Committee appointed to examine the non-thesis project of JULIE ELIZABETH LISS and find it satisfactory and recommend that it be accepted.

Cynthia E. Fitzgerald, PhD, Chair.

Margaret A. Bruya, DNSc, ARNP, FAAN.

Denise Smart, DrPH, BSN, RN.
ACKNOWLEDGMENTS

I would like to acknowledge my chair members and my family's consistent patience, diligence and support in the completion of this project. I would also like to acknowledge the support of Jane Schilke, Nancy Sloan, and Marcia Hall. Without their continued support, the journey to support the improvements in the care of women veterans would not be possible.
Journey to a Medical Home for Women Veterans

ABSTRACT

by Julie (MN) Liss
Washington State University
May 2011

The nationwide implementation of the Patient Centered Medical Home (PCMH) Model within the U.S. Department of Veterans Affairs (VA) healthcare system provided a timely opportunity to develop and implement a related program, Women Veterans Comprehensive Primary Care (WVCPC). This paper describes the process of implementing a WVCPC program at an 84-bed VA facility that provides over 30,000 outpatient visits per year to women veterans. A review of the current literature about the PCMH model establishes the importance of this model. Details are provided about aspects of the transition including increasing access to care, improving quality and veteran satisfaction. The journey toward a medical home for women veterans at the Spokane VA started in October 2010, with full implementation complete in February 2011. Early lessons learned include limitations for fully funding staff ratios, and cultural transformations within a large bureaucratic healthcare system that has struggled to provide comprehensive healthcare to women.
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................................................................................ iii
LIST OF TABLES ................................................................................................................ vi
INTRODUCTION .................................................................................................................. 1
  Women Veterans in the VHA System .............................................................................. 1
  Problem Statement ......................................................................................................... 4
  Purpose ............................................................................................................................ 5
BACKGROUND AND LITERATURE REVIEW ................................................................. 7
  Change in the VA Healthcare System .......................................................................... 7
  Patient Centered Medical Home ................................................................................... 8
  Value of Medical Home to the VHA System ................................................................. 10
  Medical Home at the Spokane VA ............................................................................... 12
  Access ............................................................................................................................ 15
  Quality ............................................................................................................................ 18
  Satisfaction .................................................................................................................. 19
  Accountability for Change ........................................................................................... 19
    Limitations of Authority ............................................................................................. 20
  Conclusion ..................................................................................................................... 20
IMPLEMENTATION ............................................................................................................. 22
  Early Steps toward Change ......................................................................................... 22
  Comprehensive Women's Health Care Providers ....................................................... 23
  Coordinating Care ......................................................................................................... 23
  Evaluation Plan ............................................................................................................. 24
  Challenges .................................................................................................................... 27
DISCUSSION .................................................................................................................... 30
  The Future of Women's Comprehensive Primary Care ............................................ 31
  Conclusion .................................................................................................................... 32
REFERENCES .................................................................................................................. 34
LIST OF TABLES

Table 1: Twelve Principles of Patient Centered Care............................................................. 4
Table 2: Specific goals of the PCMH Initiative........................................................................ 8
Table 3: Seven Key Practice Areas, Medical Home Builder (ACP Practice Biopsy)............... 13
LIST OF FIGURES

Figure 1: What comprises a Comprehensive Women's Healthcare Team? ........................................ 10
Figure 2: Roles and tasks assigned to Veteran and Teamlet members........................................... 12
Figure 3: Spokane Veteran Population Projections, 2011-2020. ...................................................... 17
Figure 4: Measurement matrix for six key areas toward a PCMH. .................................................. 25
CHAPTER ONE

INTRODUCTION

The Veterans Health Administration, the largest branch of the United States Department of Veterans Affairs, maintains and operates a health care system for veterans of military service at 171 medical centers, 350 outpatient clinics, 126 nursing home care units and 35 domiciliaries (institutional homes for aged and disabled veterans) throughout the United States (U.S. Department of Veterans Affairs, 2010a). The Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs (VA) is divided into 21 health system networks called Veterans Integrated Service Networks, (VISN) located in different regions of the country. Each VISN typically operates facilities and provides services in more than one state. Each contains medical centers, support service offices, and outpatient clinics offering primary and specialized care as well as other services for veterans. The VHA is driven by one mission, “To honor America’s veterans as heroes by providing the highest quality of health care to those who have served our nation” (VA, 2010a).

Women Veterans in the VHA System

In 2009, the VHA provided care to 5 million veterans (Congressional Budget Office, 2010). Currently the VHA is faced with the unprecedented challenge of providing comprehensive primary health care to 1.8 million women veterans comprising 7.7 percent of the total Veterans population (VA, 2010b). As recently as 1971, women constituted less than one percent of the military (VA, 2008). The recent mass influx of women veterans into the VHA system has been particularly challenging for a system that has a history of caring for a predominately male population. Based on current projections, the percentage of veterans who are female will likely increase from 7.7 percent in 2008 to 10.0 percent in 2018 and to 14.3 percent in 2033 (Office of
Policy and Planning National Center for Veterans Analysis and Statistics, 2008). These increases mean that within the next 15 years, females will represent one in every seven enrollees in the VHA, while in 2007 women who received healthcare services in the VHA represented only one in every 16 veterans (VA, 2008).

This dramatic increase in the number of women seeking services from the VA healthcare system has created multiple challenges within the VHA. According to the Under Secretary for Health Workgroup, women veterans have higher physical and mental health burdens than their female non-veteran counterparts (VA, 2008). For women veterans, primary care goals such as access, communication, continuity, comprehensiveness, and coordination are often difficult to achieve when health care services are fragmented (Bean-Mayberry, Chang, McNiel & Scholle, 2006). In addition, women veterans experience significant disparities in access to and delivery of healthcare services (VA, 2008).

