Title

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Journal

Psychological Services, 16(3)

ISSN

1541-1559

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Publication Date

2019-08-01

DOI

10.1037/ser0000226

Peer reviewed

Published in final edited form as:
Psychol Serv. 2019 August ; 16(3): 498–503. doi:10.1037/ser0000226.

Timely Access to Mental Health Care among Women Veterans

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Abstract

Using survey data on (N=419) patients at Department of Veterans Affairs (VA) clinics we analyzed women veterans' reports of timely access to VA mental health care. We evaluated problems that patients might face in obtaining care, and examined subjective ratings of VA care as a function of timely access to mental health care. We found that 59% of participants reported "always" getting an appointment for mental health care as soon as needed. In adjusted analyses, two problems were negatively associated with timely access to mental health care: 1) medical appointments that interfere with other activities, and 2) difficulty getting questions answered between visits. Average subjective ratings of VA ranged from 8.2–8.6 out of 10, and 93% of participants would recommend VA care. Subjective ratings of VA were higher among women who reported timely access to mental health care. Findings suggest that overall experience of care is associated with timely access to mental health care, and that such access may be amenable to improvements related to clinic hours, or mechanisms for answering patient questions between visits.

Keywords

access; women's health; mental health; veterans

Introduction

Women's contribution to today's U.S. military is unprecedented, with women comprising 15% of active military personnel (National Center for Veterans Analysis and Statistics, 2011). Sixty-four percent of women veterans of recent military conflicts (post-9/11) have already received health care through the Department of Veterans Affairs (VA) and their use of VA health services is rapidly increasing (Veterans Health Administration, 2017). Across eras of services, between 2005 and 2015 the number of women veterans who used VA more

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The views expressed in this study are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

than doubled, and there was a 49% increase in the proportion of woman veteran VA-users who accessed VA mental health services (Greenberg & Hoff, 2016). This growth requires the VA to meet increasing demands while adapting to the changing needs of its patients, including the growing number of women veterans.

Patient-related barriers to engaging veterans in mental health care have been explored – for example, veterans' beliefs about mental health care or perceived stigma – however very few studies have examined these issues in women (Runnals et al., 2014). In a 2015 study, investigators assessed the degree to which VA mental health care met women veterans' perceived needs, and found that most women (84%) who perceived a need for mental health care had received such care in the previous year, and that nearly all of those women (91%) used VA for at least some of that care (Kimerling et al., 2015). The authors found that mental health care's "ease of use" was associated with the degree to which it met their needs. However, the features of the health care system that make it easy or difficult to use in this context were not identified.

In 2005, VA researchers conducted interviews, focus groups, and surveys that identified some of the key "hassles" or problems that patients face in interacting with the health care system (Noel, Frueh, Larme, & Pugh, 2005; Parchman, Noel, & Lee, 2005). This research identified frequently-noted problems that make the health care system more difficult to use, that are also amenable to change. Investigators have evaluated the association between these problems and various attributes of primary care (Parchman et al., 2005), and have identified patient-level differences in the experience of these problems (Adeniji, Kenning, Coventry, & Bower, 2015), but the association between these health care system problems and mental health care access has not been evaluated. Similarly, a modest but informative literature about veterans' overall access to mental health care exists, but most of this literature comes from studies with predominantly male samples, and most studies focus on patient-level factors that are less directly informative for system-level changes to improve access.

Previous studies have examined strategies for reducing wait times in mental health (Williams, Latta, & Conversano, 2008). These studies, as well as VA directives, focus on objective metrics of timely access, often operationalized by a specific number of days between the date that mental health care is needed or desired and the date that it occurs (e.g., within 30 days). However, a patient's evaluation of timely access to care may not correspond to this window, and this metric carries multiple limitations as a proxy for timely access to mental health care (US Government Accountability Office, 2015). In addition, no studies to date have explored the timely availability of mental health care as reported by women veterans.

Our study presents an alternative approach to evaluating timely access to mental health care by assessing women veterans' perceptions of the timeliness and quality of care. Using patient-reported measures, we evaluate specific health care system problems that might inhibit access to mental health care. We also assess the association between women veterans' reports of timely access to mental health care and their subjective ratings of the quality of VA health care.

