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Providing Patient-Centered Care to Veterans of All Races: Challenges and Evidence of Success

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The patient-centered medical home (PCMH) is transforming the way primary care is delivered, but the effects of this transformation on patients of racial and ethnic minority groups is unclear. The PCMH is not designed specifically to address racial and ethnic disparities, but because minority patients tend to have worse clinical outcomes than non-minorities,[1–3] they might disproportionately benefit from a PCMH if the PCMH improves clinical outcomes for all patients. However, greater adoption of the PCMH model could also worsen health disparities if it is implemented unequally across clinics that serve minority and non-minority patients. Healthcare in this country is largely segregated, such that a small number of minority-serving facilities care for a disproportionate share of minority patients. Half of all black patients are seen at 10 % of hospitals,[4] and 75 % of minority veterans are seen at 28 % of VA facilities.[5] If minority-serving facilities are less likely to adopt or fully implement a PCMH, then racial disparities in clinical outcomes could worsen.

There is evidence of both of these phenomena in the implementation of the PCMH at the VA. The initiative, which began in 2010, brought new elements of team-based care and care coordination, including the integration of co-located mental health professionals in primary care to speed resolution of problems associated with mental health and substance use disorders.[6] While national evaluations suggest a modest effect of the VA PCMH program on healthcare use to date,[7] the program is still evolving, and some research suggests that a fully implemented PCMH may have significant benefits for veteran health. Nelson et al.[8] described a metric for VA PCMH implementation—the Patient Aligned Care Team (PACT) Implementation Progress Index (Pi^2). The Pi^2 measures not only whether a clinic had the staff and processes in place to provide team-based care, but also whether the clinic was functioning as a medical home as evidenced by high scores from veterans with regard to various aspects of care, including whether the care was accessible, coordinated, and patient-centered. They reported that facilities with higher levels of Pi^2 recorded higher scores across a wide list of quality-of-care measures, including control of blood pressure and lipid levels, that are known to have substantial health benefits over the long run. Hernandez et al.[5] used the Pi^2 score to assess whether these benefits of PCMH were reaching minority veterans. They found that clinics that served a high percentage of minority veterans tended to have somewhat lower Pi^2 scores than did clinics that served a lower percentage of minorities. Thus, on the one hand, a high-functioning PCMH has the potential to improve veteran health over the long term, which may disproportionately benefit minority veterans; on the other hand, PCMH implementation at the VA has been less robust at minority-serving VA facilities. A key question, therefore, is which of these effects dominates.

The paper by Jones et al.[9] in this issue makes substantial contributions toward addressing this question. The study considers a very large, geographically and racially diverse sample of veterans with mental health and substance use disorders, which is a particularly high-risk group who may especially benefit from the team-based care of a PCMH. Jones et al. compared patient-reported satisfaction with seven aspects of care across four racial groups. They used a novel approach of assessing racial differences in rates of positive as well as negative responses, rather than just focusing on an overall score. In adjusted analyses, the authors found a number of statistically significantly differences in patient experiences across racial groups.

Like all good disparities researchers, Jones et al. chose to highlight the gaps between white and nonwhite racial groups where nonwhite veterans expressed more negative or less positive experiences with various aspects of care. These gaps represent opportunities to improve the experiences of minorities and potentially to reduce racial health disparities. In particular, the researchers found consistently less favorable experiences among Asian/Pacific Islanders and American Indian/Alaska Native veterans regarding communication with their provider and the helpfulness and respectfulness of staff.

However, their study also contained decidedly positive findings, especially for black veterans. In adjusted results, black patients reported either lower rates of negative scores or higher rates of positive scores, or both, on six of the seven PCMH domains considered. This is consistent with recent findings on black–white differences in patient-reported experience of hospital stays,[10] in which satisfaction among black patients was statistically significantly higher than that in whites for seven of ten measures of hospital experiences, and

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significantly lower for one measure. The adjusted findings for Hispanic veterans in the Jones et al. study were also net positive for six of the domains—two reflecting better experiences for Hispanics than whites (i.e., either more positive or less negative), one reflecting worse experiences, and three with no statistically significant difference despite a very large sample of Hispanic veterans. Black and Hispanic veterans represented 93 % of minority veterans in this study, so the great majority of minority veterans reported care experiences that were comparable to or better than those reported by white veterans for six of the seven domains investigated. The unadjusted data on experiences were not so uniformly favorable, but there were significant differences in patient demographics and other characteristics, and the authors chose to adjust for those characteristics that were more or less immutable from the perspective of administrators and providers who are trying to establish a PCMH.