Historically the VHA has not had a lot of experience caring for women veterans. As one example, there has been separate management of reproductive and non-reproductive healthcare needs for women, with limited numbers of providers available who were interested in or proficient at providing gender-specific healthcare services to women. Simply applying the VHA-for-men-only approach has resulted in system-wide gaps in the provision of preventative measures for women who have hypertension, elevated serum lipids, or diabetes. Since 2007, the Office of Quality and Patient Safety has determined that when compared to with male veterans, women are less likely to have been screened or treated for diabetes and elevated cholesterol (VA, 2008). In addition, while the quality of gender-specific healthcare services is higher compared to the private sector, women veterans frequently receive multi-visit, multi provider exams for the same problem or visit type (Frayne, et al., 2006). In fact, among women and men with both
medical and mental health conditions, women used outpatient services more heavily than did men (Frayne, et al., 2007). It should be said that this may be a reflection of fragmentation of gender specific care from overall primary care more than an indication of higher utilization overall.

While research is increasing surrounding the unique healthcare needs of women veterans, much more information is needed to further understand the health care needs of this population (Voght, et al., 2006). In one study of women who received care in the VHA system, women veterans consistently stressed the need for their providers to assist them to navigate the healthcare system and to be their advocate (Yano, Goldzweig, Canelo, & Washington, 2006). This finding emphasizes the extent of need for women veterans to have care that is better coordinated and more comprehensive.

**Transforming the VA System**

In an effort to deliver President Obama’s vision to transform the VA into a 21st century organization, Eric Shinseki, the United States Secretary of Veteran’s Affairs, convened a Universal Services Task Force to define a comprehensive approach to care that the VHA will provide to all enrolled veterans without respect to location, facility or provider (Pendergrass, 2009). The Task Force identified three overarching themes that the VA should address when adopting the principles for transforming VA healthcare to a more efficient and effective system of care and service delivery. These themes are patient-centered care, coordination of care, and access to care. As shown in Table 1, twelve principles define this new patient centered culture. The task force defined a comprehensive set of healthcare concepts that the VHA will provide to all enrolled veterans in a more patient-centered way based on a comprehensive review of literature, discussions, and site visits to VHA and Non-VHA industry leaders. These principles
are intended to enable VHA to raise standards to which VHA will hold itself accountable when delivering care to America’s veterans.

**Table 1: Twelve Principles of Patient Centered Care**

1. Honor the veteran’s expectations of safe, high quality, accessible care.
2. Enhance the quality of human interactions and therapeutic alliances.
3. Solicit and respect the veteran’s values, preferences and needs.
4. Systemize the coordination, continuity, and integration of care.
5. Empower veterans through information and education.
6. Incorporate the nutritional, cultural and nurturing aspects of food.
7. Provide for physical comfort and pain management.
8. Ensure emotional and spiritual support.
9. Encourage involvement of family and friends.
10. Ensure that architectural layout and design are conducive to health and healing.
11. Introduce creative arts into the healing environment.
12. Support and sustain an engaged work force as key to providing veteran centered care.


**Problem Statement**

Within the huge and complex VHA system, care for women veterans has too often been fragmented, decentralized and needlessly complex. These problems have resulted in inefficiencies, disparities, and reduced quality of care for women veterans. The challenge of providing comprehensive care to a rapidly increasing population of women veterans presents tremendous opportunities to improve the provision of patient care services. One model, the
Patient Centered Medical Home (PCMH) model of care, has been proposed as a potential solution to multiple issues related to women veterans’ health care. System-wide implementation of a PCMH model provides an operational opportunity to define a comprehensive set of health-care services that the VHA will provide to all enrolled veterans, and particularly to women veterans, in a more patient-centered way, without respect to location, facility, or provider (VA, 2009).

**Purpose**

The purpose of the project described here was to create a Women Veterans Comprehensive Primary Care (WVCPC) project as part of implementing a PCMH model at the Spokane VA Medical Center. From the outset, it was clear that the PCMH model has the potential to create an environment in which veterans would be able to receive comprehensive, person-centered care for all health care needs, including reproductive health care. Aligning improvements in the provision of women’s healthcare services with the nation-wide initiative to introduce the PCMH model had the potential to facilitate improvements in direct care services, reduce gaps in access and care, and improve preventive services for women utilizing VA healthcare services.

The implementation of a PCMH model of care to transform healthcare services at the Spokane VA Medical Center (SVAMC) required changes to the physical infrastructure and reassessment of roles and responsibilities. Budgets needed to be reviewed and modified. Staffing plans had to be developed and implemented. Care processes needed to be evaluated and reconfigured. Data based evaluation plans needed to be developed.

This paper describes the journey to transform health care services in ways that allow the Spokane VAMC to ensure continuous and equitable care for women veterans. In addition to
describing the implementation project, this paper identifies project gaps and limitations and describes future stages of the project that will help to ensure its ongoing success. Although developed for VHA facilities, other healthcare systems seeking to develop integrated healthcare systems can benefit from the adoption of this model to increase quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions.
CHAPTER TWO

BACKGROUND AND LITERATURE REVIEW

The VHA is unique among health care systems in size, scope, resources, integration, political prominence, and public interest (VA, 2009). This chapter includes a review of the literature that describes a project that is intended to transform the way the VHA provides care to America's veterans. It also describes the importance of the PCMH to the VA, and the potential of the PCMH model, and particularly a related program, a Women's Veterans Comprehensive Primary Care model, to improve women's healthcare across the VA system.

