Women's Health During Health Care Transformation

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In the complex dynamic of today's health care transformation, an essential component is the promise and potential to improve women's health and health care. Moreover, women's vital roles as decision makers, providers, and caregivers mean that the transformation in progress is certain to enhance access to and quality of care for individual women, as well as their families and extended social networks.

The driving force for health care transformation is the Affordable Care Act of 2010 (ACA). Many physicians are already familiar with provisions in the ACA to expand health care insurance coverage to women and their families. In 2014, it will be illegal for insurance companies to deny coverage to anyone with a pre-existing condition, including pregnancy. In addition, sex will no longer be a pre-existing condition: insurers will not be able to charge women higher premiums than they charge men. Some provisions have already been enacted, such as providing coverage for dependent children through age 26 and no longer allowing coverage of children to be denied because of a pre-existing condition.

It is especially exciting that expanded coverage for women's health explicitly includes preventive services. The law requires new health plans to cover recommended preventive services, including vaccinations, cost-free. Regular well-baby and well-child visits are also covered from birth through age 21. These services do not require a co-pay or co-insurance when offered by providers in the insurer's network. Preventive services include evidence-based services rated "A" or "B" by the U.S. Preventive Services Task Force; for example, depression screening, flu shots and colorectal cancer screening for adults over 50. In addition, there are over 20 services targeted to women such as annual well-woman visits to obtain the recommended preventive services, domestic and interpersonal violence screening and counseling, contraception and contraceptive counseling, and chlamydia infection screening for younger women and other women at higher risk.

When coverage increases, how will access and coordinated care follow? Expanding access and coverage is

absolutely necessary to improve health and health care, but it is not sufficient. Our current system is highly fragmented as well as costly, so improving care delivery and enhancing coordination across settings are important to assure better access that result in improved health. The Affordable Care Act thus includes numerous provisions focused on improving quality of healthcare services. One model that has captured the attention of the primary care community is the patient-centered medical home (PCMH). This approach, with its strong focus on coordination and integration of services has enormous potential for women's health since historically, even primary care for women has too often represented a patchwork quilt with gaps.¹ PCMH is particularly relevant to women's role as health care coordinators for families. Effective, meaningful use of health information technology (IT) is vital to translating this exciting model into reality. Developing effective PCMH models will require significant workforce development, teamwork enhancement and fundamental payment reform.

Of the key features of PCMH, providing "comprehensive" care is probably the most challenging, particularly the urgency of addressing medical and behavioral health needs. Traditional primary care settings are comfortable with care coordination for healthy patients or those with a mild or common illness such as osteoarthritis or simple hypertension. However, treatment options have increased in both number and complexity. Patients increasingly have multiple morbidities, each needing more "specialized" or comprehensive care. Often, the specialized care relates to a behavioral-health morbidity. AHRQ-supported researchers have outlined programmatic and policy actions that are needed to facilitate integration of behavioral health care within a PCMH. These include: develop a strategy to normalize mental health into mainstream medical practice, integrate reimbursement mechanisms, create a roadmap for implementation, determine mechanisms to address the needs of those with complex mental health problems, and disseminate the tools needed by primary care providers.²

Promoting mental health of women and their families is an important strategy to address access and health disparities issues. Achieving equity in health requires two things. First, addressing the root causes of health inequities and second, resource allocation and interventions to specifically

address the unique needs of disadvantaged populations. Disparities in care must be described and considered. Every year since 2003, AHRQ reports to the Congress on the state of healthcare quality and healthcare disparities. During that period, we have documented steady, albeit slow, improvements in quality and safety, especially for acute conditions. However, though there are a few areas for optimism with respect to reducing disparities associated with race, ethnicity, gender, income and education, disparities remain pervasive across numerous domains. Specifically:

- Overall, improvement in the quality of care remains suboptimal and access to care is not improving (yet!).
- Few disparities in quality are getting smaller and almost no disparities in access are getting smaller.
- Particular problem areas include cancer screening and management of diabetes.
- Quality of care varies not only across types of care but also across parts of the country.

In terms of women's health, measures show a mixed picture of health care quality and disparities. A few examples³:

- In all years, females were more likely than males to be unable to get or delayed in getting needed medical care, dental care or prescription medicines.
- In 2009, adult females with a major depressive episode were more likely than their male counterparts to receive any treatment for depression in the last 12 months (67.4 % vs. 59 %). However, since 2008, the rate for females has decreased, while the rate for males has increased.
- From 2000 to 2008, the percentage of women ages 50–74 who reported they had a mammogram in the past 2 years did not change significantly.
- From 2000 to 2007, the rate of advanced stage breast cancer in women ages 50–64 decreased from 106 to 96 per 100,000 women. Rates among women ages 40–49 and age 65 and over did not change significantly.

Accelerating Quality Improvement Is Imperative. High quality, affordable, patient-centered care is an outcome that has coalesced across settings, providers and insurers to become a shared goal with action-based focus. The ACA offers many opportunities to improve the quality of healthcare delivered to Americans. These opportunities include:

- the creation of an Interagency Working Group on Healthcare Quality;
- increased quality measure development; and
- support for the expansion of quality-focused entities such as accountable care organizations and patient centered medical homes.