Method

Participants

Data were derived from the second wave (12-month follow-up) of a multi-site survey about women veterans' health care at VA, conducted as part of a cluster-randomized controlled trial of evidence-based quality improvement strategies for implementing patient-aligned care teams (PACT) for women veterans (*Implementation of Women's Health Primary Care Teams Study)* (Yano et al., 2016). The parent study design and rationale are described in a previous publication (Yano et al. 2016). Participants in the parent study were women veterans with ≥ 3 visits to a VA primary care or women's health clinic within the prior year. Potential participants were identified by stratified random sampling of clinic rosters from primary care and women's health clinics at 12 VA medical centers participating in a national Practice-Based Research Network (PBRN) for women veterans (Pomernacki et al., 2015). The cumulative response rate of the second survey wave was 39% (i.e., 84% of the first wave, which had a response rate of 46%) (American Association for Public Opinion Research, 2011). The current study includes participants in the second survey wave who reported having received any mental or behavioral health care in the previous 12 months, and rated the timeliness of that care (N = 419).

Procedure

An advance information packet about the study was mailed to participants, and up to 12 attempts were made to contact each potential participant using a computer-assisted telephone interviewing system. The study was approved by the Institutional Review Board at VA Greater Los Angeles.

Measures

Survey measures were derived from validated instruments adapted using pilot tests and cognitive interviews with women veterans.

Timely access to mental health care—Timely access to mental health care was measured with the survey question "In the last 12 months, when you needed to schedule an appointment for mental or behavioral health care through the VA, how often were you able to get an appointment as soon as you needed? Always, usually, sometimes, or never?" This question was adapted from the Experience of Care and Health Outcomes (ECHO) Survey (Agency for Healthcare Research & Quality, 2016). In our primary analyses, we used the "top box" approach that is frequently employed to analyze left-skewed ratings. Namely, we conservatively defined timely access to mental health care as an answer of "always," and conducted sensitivity analyses using the less stringent criterion response of either "always" or "usually."

Covariates—We included self-reported measures of age, race/ethnicity, and employment status as covariates in adjusted models. Because access to mental health care may be moderated by general health status, we included an overall measure of self-reported health, rated on a five-point Likert-type scale (DeSalvo, Fan, McDonell, & Fihn, 2005). We included the Patient Health Questionnaire for Depression and Anxiety (PHQ-4), a four-item

inventory rated on a four-point Likert-type scale, with a sum score of six or higher indicating moderate to severe anxiety/depression (Löwe et al., 2010). We used the four-item Primary Care Posttraumatic Stress Disorder (PC-PTSD) Screen (Lang & Stein, 2005), as well as the VA's two-item screen for military sexual trauma (MST) (Kimerling, Gima, Smith, Street, & Frayne, 2007).

Health care system problems—Possible problems with obtaining timely access to mental health care were measured with four items from the 16-item Health Care System Hassles measure, which was developed within the VA health care system (Parchman et al., 2005). The 16-item inventory includes items of relevance to health care in general, as well as items that query problems seeking specific types of care or procedures that are outside the scope of this study (e.g., primary care, imaging). Based on available research on women veterans' mental and physical health comorbidity (Runnals et al., 2014), patterns of health care utilization (Washington, Kleimann, Michelini, Kleimann, & Canning, 2007), and the connection between mental health status and provider communication (Martino et al., 2011), we selected four items from the full scale, a priori: 1) "difficulty getting questions answered, or getting medical advice, between scheduled appointments at VA;" 2) "having your concerns ignored or overlooked by your VA provider;" 3) "medical appointments that interfere with your work, family, or hobbies;" and 4) "poor communication between any of your different doctors or clinics." Items were rated on a four-point scale, from *No Problem* to *Very Big Problem*, with ratings above two indicating the presence of a problem or "hassle."

Subjective ratings of quality of care—To measure patients' subjective ratings of the quality of VA health care, we asked them to rate the quality of care received in the past 12 months, on a scale from 0 = lowest quality to 10 = highest quality, for 1) VA mental health care 2) VA primary care, and 3) VA health care overall. These questions were adapted from the VA's Survey of Healthcare Experiences of Patients (SHEP). In addition, we asked participants to indicate whether they would recommend VA care to other women veterans on a four-point scale, which ranged from *Strongly Recommend* to *Strongly Not Recommend*.

Analyses

First, we compared participants who reported timely access to mental health care to those who did not using chi-squared tests for categorical independent variables and a univariate regression model for continuous variables. In all analyses, we used survey weights to account for the non-proportional sample design and for non-response. The application of these survey weights also accounts for clustering of participants within clinics.

We used multivariate logistic regression to identify factors associated with timely access to mental health care – i.e. to explore whether each of four health care system problems might be barriers to timely mental health care access, and to examine patient-level factors' association with timely mental health care access. We conducted these analyses using an analytic sample consisting of complete cases (n = 392). We compared this sample with the full study sample to check for bias in the analytic sample and examined correlations among variables to avoid multi-collinearity in the multivariate model.