Change in the VA Healthcare System

By early 2010, the VA Healthcare system had embarked on an effort to contemporize its approach to the provision of primary care to the veteran population. Building on a private sector model, the VA's Patient Centered Medical Home (PCMH) Model was developed to improve outcomes of care, engage patients in greater levels of self-care, and to optimize operational efficiencies across all healthcare settings. This system-wide emphasis on the PCMH Model offered VHA facilities excellent opportunities to emphasize the provision of gender-specific care to increasing numbers women who are entering the VHA for care. To achieve comprehensive primary healthcare for every woman veteran, the PCMH Model's systematic approach to the coordination and integration of services offers the promise of improving access, ensuring optimal care, and improved health outcomes for women veterans. Supporting guidance and funding came from the Office of Healthcare Transformations. Various fiscal and programmatic initiatives supported the redesign of comprehensive health care for women that were intended to decrease fragmentation, systemize coordination, and improve continuity of care to address the needs of women Veterans through a national women's health assessment, national clinical inventory of
women’s healthcare delivery, and ongoing provider education.

**Patient Centered Medical Home**

The PCMH is a conceptual and functional practice re-design in primary care that emphasizes care coordination, continuity, evidence based practice, enhanced access and payment reform (American College of Obstetrics and Gynecology, 2009). The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record and for coordinating care for children with complex healthcare needs. A policy monograph by the American College of Physicians, identified issues and addressed major concerns regarding the status of the US healthcare system, and called for a comprehensive public policy change in the delivery of healthcare based on the principals of the Chronic Care Model (American College of Physicians, 2007). This model describes the provision of continuous and coordinated care throughout a patient’s life to maximize outcomes.

The VHA has adapted PCMH principals and developed measurable goals that align VA with national health care reform initiatives and that will help to ensure that veterans access to high quality primary care. See Table 2 for a list of the specific goals of the PCMH. These goals will be used to align the VHA with national healthcare initiatives, while ensuring that veterans’ health is managed with quality and effectiveness.

**Table 2: Specific goals of the PCMH Initiative**

- Optimize access (including alternatives to face-to-face care to meet the Veteran’s expectations.)
- Redesign primary care practices to become patient-centric.
- Improve care management and coordination of care, facilitating continuity of care.
- Integrate Health Promotion/Disease Prevention, Mental Health, geriatrics, Women’s Health and other Specialty Care Services within Primary Care.
- Revitalize health professions training in the ambulatory care environment by better aligning trainee education with clinical care.
• Develop measurement and evaluation tools pertinent to the patient centric Medical home.
• Develop a sustainment model to ensure PCMH growth and development.

*Note. Specific Goals of VHA for Medical Home Model. From The VA Patient Centered Medical Home Summit, April 2010, Las Vegas Nevada, Reprinted/adapted with permission.*

In addition to the goals described above, the PCMH model includes operational descriptors of care such as accessibility, continuity, comprehensiveness, family-centeredness, coordination, compassion, and culturally effective care (American College of Obstetrics and Gynecology, 2009). Within the model of a PCMH, emphasis is placed on collaboration among healthcare specialists to improve care coordination across sites and specialties, optimization of healthcare quality and safety, and ensuring affordable care (Patient Centered Primary Care Implementation Work Group, 2010).

The PCMH Model introduces panel management (care management) to the VHA system. Within the VHA system, each patient panel is managed by a teamlet, operating within an overall team (comprised of specialty support staff) and including a physician, a nurse practitioner or Physician Assistant, a Registered Nurse, a Licensed Practical Nurse, and a clerk. The function of these teamlets requires collaboration and coordination of services and requires that each individual member of the team function to the top of their licensure. Each teamlet assumes responsibility for patient care and is responsible for arranging any specialty care referrals the patient might need. See Figure 1 for an illustration of the relationship between Primary Care Teams and Teamlets as envisioned for Women Veterans Comprehensive Primary Care Teams in the VHA system.
Value of Medical Home to the VHA System

The VHA desires to be a leader in the delivery of health care services (Patient Centered Primary Care Implementation Work Group, 2010). In order to achieve this goal the VA has begun the journey towards implementation of a PCMH Model in all of its ambulatory care sites. The VA expects to spend 250 million dollars in the next five years to transition its 171 medical centers and 350 community based outpatient clinics into patient centered medical homes (Robert Wood Johnson Foundation, 2010). The objective of the VHA PCMH model is to improve patient satisfaction, clinical quality, safety and efficiencies by becoming a national leader in the delivery of primary care services (Patient Centered Primary Care Implementation Work Group, 2010).

Various stakeholders emphasize different benefits for adopting the PCMH Model within the VHA system (Reid, et al., 2010). Primary care providers are encouraged to adopt PCMH
because it offers improvements in work life through optimization of panel sizes, responsibility for care coordination, and other advantages. Healthcare policymakers and organizational leaders are encouraged by the model’s promise of reduction in costs and improvements in quality.

Consumers are encouraged to view PCMH models as offering improved access and better overall healthcare experiences. Because the introduction of the medical home model is relatively new, there is little published scientific evidence of its overall effectiveness. However, there is substantial evidence for the effectiveness and importance of many of its key characteristics given that most of them align with the empirically derived framework of the Wagner Chronic Care Model (Wagner, 1998). This model is based on a substantial and growing body of literature that has linked use of clinical information systems and registries, decision support, performance measurement and feedback, delivery system interventions and patient self-management support to improved clinical outcomes and patient experience of care.

