VETERAN ACCESS TO CARE EVALUATION

Measuring Access to Care in VHA: Novel Metrics and Future Possibilities

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PACT Demonstration Lab
Cyber-Seminar Series

Conflicts of Interest:
None

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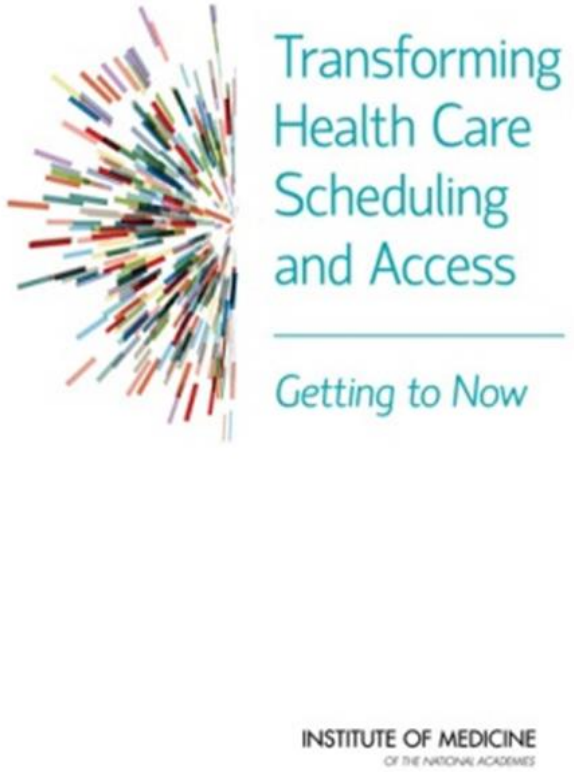
VETERAN ACCESS TO CARE EVALUATION

OBJECTIVES

- Describe historical metrics of healthcare access, currently used and available metrics, and explore future possibilities for measurement.
- Access metrics will include both actual (objective) and perceived (subjective) measures from both the patient and health system perspective.
- Input on what is needed by both researchers and administrators for measuring and improving access will be solicited.

2015 INSTITUTE OF MEDICINE REPORT



- *"The IOM report* Crossing the Quality Chasm *(2001) identified six fundamental aims for healthcare-that it be: safe, effective, patient-centered, efficient, equitable, and* ***timely****. Of these fundamental aims,* ***timeliness*** *is in some ways the least well studied and understood."*

ACCESS: DEFINITION

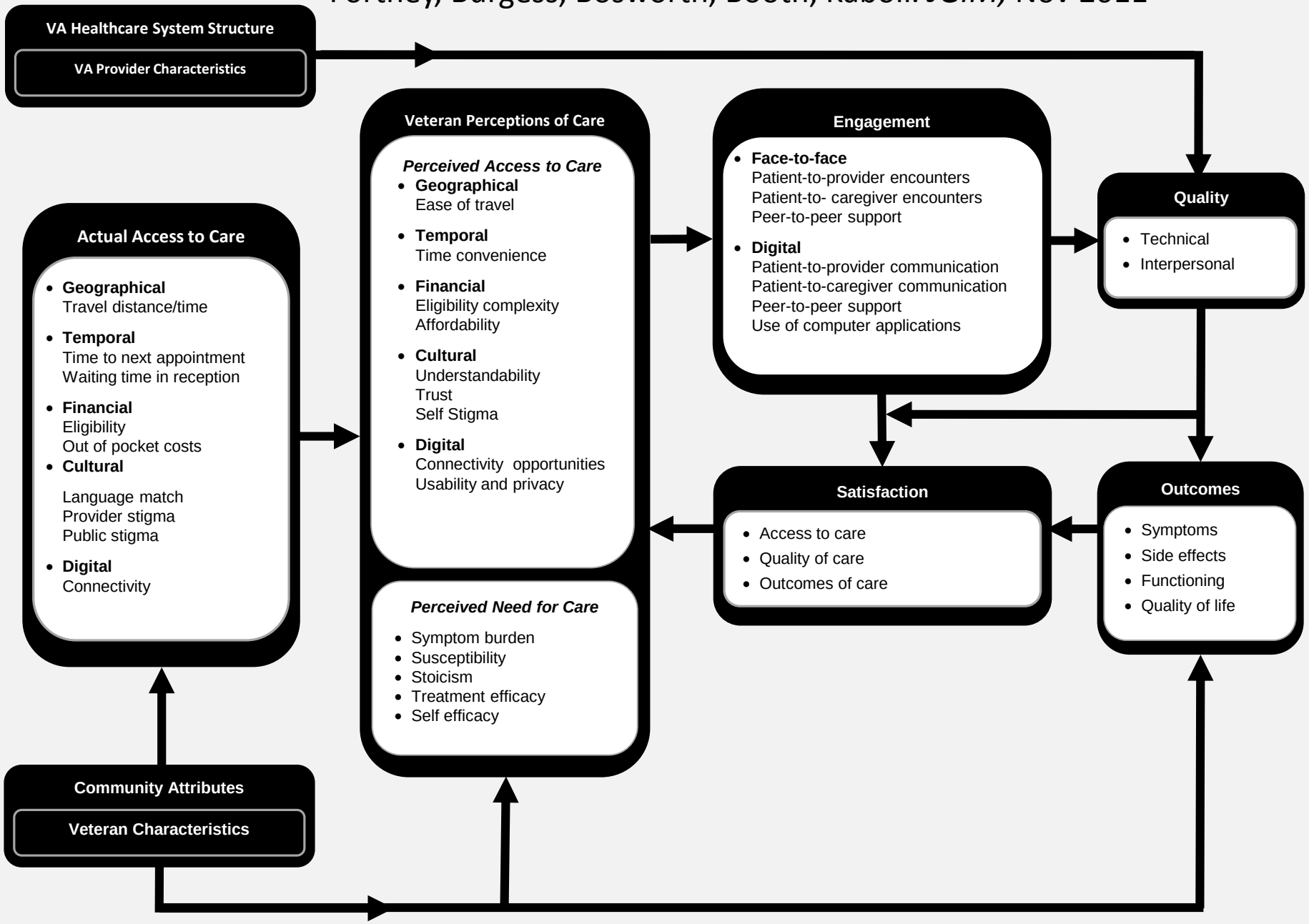
New 21st Century Definition (Fortney, *et al. JGIM,* 2011)