We used chi-squared tests to evaluate whether women veterans reporting timely access to mental health care would give higher subjective quality ratings. These analyses were conducted using an analytic sample of participants who provided all four subjective quality ratings (n = 399). We conducted sensitivity tests using marginal effects based on multivariate linear regression models to determine whether these differences were statistically significant after adjusting for patients' sociodemographic factors, self-reported health, and mental health screens.

Results

Timely Access to Mental Health Care and Sample Characteristics

In our sample of 419 women veteran primary care users who had received mental health care in the previous 12 months, 248 (59%) reported "always" getting an appointment for mental health care as soon as needed, and another 93 (22%) reported "usually" getting an appointment as soon as needed (see Figure 1). Sample characteristics, descriptive statistics and bivariate associations between timely access and all variables of interest are presented in Table 1.

In unadjusted analyses, participants with worse self-reported health were somewhat less likely to report timely access (p =.01), as were those who screened positive for PTSD (p = .02) or for anxiety/depression (p = .01) (see Table 1). Each of the four health care system problems assessed were negatively associated with timely access to mental health care (all p < .01).

Regression Model of Timely Access to Mental Health Care

In the adjusted model, two health care system problems were significantly negatively associated with the odds of reporting timely access to mental health care: "difficulty getting questions answered between visits" (OR: 0.42, 95% CI [0.21, 0.84]) and "appointment times conflicting with other activities" (OR: 0.44, 95% CI [0.23, 0.87]) (see table 2). In the adjusted model, neither of the other health care system problems were associated with timely access to mental health care, nor were any of the sociodemographic or health status indicators.

In a sensitivity analysis examining associations with the odds of reporting timely access to mental health care "always or usually," the association with "appointment times conflicting with other activities" was even greater (OR: 0.25, 95% CI [0.11, 0.55]), while the association with "difficulty getting questions answered between visits" diminished (OR: 0.53, 95% CI [0.25, 1.10]) and was no longer statistically significant. The direction and approximate magnitude of the other health care system problems were unchanged.

Subjective ratings of VA health care

Ratings of VA health care were generally high, with mean ratings ranging from 8.2 to 8.6 out of 10 regarding the quality of VA mental health care, VA primary care, and VA health care overall, and 93% of respondents reporting that they would "recommend" / "strongly recommend" VA health care to other women veterans (Table 3). Timely access to mental

health care was significantly positively associated with all four of these indicators ($p < .01$). The direction, significance, and approximate magnitude of these associations were unchanged in sensitivity tests that adjusted for sociodemographic factors, self-reported health, and mental health screens.

Discussion

Our study is the first, to our knowledge, to report women veterans' perceptions of the timeliness of their access to VA mental health care. Most women in our sample reported always getting an appointment for VA mental health care as soon as needed (59%), and another 22% reported usually getting an appointment as soon as needed. Women veterans who reported having appointments interfere with other activities or having difficulty getting questions answered between visits were less likely to say they were always able to get a mental health appointment when needed.

Reports of "having appointments interfere with other activities" suggest that more flexible clinic appointments may improve the perceived timeliness of access to mental health care. When resources and external supports are limited, women veterans face tough choices between competing demands, and potentially delay or forgo their own mental health treatment and prioritize other obligations, like work or childcare (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). As such, our findings support VA policies aimed at increasing appointment time availability to include weekend or evening clinic hours (Veterans Health Administration, 2013). These findings also support ongoing development of open access scheduling, non-face-to-face visit modalities (e.g., telemedicine), and community or primary care-based mental health interventions (Post, Metzger, Dumas, & Lehmann, 2010), to reduce the need for frequent in-person visits for veteran patients.

Our study also identified the ability to get questions answered between visits as an important factor in access. This finding argues for continued investment in mechanisms for remote communication between providers and patients. The ability to ask questions related to clinic care between visits may help to reduce the need for in person visits, and can provide opportunities to assess for urgency. This has prompted VA medical centers to evaluate and seek to improve their call centers and phone triage systems, and expand secure messaging capabilities for patients to contact VA providers. Options that allow patients to contact providers outside of a standard clinic visit can also contribute to the efficiency and flexibility of the health care system as a whole, by helping to keep more appointments available for patients whose needs must be addressed in standard clinical settings. Additional research is needed to determine whether secure messaging, telephone clinics, or improved methods of answering systems for mental health visits improve patients' (or subgroups of patients') perceptions of access to care.