The adoption of the medical home model also integrates The Institute of Medicine's Aims for the 21st century that includes patient-centered, timely, efficient and equitable care (Institute of Medicine, 2001). There is a growing body of evidence illustrating primary medical care's value in assuring a health care system of higher quality at lower cost and with more equity (Nutting, Miller, Crabtree, Stange, & Jaen, 2009). It is expected that within the VHA system, the PCMH Model will demonstrate quality improvement, greater veteran satisfaction, and cost savings from decreased hospital visits and fewer readmissions through patient focused care (Reid et al., 2009). The primary care and practice characteristics associated with this evidence are first-contact care with easy access, comprehensive care (degree to which primary care clinician provides a broad range of services), sustained partnerships or longitudinal care, coordinated care, and personal or patient-focused care with family and community orientation (Miller, Crabtree, Nutting, Stange,
& Jaen, 2010). As shown in Figure 2, these practice characteristics can be further realized through standardization of work and processes with clear delineation of responsibilities to ensure that members of the team know and understand their role in patient care.

**Figure 2: Roles and tasks assigned to Veteran and Teamlet members.**

From The VA Patient Centered Medical Home Summit, April 2010, Las Vegas Nevada, Reprinted/adapted with permission.

**Medical Home at the Spokane VA**

Each facility within the VHA has been charged with developing a PCMH approach of its own (within the overall VHA-PCMH framework) that will address the unique characteristics of its population. In Eastern Washington, one specific focus of the implementation of the PCMH model has been to use this model in providing improved healthcare services to women veterans.

Providing women’s health services at the Spokane VAMC and its community based
outpatient clinics (CBOC's) poses a variety of challenges. The first is the size of its catchment area, one that covers 18 counties, 3 states, 60,000 square miles, and over 10,000 known women veterans (VA, 2010b). In addition to the current 1480 women veterans served at the Spokane VAMC, (J. Schilke, Personal Communication, January 11, 2011 ), this model could allow the Spokane VA to provide services for the remaining 8605 known women veterans who reside in the catchment area but who do not receive care at this facility (Vet Pop, 2007).

In December 2010, guided by the Universal Services Task Force Report, and the American College of Physicians, individuals who provide direct care to women veterans at the Spokane Veteran Medical Center (SVAMC) completed the Medical Home Builder (MHB), an assessment process that allows a comprehensive review of existing health care practices. See Table 3 for a list of the seven key areas assessed through this self-paced process.

**Table 3: Seven Key Practice Areas, Medical Home Builder (ACP Practice Biopsy)**

1. Patient Centered Care and Communication
2. Access and Scheduling
3. Organization of Practice
4. Care Coordination and Transitions in Care
5. Use of Technology
6. Population Management
7. Quality Improvement and Performance Improvement


The resulting report, called a practice biopsy by its developers, was prepared to identify opportunities for improvements in practices. The process is designed to facilitate program
assessment and to encourage a shared discussion among multiple stakeholders within a practice (American College of Physicians, 2007). The process required several meetings over two weeks, with team and teamlet members who provide care to women veterans meeting to discuss the assessment process and findings. Team members each completed the assessment, and then met to review and discuss their responses in order to clarify potential discrepancies in results. This baseline assessment data was then entered into the national Women Veterans Strategic Healthcare Group SharePoint site.

Each self-assessment area is linked to standards published by the National Committee for Quality Assurance (National Committee for Quality Assurance, 2010). Assessing all of the primary care domains outlined in the Institute of Medicine (IOM)—comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience (Institute of Medicine, 2001). This further ensures that every recognized or accredited entity provides care consistent with the Joint Principles (American College of Physicians, 2007). Programs are evaluated in each of these areas independently of one another, or all together, allowing a focus on areas that need attention. Results of a practice biopsy process can be used to assist program planners to identify tools and resources necessary to make or facilitate the implementation of quality improvement changes and prepare the organization for recognition as a Medical Home provider. Aligning comprehensive primary care for women veterans with these principles ensures meaningful measurement of practice redesigns. Results of biopsy scores can further guide stakeholders in selecting the types of intervention that are needed to accomplish the stated goals and objectives. There is further incentive to attain Medical Home designation in the form of increased Medicare reimbursement rates, and performance based components for achievement of quality and efficiency goals.
Currently, the Spokane VAMC results are being compiled with all other facility biopsy results by the Women Veterans Strategic Healthcare Group and will be disseminated to each VISN 's at a meeting to be held in April 2011.

Access

Healthcare access has been defined as the ability of an individual to use personal health services to achieve the best possible health-related outcomes. Obstacles to healthcare access can include affordability, location, ease of arranging visits, and geographic accessibility (Hall, Lemak, Steingraber & Shaffer, 2008). Efficient access within the medical home model will be defined by increases in telephone and group visits, reducing unnecessary return visits, and improved care coordination by all team members. Improving telephone services and communication through secure messaging on the internet are a few of the areas that VHA can reduce face-to-face visits.

VHA's eligibility rules are complex and women veterans often do not understand the benefits that are available to them. Additionally, these benefits, managed by different administrations within VA, are rarely communicated in a comprehensive way to veterans. In addition, many veterans' services and programs were designed with men in mind, and many women do not self-identify as veterans (Business and Professional Women's Foundation, 2010). The Office of Public and Intergovernmental Affairs (OPIA) is an organization within the Department of Veterans Affairs charged with overseeing consumer affairs, intergovernmental affairs, international affairs, homeless veterans programs, and government-to-government Native American issues. In a recently published report, OPIA described the importance of using clear imagery and messaging when communicating with women about available VA services using media messaging and news releases (VA, 2010c). According to this report, the inclusion of
women veterans in general outreach and media messaging and development of healthcare services solely for women veterans will help to ensure that women become aware of their veteran status and empower them to apply for VA's services and benefits to which they are entitled.