Another significant initiative called for in ACA is the development of a national strategy to improve healthcare quality. Recognizing multiple efforts under way by the public and private sectors to improve quality, the act calls on the U.S. Department of Health & Human Services (DHHS) to identify priorities to improve the delivery of healthcare services, patient health outcomes, and population health. The National Quality Strategy also should include provisions to align efforts of public and private payers and reflect the “meaningful use” requirements for health IT (www.ahrq.gov/workingforquality).

WHAT CAN THE U.S. LEARN FROM THE VA IN GENERAL AND IN SUPPORT OF WOMEN'S HEALTH?

While we face enormous challenges ahead as we embark on health care transformation as a country, the Veterans Health Administration (VA) healthcare system—the only national integrated healthcare system in the US—has made many of the advances over the past 20 years that we seek to accomplish now.⁴ Veterans enrolled in the VA “health plan” are not turned away for pre-existing conditions (though they may have a co-pay for non-service-connected care). The VA has launched medical homes and already serves as an accountable care organization, given its integration across hospitals, nursing homes, and outpatient primary, specialty, surgical and mental health care programs, in addition to home-based primary care and major initiatives to increase non-face-to-face care. The VA's electronic medical record already spans all of those care settings, and leverages its enormous data resources with decision support functions that support practice improvement and evidence-based policymaking.⁵ The VA has also a decade-long primary care-mental health integration initiative, which has already co-located mental health professionals and/or implemented collaborative care in virtually every VA primary care practice nationwide.⁶

VA initiatives in women's health care delivery have capitalized on these system-level advantages and map to ACA priorities.⁷ For example, the VA reports quality indicators by gender, making reductions in documented gender disparities a formal part of network-level incentivized performance plans, which have made important inroads. VA already covers women's preventive services and have achieved much higher rates than outside the VA.⁸ To address the rapid influx of women Veterans into VA care, the VA also developed women's health mini-residencies, training over 1,500 providers to ensure proficiency, established national policy requiring comprehensive care delivery to women Veterans in “one-stop shopping” models, and recently instituted after-hours care policies to accommodate working Veterans (women and men). VA also

covers maternity care and recently added seven days of routine medical care for the newborn.

Specific implications of ACA for women Veterans are not clear as yet. Like other women in America, women Veterans will have more choices and may elect care delivery options outside the VA. Non-VA options may provide access through geographically closer facilities in environments with more women, but especially for women Veterans with service-connected disabilities, dual use may involve challenges ensuring continuity and coordination, as well as impair access to other needed services for which VA has special expertise, such as VA mental health services. The VA also serves the Veteran (and active duty military under selected arrangements) and not family members (except under CHAMPVA), including support for their transition from military service to civilian life, and is in contrast to most other health plans. Helping women Veterans bridge care needs that may go beyond the VA's typical boundaries may need to become an even higher priority.

FINAL THOUGHTS

Making the most of ACA-directed initiatives and responding to the social and economic urgency inherent in the scale of healthcare improvements represents an unprecedented leap forward for women's health, but will also involve changes in virtually all domains of general internal medicine: education, clinical care, research, patient engagement and advocacy. It is not yet routine that all health care professionals learn about the importance of teamwork or acquire the skills to participate as team members. Implicit in the ACA's promise of fair, affordable coverage is the need for individual women to be partners in their care, and to have clinicians who have the capacity and skill to respond. Transparency regarding clinical performance, with a strong focus on patients' experience of care, is a reality now—but clinicians desperately need support to improve and opportunities to learn from colleagues striving toward the same goals. In addition, dramatic changes in the capacity of systems to respond to individual women's needs and preferences will require substantial changes to business as usual, e.g., after-hours care, and schedules that fit with the time demands of women's daily lives.

These changes represent an incredible opportunity for health care researchers to apply their skills and methods to rapid learning and evaluation, but this will require a participatory model that is quite different from research of the past.⁹ Research that involves ongoing consultation with stakeholders, including patients, may be perceived as less efficient, but the potential for impact and engagement is enormous. Enlightened institutions will create alternative career

paths, promote multidisciplinary research and adjust promotion/tenure criteria to reward novel and patient-centered research on health services.

The American healthcare system is as diverse as it is vast—ranging from solo physician practices to large integrated delivery networks spanning many states. Yet wherever they practice, no matter the setting, healthcare practitioners are united in their goal of providing high-quality, affordable care for their patients. Registries and similar approaches to collecting clinical data systematically can generate important hypotheses, facilitate longitudinal follow up, and help assure that resources used for clinical trials are invested as wisely as possible.

Women need to see quality, equitable and coordinated care on the other side of where the barrier used to be. Research that improves health care has to be firmly grounded in patients' concerns and questions to assure relevance. We now know that research that is responsive to patients' needs and preferences can make a huge impact and result in:

- Better translation, dissemination and use of research results
- Better evidence to inform guidelines
- Targeted quality improvement (QI) for women to improve quality and safety
- Using research to address concerns of diverse patients and clinicians

Taking advantage of the opportunities that currently exist for advancing women's health research will lead to improved health services. The VA has already leveraged these opportunities and stands at the forefront of women's health research and quality improvement. Women's health efforts within VA, some of which are described in this supplement, can serve as models for providers and patients in the health care system interested in promoting health care for women, their families and communities.

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