Women veterans' ratings of mental, primary and overall health care at VA were generally very high; each averaged above 8 (on a scale from 0–10). Likewise, the vast majority of women (93%) indicated they would recommend or strongly recommend VA to other women veterans. Our findings suggest that timely access to mental health care may shape (positively and negatively) women veterans' opinions of other aspects of care at the VA. Timely access

to mental health care was associated not only with ratings of mental health care quality, but also with ratings of primary care and health care overall. These findings align with VA priorities, including the goal of same-day access to clinically indicated mental health services, as part of the MyVA Access initiative.

Of particular interest is the association between timely access to mental health care and willingness to recommend VA to other women veterans. Word of mouth among veterans has been shown to be an overwhelmingly important factor in the decision to seek care at the VA, particularly among women veterans (Washington et al., 2007).

This study is limited by some methodological factors. First, we rely on patients' subjective experience of timeliness. We believe this is an important measure, but were not able to compare it to objective measures of appointment wait times. Second, the health care system problems we examined were reported for VA health care as a whole, and were not specific to mental health care. This creates a conservative bias that could obfuscate a true association, but decreases the likelihood of spurious associations. Third, our study population consists of women veterans who are active users of VA primary and mental health care, and may not be fully representative of the larger population of woman veterans. Fourth, our data were cross-sectional and we are limited in our ability to infer causal relationships.

This study was the first to report women veterans' experiences of timely access to mental health care and satisfaction with VA mental health care. Encouragingly, most women veterans report timely access to care and give high ratings of the quality of care they receive at VA. The study highlights opportunities for addressing barriers to timely access to VA mental health care (i.e., "appointment times conflicting with other activities," "difficulty getting questions answered between visits") through patient-centered health care innovations, such as non-traditional clinic hours, open access scheduling, telemedicine, and secure messaging.

Acknowledgments

The parent study, Implementation of Women's Health Patient Aligned Care Teams (WH-PACT) (Project CRE 12-026), is a cluster randomized trial registered in ClinicalTrials.gov (), funded by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development (HSR&D) Service through the CREATE initiative. Support was also provided by the VA HSR&D-funded Women's Health Research Network through involvement of the VA Women's Health Practice Based Research Network (Project SDR 10-012) and by the VA HSR&D Center for the Study of Healthcare Innovation, Implementation and Policy (CIN 13-417). Dr. Yano's effort was funded by a VA HSR&D Senior Research Career Scientist Award (Project RCS 05-195). Dr. Schweizer was supported by the VA Office of Academic Affiliations through the VA Advanced Fellowship Program in Women's Health. The authors gratefully acknowledge the contributions of Catherine Chanfreau-Coffinier, Jill Darling, the WH-PACT survey team, Davis Research, and the women veterans who participated in the survey.

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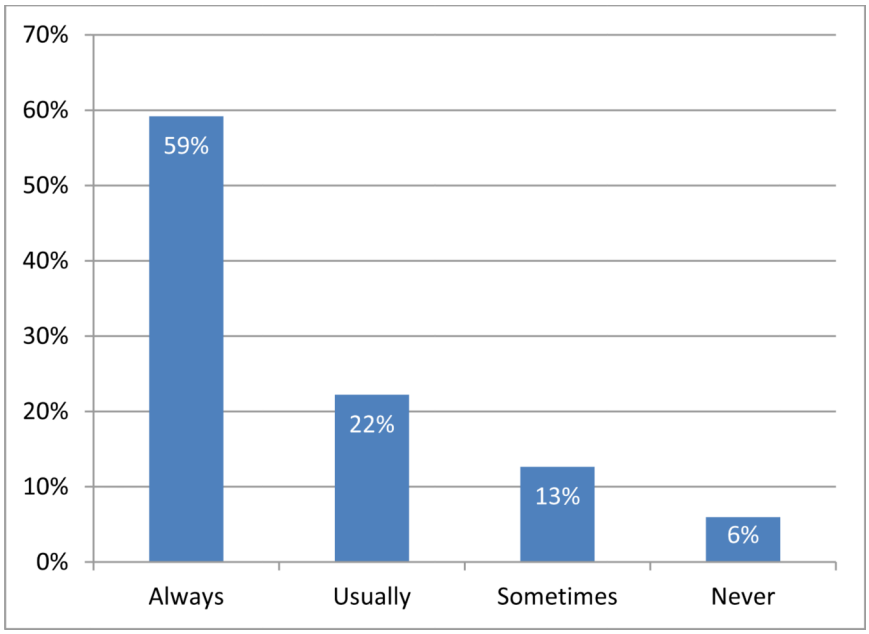