Currently 23% of eligible men but only 16% of eligible women use available VA services (VA, 2010d). The Women Veterans Health Strategic Healthcare Group has established three-year goals directed at decreasing gaps in utilization of VA services between men and women veterans who utilize VA healthcare services. The National Survey of Women Veterans (VA, 2009) identified barriers to the use of VA healthcare services among women who considered but did not use VA care. Of those who participated, 31% did not think they were eligible for VA services while 21% indicated that they did not know how to apply for benefits and 20% said the nearest VA location was too far from their home to make access feasible. Figure 3 illustrates the number of women who are projected to be living in the catchment area of the Spokane VA between now and 2020. These figures serve as a basis for the development of strategic planning for VA services to be developed in the Spokane and surrounding rural areas.
Once a woman veteran is enrolled in the VA healthcare system, she can begin to receive available healthcare benefits. Issues related to access, however, are not limited to enrollment. In order to serve the ever-changing needs of a younger veteran population, the need for expanded clinic hours and technology to support optimal care through non face-to-face visits is imperative to serve the ever-changing needs of the younger, female veteran population. Enhanced access to care through systems such as open scheduling and secure messaging for communication between patients and their care teams is needed as well. Recent adoption of one provider for all of women’s healthcare needs reduces the need for multi-provider, multi-visit appointments to address gender specific needs and increased wait times. Coordination for all providers working as members of interdisciplinary teams and specialty care service units within each collocated service area is considered to provide optimal “one stop shopping.”
Quality

The Veteran’s Health Administration defines quality care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (VA, 2010e). For the PCMH model, quality is defined as the provision evidence-based health care services, the use of clinical decision-support tools, implementation of quality improvement efforts, patient and family participation, and information technology support (National Committee for Quality Assurance, 2010). Optimally, the patient’s experiences should be the fundamental source of the definition of quality (Berkowitz, 2007). In the arena of quality, the VHA performance measures largely are derived from rates of providing evidence-based health care services. Recently gender disparities were identified nationally in the management of chronic diseases such as diabetes, hypertension, and hyperlipidemia (VA, 2008). In addition, reducing fragmentation of gender-specific care has been a high priority across the VHA. Interpersonal continuity of care is important to a majority of patients, particularly those from vulnerable groups (Robert Graham Center, 2007), further emphasizing the importance of a one provider approach for comprehensive women’s healthcare.

The PCMH model is intended to reduce gaps in care and provide additional opportunities for each provider to offer comprehensive services to each client based on individualized needs assessments. The American College of Obstetrics and Gynecology (2009), describes the PCMH model for women as having the potential to encourage health care providers to pursue practices that achieve evidence-based outcomes so that women will enter their reproductive years healthy, maintain their reproductive health, and age well. Other advantages of the PCMH model include early identification, prevention, and treatment of chronic diseases, which offers the potential to decrease the cost of managing chronic health conditions.
Satisfaction

Patient satisfaction has assumed greater importance as one measure of the quality of healthcare services provided by the VA health care system. Specific to women veterans, consumers of health care services want to help define the care they want and need as well as when they will receive that care. Women veterans also want access to information necessary to make appropriate choices (Nutting, et al., 2009). Women veterans express higher patient satisfaction when care is located in one setting with one provider (Bean-Mayberry, et al., 2003). Issues are addressed first by the primary care provider as they are able to manage most of the veterans needs both acutely and on an ongoing basis (Robert Graham Center, 2007).

The PCMH model offers opportunities for integrating primary care services with the rest of the VA healthcare system and facilitating engagement of veterans in their own care. The PCMH model is patient-driven, with the focus being on the person rather than the disease or provider. Where the PCMH model has already been developed, care has been described that is not only assessable but also accountable, comprehensive, integrated, patient centered, safe scientifically valid, and satisfying to both patients and their physicians (Bush, 2004).

Accountability for Change

In 2007, in an effort to identify and meet the ever-changing needs of women veterans, the United States Congress mandated the development of positions identified as Women Veteran Program Managers (WVPM) at each VA Medical center. These WVPM’s are charged with all oversight and collaboration of care pertaining to women veterans. This includes the implementation and monitoring of gender specific performance measures, responsibility for increasing enrollment through outreach activities, and managing statistics and demographics to adapt to the changing needs of women veterans (VA, 2007). In all, 171 WVPMs have been
employed system wide to address the needs and concerns of 1.8 million women veterans currently seeking care or expected to enroll in the system (VA, 2010f).

To accomplish these tasks, WVPMs use a variety of strategies including building partnerships with key facility stakeholders and bridging community partnerships. This often requires knowing how to contend with administrators, physicians, and high-powered stakeholders without negatively impacting professional relationships.

**Limitations of Authority**

To accomplish their mandate, WVPM’s must influence systems across multiple service lines. Paradoxically, however, although the WVPMs as a whole are recognized as systems experts with tremendous responsibility, they have been granted little system-side authority. Although recommendations have been made to align WVPM’s under the Chief of Staff at facilities, many WVPM’s remain organizationally located as part of each facility’s Nursing Service department. This leaves them with little authority when working with physicians whose organizational location is separate and distinct. As one result, WVPM’s may be perceived as having the ability to implement national policies to support the provision of healthcare for women veterans. Without formal power generated by organizational authority or positional rank, WVPMs often use influence to affect outcomes, enhance positive work environments, and promote quality care (Zuzelo, 2010).

**Conclusion**

The current literature supports the need for the VHA to position itself to be a national leader in the delivery of healthcare to women veterans. While VA has taken some steps to improve the availability of services for women veterans, the adoption of the PCMH presents a timely opportunity to provide comprehensive primary care to all veterans. WVPMs are ideally
situated to take leadership positions in extending the mission of the PCMH model into women’s healthcare, helping to ensure the future of comprehensive women’s healthcare in the VA system.
CHAPTER THREE
IMPLEMENTATION

The purpose of the project described here was to create a Women Veterans Comprehensive Primary Care (WVCPC) project as part of implementing a PCMH model at the Spokane VA Medical Center. This chapter discusses the implementation process which included defining comprehensive primary care services, developing a cohesive team of women’s’ health care providers, and ensuring adequate staffing to meet these goals. This chapter discusses the change process, evaluation of the model, challenges associated with its implementation, and the future of women’s healthcare in the VA system.