The one domain in which experiences were consistently worse for minority veterans compared to whites, even after adjusting for patient characteristics, was access to care, which reflects a veteran's perceived ability to get an appointment when one was needed, and to get appointments on weekends and evenings. Black, Hispanic, and Native American/ American Indian veterans all reported higher negative scores and lower positive scores for access than did white veterans. However, access is different from other domains of the PCMH experience, because it is more closely tied to the facility where a veteran receives care than are other measures. Veterans of different races may have disparate experiences with particular providers or staff within a facility, but weekend appointments either exist or not for all veterans at the facility. Moreover, facilities that face high demand for care relative to their capacity have longer wait times for all veterans, and some evidence suggests that such facilities tend to serve a large number of black veterans. This can be seen in Figure 1, which depicts data from the 21 regional Veterans Integrated Service Networks (VISNs). For each VISN, the percentage of veterans who said they were "always" able to get an appointment when they needed one is plotted against the growth in VA users from 2006 to 2015 for that VISN. The sizes of circles are proportional to the number of black veterans served at the facility in 2015. Faster growth is correlated with worse reported access (Pearson correlation coefficient −0.72; $p < 0.001$) and a somewhat higher number of minority patients (correlation 0.37; $p = 0.096$). For example, the highlighted VISNs in Figure 1 serve New England and the Southeast (Georgia, Alabama, and South Carolina), respectively. In 2006, these two VISNs served comparable numbers of veterans, but over the next decade the New England VISN grew by 5 %, while the VISN serving the Southeast grew by 45 %. The Southeast VISN also has the highest number of black veterans of any VISN. It may not be surprising that veterans in the minority-serving facilities in the Southeast are experiencing access problems.

Jones et al. chose not to control for facility-level effects in their adjusted analysis, so the worse experiences of black,

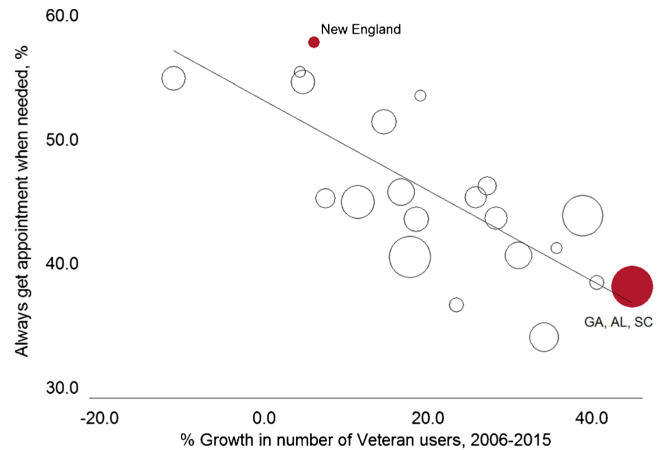

Figure 1 Relationship between the growth in veteran users from 2006 to 2015 and the percentage of veterans in 2015 who responded that they were "always" able to access VA care when it was needed, by Veterans Integrated Service Network (VISN). VISNs represent regions of the country. The size of the bubble represents the number of black veteran users in each VISN. The highlighted VISNs had a similar number of veteran users in 2006. Source: Veterans Health Administration Support Service Center (VSSC).

Hispanic, and Native American/American Indian veterans may simply reflect the fact that these veterans disproportionately reside in regions where the growth of the veteran population is outpacing the ability of the VA to provide timely care. Controlling for site might also inform whether racial differences in experiences are attributable to less robust implementation of the PCMH at minority-serving facilities or differences by race in experiences of PCMH at a facility.

Of course, statistical adjustments that reduce odds ratios do not eliminate disparities; they merely highlight pathways by which disparities might be addressed. There are racial disparities in experiences of access to care in the VA that the study by Jones et al. identify, and there are racial differences in the experience of that care. This underscores two major challenges facing VA primary care: that of providing veterans with timely access to care, and that of providing patient-centered care to veterans of all races and ethnicities once they have engaged with the system. Jones et al. show that the VA continues to struggle with the first of these, perhaps because VA facilities have failed to keep pace with a growing veteran population. But their study also provides evidence that the strong institutional commitment to reducing disparities at the VA[11] may be paying dividends in terms of the experiences of primary care for black and Hispanic veterans with mental health and substance use disorders.

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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