Figure 1.
Timely Access to Mental Health Care Reported by Women Veterans (n = 419)

Table 1

Participant Characteristics

		Timely Access to Mental Health Care		
	Full Sample (n=392)	**Always (n=231)**	**Usually/Sometimes/Never (n=161)**	***p* value**
Sociodemographics				
Age				.26
18–44 *	92 (23.5)	49 (21.2)	43 (26.7)	
45–64 *	240 (61.2)	142 (61.5)	98 (60.9)	
65+ *	60 (15.3)	40 (17.3)	20 (12.4)	
Race				.27
White *	244 (62.2)	148 (64.1)	96 (59.6)	
Black *	91 (23.2)	55 (23.8)	36 (22.4)	
Other *	57 (14.5)	28 (12.1)	29 (18.0)	
Lesbian, Gay, or Bisexual	45 (11.5)	21 (9.09)	24 (14.9)	.08
Employment Status				.84
Employed *	140 (35.7)	81 (35.1)	59 (36.7)	
Unemployed *	41 (10.5)	23 (10.0)	18 (11.2)	
Not in the labor force *	211 (53.8)	127 (55.0)	84 (52.2)	
Physical and Mental Health Screens				
Self-Reported Health (out of 5) †	2.69 (0.98)	2.79 (1.03)	2.53 (0.89)	.01
MST+ *	281 (71.7)	160 (69.3)	121 (75.2)	.21
PTSD+ *	200 (51.0)	107 (46.3)	93 (57.8)	.02
Moderate/Severe Anxiety/Depression *	149 (38.0)	75 (32.5)	74 (46.0)	.01
Health Care System Problems				
Difficulty getting questions answered *	64 (16.3)	20 (8.66)	44 (27.3)	< .001
Concerns overlooked by provider *	61 (15.6)	21 (9.09)	40 (24.8)	< .001
Appointment times conflicting with other activities *	55 (14.0)	20 (8.66)	35 (21.7)	< .001
Miscommunication among providers/clinics *	74 (18.9)	28 (12.1)	46 (28.6)	< .001

* Number of respondents (weighted percentage)

† Weighted mean (SD)

MST: Military Sexual Trauma; PTSD: Posttraumatic Stress Disorder

Table 2

Regression Model of Timely Access to Mental Health Care (n = 392)

	OR	95% CI
Sociodemographics		
Age (Ref: 18–44)		
45–64	1.18	[0.70, 2.00]
65–99	1.55	[0.70, 3.44]
Race (Ref: White)		
Black	0.95	[0.56, 1.61]
Other	0.70	[0.37, 1.32]
Lesbian, Gay, or Bisexual	0.58	[0.30, 1.12]
Employment Status (Ref: Employed)		
Unemployed	1.17	[0.55, 2.45]
Not in the labor force	1.04	[0.62, 1.74]
Physical and Mental Health Screens		
Self-Reported Health (out of 5)	1.15	[0.89, 1.48]
MST+	1.11	[0.66, 1.88]
PTSD+	0.74	[0.46, 1.17]
Moderate/Severe Anxiety/Depression	0.93	[0.57, 1.52]
Health Care System Problems		
Difficulty getting questions answered between visits	0.42*	[0.21, 0.84]
Concerns overlooked by provider	0.57	[0.27, 1.19]
Appointment times conflicting with other activities	0.44*	[0.23, 0.87]
Miscommunication among providers/clinics	0.88	[0.46, 1.70]

* $p < 0.05$

Table 3

Women Veteran Mental Health Care Users' (n=399) Subjective Ratings of VA Stratified by Timely Access to Mental Health Care

Outcome Variable		Timely Access to Mental Health Care	
	Full Sample	**Always**	**Usually/Sometimes/Never**
Quality of care rating:	Mean (SD)	Mean (SD)	Mean (SD)
VA mental health care (0–10) ***	8.51 (2.05)	9.20 (1.32)	7.43 (2.47)
VA primary care (0–10) ***	8.66 (1.78)	8.95 (1.59)	8.21 (1.96)
VA health care overall (0–10) ***	8.18 (1.92)	8.57 (1.66)	7.56 (2.12)
Recommend or strongly recommend	N (%)	N (%)	N (%)
VA to other women veterans **	370 (92.7)	233 (95.9)	137 (87.8)

* $p < 0.05$

** $p < .01$

*** $p < .001$