Early Steps toward Change

The VA system had made significant progress toward implementing comprehensive healthcare services for women veterans when the VHA announced its intention to implement PCMH across the VA system. Specialty women’s healthcare providers had been identified. However the introduction of plans to implement the PCMH model, underscored the importance of developing programs that had the potential to improve women’s healthcare services.

In April 2010, the VA held the Medical Home Transformation summit with over 3500 participants in Las Vegas Nevada to focus on communication, collaboration, and coordination of the implementation of the PCMH model at VHA facilities throughout the United States. Each VA facility sent primary care teams consisting of providers, RN’s, Health Technicians and clerks. Participation was mandatory for all WVPMs. These initial participants were identified as key stakeholders in the transformation of VHA care to a PCMH model.

Participation in this conference provided WVPM’s an opportunity to return to VHA facilities, receive leadership support, and gain momentum for implementation. Beyond the
summit, the participants created action plans to implement learned strategies and implant medical home strategies at accelerated rates at their local facilities.

Early in its efforts to address women's healthcare needs within the VHA, a decision was made to develop a group of dedicated healthcare providers who would offer women's comprehensive healthcare services. Providers were surveyed for interest in being identified as a comprehensive women's healthcare provider, with additional training offered for those who self identified. Training in contraception and menopause management, breast cancer screening as well as preconception counseling was attended by staff at regional sites. Women veterans who were assigned to providers who could not offer these services were notified by letter of the opportunity to have one health care provider care for all of their healthcare needs.

**Comprehensive Women's Health Care Providers**

The Spokane VA has implemented a variety of strategies in its effort to improve healthcare services for women veterans and to incorporate the requisite PCMH design components. For example, all comprehensive women's health care providers working in the facility were relocated from various sites to become collocated within the integrated primary care setting. Panel sizes for designated women's healthcare providers were reduced by 20 percent to accommodate the increased utilization and gender specific care. Expanded appointment times were adopted to accommodate gender specific care. Morning meetings (known as team huddles) that include providers, nurses, and clerks, pre-appointment planning, and chart reviews began and thus allowed teams to improve efficiency. Scheduled telephone visits were implemented in order to accommodate the needs of student and working veterans.

**Coordinating Care**

In each facility, WVPM's worked closely with Human Resources, Ambulatory Care, and
staff from the office responsible for coordinating care from veterans of the current wars in Afghanistan and Iraq (known as Operation Enduring Freedom [OEF] and Operation Iraqi Freedom [OIF]) to participate in newly developed staff orientation programs. These individuals were also included as participants in newly developed patient orientation programs. These measures ensured that as new patients entered the Spokane VAMC clinic system for care, she would be assigned to a comprehensive women’s health care provider rather than a generalist.

As part of the effort to improve care for women veterans, the Spokane VA WVPM meets with each new woman veteran, reviews services available and answers questions as needed. During this visit the WVPM, a Registered Nurse, performs an individualized assessment of each woman veteran’s perceived healthcare needs, allowing the development of a tailored approach to patient assignment and referrals. This visit is documented in a note placed into the electronic medical record so that care providers who see the woman during future visits can refer to this initial note, helping to ensure continuity of care and reduce duplication of services. In the WVPM’s absence, the veteran’s information is forwarded to the WVPM and a phone call follow-up occurs.

Improving care coordination also requires increasing fiscal support for hiring of additional support staff. As part of planning for adequate staffing, the WVPM assisted in the preparation of staffing plans for VHA facilities in Spokane, Coeur d’Alene, and other community-based clinics in the service area.

Evaluation Plan

The core concepts of the PCMH include the coordination and integration of healthcare services into a seamless experience for the veteran, one that is characterized by enhanced access, increased quality, and improved patient satisfaction. Given the allocation of resources required to
implement the PCMH model system-wide throughout the VA, and to parallel with that the
development of WVCPC programs, measurement of a variety of indicators of success will be
undertaken. *Figure 4* illustrates the Measurement Matrix that has been developed to evaluate the
adoption of PCMH. Many of the indicators described in this matrix will be monitored using
VISTA, the VA-wide electronic health record system. These will include issues related to access
such as scheduling delays as well as continuity of care as measured by such factors as use of
Emergency Department services for non-urgent issues such as follow-up for problems managed
initially in the primary care setting. Other indicators of program success will be measured using
other VA data management and decision support tools.

### PCMH Measurement Matrix

<table>
<thead>
<tr>
<th>Panel Management</th>
<th>Patient Engagement and Satisfaction</th>
<th>Continuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Panel size</td>
<td>• SHEP scores (selected)</td>
<td>• Provider: % visits with assigned PCP</td>
</tr>
<tr>
<td>• Panel capacity</td>
<td>• Patient complaints (Patient Advocate)</td>
<td>• Team: % visits with team</td>
</tr>
<tr>
<td>• Teamlet staff</td>
<td>• My HealtheVet enrollment</td>
<td>• ED visit rate</td>
</tr>
<tr>
<td>• Staff turnover rate</td>
<td>• % IPA</td>
<td>• Patient longevity</td>
</tr>
<tr>
<td>• PCMM Team setup</td>
<td></td>
<td>• # PCPs seeing panel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access</th>
<th>Clinical Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Desired Date appointments</td>
<td>• Clinical Indicators (selected)</td>
</tr>
<tr>
<td>• Same day</td>
<td>• Admission rates</td>
</tr>
<tr>
<td>• Within 7 days</td>
<td>• ED visit rates</td>
</tr>
<tr>
<td>• Within 14 days</td>
<td>• Panel case mix</td>
</tr>
<tr>
<td>• 3rd next available</td>
<td></td>
</tr>
<tr>
<td>• No-show rate</td>
<td></td>
</tr>
<tr>
<td>• Telephone access data</td>
<td></td>
</tr>
<tr>
<td>• #Group clinic encounters</td>
<td></td>
</tr>
<tr>
<td>• #Telephone clinic encounters</td>
<td></td>
</tr>
<tr>
<td>• Admission rate</td>
<td>• Specialty referral rates</td>
</tr>
<tr>
<td>• Specialty referral rates</td>
<td>• Team contacted within 48 hrs of admission</td>
</tr>
<tr>
<td>• Team contacted within 48 hrs of admission</td>
<td>• Pt contacted within 48 hrs of discharge</td>
</tr>
<tr>
<td>• Consult tracking</td>
<td>• Panel case mix</td>
</tr>
</tbody>
</table>

*Figure 4: Measurement matrix for six key areas toward a PCMH.*

From The VA Patient Centered Medical Home Summit, April 2010, Las Vegas Nevada, Reprinted/adapted with permission.
Although quantitative data is valuable in measuring a variety of indicators, it will also continue to be important to measure gender-specific services such as cervical cancer screening, mammogram frequency, and Bone Density screening. The provision of improved healthcare access and services for women veterans will also require the use of qualitative data such as that can be measured using patient surveys. In qualitative evaluation, emphasis is placed on the uniqueness of human experiences, eschewing efforts to impose categories or structures on experiences, at least until they are fully rendered in their own terms (Mc David, Hawthorn, 2006). In *Figure 4*, above, these qualitative data are reflected as the Survey of Healthcare Experiences of Patients (SHEP). These scores will reflect the measurement of women veteran satisfaction with a variety of aspects of care. Reports will be provided to the WVPM about quantitative and qualitative data. These data will be utilized to generate a comprehensive understanding about the quality of the PCMH for women veterans. To ensure that ongoing evaluation can occur in real-time, the WVPM will work closely with Continuous Quality Improvement (CQI) staff to aggregate data results.

Provider satisfaction will also be measured as part of evaluating the changes required for the implementation of the PCMH model and the development of WVCPC programs. This will be done informally as the WVPM meets with providers frequently, but will also be undertaken formally through the use of questionnaires and surveys published by system-wide administrators.

To some extent the ability of the VHA to sustain these new programs using funding allocated by the U.S. Congress will depend on the reports made each facility that describe success. New PCMH and WVCPC programs will need to demonstrate their effectiveness by providing positive reports about performance measures that reflect improvements in patient satisfaction, enrollment, and access to timely care.
Challenges

Responsibility for implementing the PCMH Model for women veterans at the Spokane VA has been the responsibility of the Women Veterans Program Manager (WVPM), although no additional program development or management authority has been allocated to this role to facilitate this important transition. Despite this significant limitation, the Spokane VA's WVPM has been successful in implementing integrated strategic program changes with all levels and services of the Spokane VAMC, helping to ensure the future success of PCMH for women veterans at this facility.

Moving to a patient-centered medical home model of care can present significant challenges for any health care organization and, in particular, for healthcare providers. Healthcare providers who are attuned to the unique healthcare needs of women veterans can respond more quickly and more effectively when health problems arise in this growing population (Fitzgerald, 2010). To some extent, support for providers is an important part of helping to ensure their satisfaction with the changes. Throughout the change process, the WVPM provided information to providers and staff directed toward improving their understanding the impact created by the increasing numbers of women veterans and the change in the age distribution. It was important for the WVPM to communicate with providers about the needs of young women veterans, newly available treatment modalities, and suitable pharmaceuticals, among other things. In addition, the WVPM monitors the use of gynecological and mental health treatments by women veterans and helps to guide the hiring and education of staff proficient in these areas.

As previously described, adjustments in panel sizes were made early in the program to offer providers longer visits with women veterans. Unfortunately, these panel size adjustments
were unsustainable. Fortunately, even with an increase in panel size, visit times have not decreased although this has resulted in longer wait times. The introduction of telephone visits was piloted to help overcome scheduling difficulties, but this has been met with significant resistance from the veterans themselves for a variety of reasons.

Despite offering women the opportunity to be reassigned to a comprehensive health care provider, many veterans opted to stay with their current providers rather than changing to a designated women's healthcare provider. This has meant that women veterans have two care providers, one who provides most primary care services and another who is educationally prepared to provide gender-specific services. Honoring the veterans' preference has been seen as paramount. As a result, complying with these requests has meant an increase in workload for women's comprehensive health care providers.

Finances are an ongoing challenge in every federal organization, especially during wartime. Related to this change, financing required the allocation of money to hire staff proficient in providing women’s health care and provide ongoing education for them. Funding had to be allocated to provide equipment and supplies needed to provide for women veteran’s unique needs. Financial planning needed to consider the anticipated rapid growth in the number of women seeking care at VA facilities. For Fiscal Year (FY) 2011, the VHA requested an increase of $18.6 million (or 9.4%) over the FY 2010 budget to meet gender specific health care needs and continue to enhance primary care for women (Congressional Budget Office, 2010).

Provision of services to veterans who use the SVAMC can be a challenge because of Spokane’s location as the hub of a highly rural area that encompasses 18 counties. To better access the number of rural women veterans, many VISN’s have designated outreach coordinators that work to increase growth of enrollees. By mid-2010, the Spokane VAMC began partnering
with several established rural clinics to provide care to those veterans living in that service area. The challenge remains to ensure that veterans receive the same quality of care through the use of these community partnerships as they do within other VHA sites.
CHAPTER FOUR

DISCUSSION

The entire VHA system is experiencing an influx of women veterans whose healthcare needs are different than the needs those of the men who were traditionally served by this large bureaucratic healthcare system. By 2020, women will represent one in every seven enrollees in the VHA system, versus one in every 16 in 2007 (VA, 2008). To meet the needs of these women veterans, the VA must respond by developing comprehensive, patient-centered models of care and programs directed to address the comprehensive physical and mental healthcare needs of women who have served in the US military.

One effort that has been made to improve healthcare services to women veterans is the Women Veterans Comprehensive Primary Care (WVCPC), a program implemented to provide women veterans with care in a Patient-Centered Medical Home (PCMH) model. The development of the WVCPC at the Spokane VA was undertaken between October 2010 and February 2011 and resulted in improvements in a wide array of healthcare services for women veterans. Responsibility for implementing the PCMH Model for women veterans at the Spokane VA has been the responsibility of the Women Veterans Program Manager (WVPM), who has been successful in implementing integrated strategic program changes with all levels and services of the Spokane VAMC, helping to ensure the future success of PCMH for women veterans at this facility.

Throughout the implementation period, under the leadership of the WVPM, clinical leaders and staff implemented a variety of team based process improvements, including specialized appointments for gender-specific healthcare concerns, improved telephone communication with patients, and increasing continuity of care (through assignment of women
veterans to a comprehensive women’s health care provider). Data are collected and reported about a number of patient outcome variables in an effort to measure the success of this new project. While early success has been mixed, there have been significant gains. For example, at 87.2% Spokane VAMC has the 2nd highest number of women veterans assigned to a comprehensive women’s healthcare provider in the VISN (J. Schilke, personal communication, October 12, 2010). In addition to helping the WVPM to monitor the current success of the WVCPC, a variety of data including results from ongoing focus groups and ad hoc inquiries will contribute to an understanding about the sustainability of this care model and will help guide the growth of women veteran’s health services into the future.

Ensuring program sustainability, communication with community partners, and recruitment and retention of healthcare providers will be important to the ongoing success of the WVCPC program. Improvements in information dissemination and patient education have been needed to ensure that women veterans are better informed about services available to them at the SVAMC and about the nature of the PCMH and its advantages for women veterans. Principles and practices of the PCMH model have been especially important as the VHA assumes responsibility for the lifetime care of increasing numbers of women veterans. The potential exists for the VHA to continue to make improvements for women veterans in access, quality, and satisfaction with care.

**The Future of Women’s Comprehensive Primary Care**

It has been essential to the success of the WVCPC model to date that women veterans have access to information that accurately describes the care and services they are entitled to obtain through the VHA system. To continue this success, a designated outreach coordinator position will need to be created to help ensure strong partnerships with community providers
who may be providing care to women veterans who are eligible to receive care in the VHA system.

Efforts will be continued to realize the full potential of the PCMH model within the VA. This patient-centered approach to care management has the potential to improve patient care and minimize provider burnout. Increasing access to care through improved communication with patients will continue to be important. Maintaining primary care staffing ratios will help to ensure that the right provider is available to care for women veterans in every clinical situation. To this end, the VHA will need to continue its presence emphasis on the improved recruitment and retention of healthcare providers (physicians, nurse practitioners, and physician assistants) who are interested in and committed to the provision of healthcare services to women veterans. To help ensure that adequate numbers of providers are available to meet patient needs, leadership support will be required to fund continued education and training of providers. Furthermore, providers will need new and continually improving skills and knowledge in assessing and treating chronic diseases as well as in providing preventive health services that are required by the PCMH model.

Despite the long list of challenges that face the Spokane VA in establishing a PCMH model for the care of women veterans, this model is realizing its potential to increase veterans’ satisfaction and to enhance the image of the SVAMC through reduction in duplication of services and fragmentation of care. Success in implementing a PCMH model of care at the Spokane VA will help to ensure the long-term viability of programs to support the health and well-being of women veterans well into the future.

Conclusion

This paper has described the process used at one VHA facility to implement a federally
mandated program, the Women Veteran’s Comprehensive Primary Care Program, a Patient-Centered Medical Home model of care for women who have served in the U.S Military. This process involved engaging all stakeholders involved in improving the provision of healthcare to women veterans. Success has been realized in improvements in identified comprehensive women’s healthcare providers at all sites, recent adoption of improved chronic care disease management, and increases in outreach activities. To sustain this success, the VHA will need to maintain its commitment to providing high quality care to women veterans, to hiring and educating providers who can provide gender-specific care, and to making necessary improvements in patient care processes. Close monitoring of data about progress in all areas of the PCMH model will be needed.

The process described here demonstrates the integration of evidence-based research findings to program development and discusses the application of nursing research to that process. By adding to nursing’s overall knowledge base, details about the implementation of this project can be applied to other VHA facilities as well as to community practices.
REFERENCES


American College of Obstetrics and Gynecology (2009). Women’s Medical Home Policy
Executive Board. Retrieved from:
http://www.acog.org/departments/dept_notice.cfm?recno=19&bulletin=5027


doi:10.1111/j1745-7599.2010.00520.x


Pendergrass, S. (2009, March). Transformational Initiatives. Presented at VA Spokane Town Hall meeting at the Spokane VA Medical Center, Spokane WA.


National Survey of Women Veterans. Enhancing Research-Clinical Partnerships for Improving the Care of Women Veterans. Retrieved from:

http://www.va.gov/about_va/vahistory.asp


U.S. Department of Veterans Affairs, (2010c) Office of Public and Inter governmental Affairs, Quality and Safety Report. Retrieved from:
http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2030


Vet Pop, ( 2007). Department of Veterans Affairs. Retrieved from:
http://www1.va.gov/VETDATA/Demographics/Demographics.asp.