- **Access to Care** represents the potential ease of having *virtual* or *face-to-face* interactions with a broad array of healthcare providers including clinicians, caregivers, peers, and computer applications.
  - **Actual:** represents those directly-observable and *objectively* measurable dimensions of access.
  - **Perceived:** represents those self-reported and *subjective* dimensions of access.

ACCESS: FRAMEWORK/MODEL

- Set of specific dimensions that characterize the fit between the patient and the healthcare system
- Less focus on patient-to-provider face-to-face encounters
- Dimensions of access:
  - Geographical
  - Temporal
  - Digital
  - Financial
  - Cultural

Fortney, Burgess, Bosworth, Booth, Kaboli. *JGIM,* Nov 2011



Actual Access to Care

- **Geographical**
  Travel distance/time
- **Temporal**
  Time to next appointment
  Waiting time in reception
- **Financial**
  Eligibility
  Out of pocket costs
- **Cultural**
  Language match
  Provider stigma
  Public stigma
- **Digital**
  Connectivity

Measurement

Geo-coded distance/time

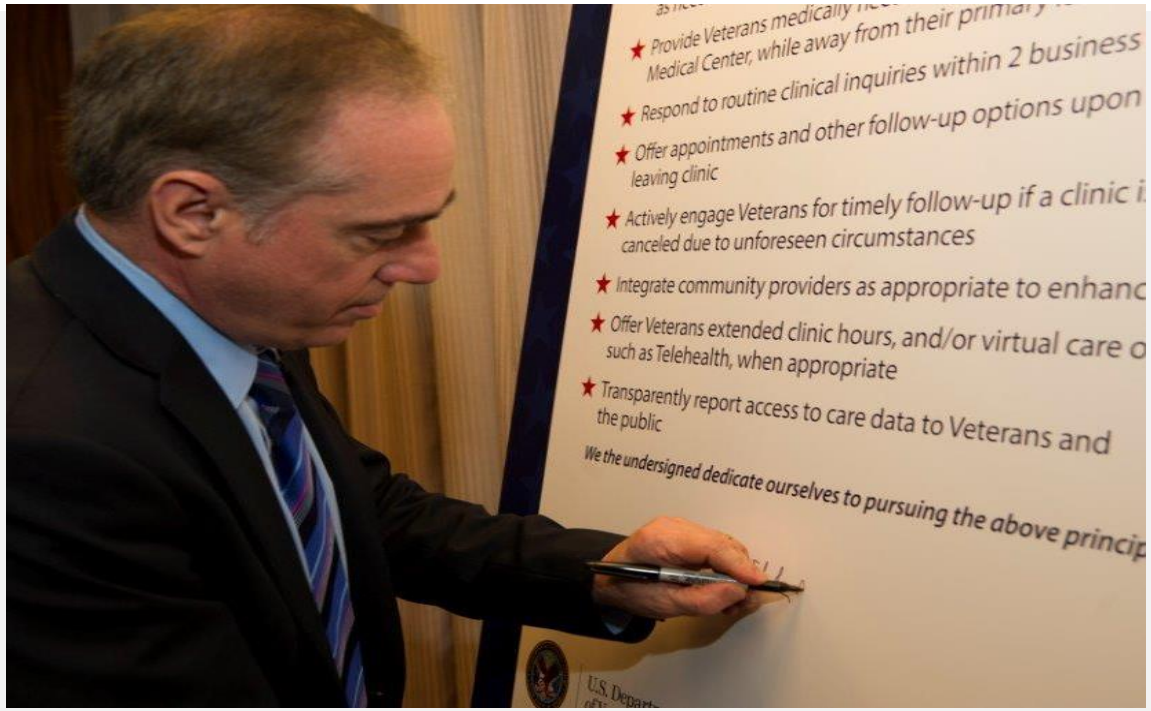
Third Next Available
Same Day Access
ED Wait times

Insurance
Co-pays

Interpreters/Native speakers

Speed of response and abandonment of phone calls
Response to secure messages
Broadband coverage

THREE-PRONG APPROACH TO MYVA ACCESS



Former Secretary of Veterans Affairs, Dr. David Shulkin, signing the MyVA Access Declaration April 7, 2016

MyVA Access Declaration

Prong 1

Prong 2

Access Improvement Solutions

National Deployment Strategy

Prong 3

PRONG 1: MYVA ACCESS DECLARATION

We aspire to provide access to care based on the following core principles:

- ✪ Provide timely care, including same day services in Primary Care, as needed
- ✪ Provide timely Mental Health care, including same day services, as needed
- ✪ Provide Veterans medically necessary care from another VA Medical Center, while away from their primary facility
- ✪ Respond to routine clinical inquiries within 2 business days
- ✪ Offer appointments and other follow-up options upon leaving clinic
- ✪ Actively engage Veterans for timely follow-up if a clinic is canceled due to unforeseen circumstances
- ✪ Integrate community providers as appropriate to enhance access
- ✪ Offer Veterans extended clinic hours, and/or virtual care options, such as Telehealth, when appropriate
- ✪ Transparently report access to care data to Veterans and the public

PRONGS 2 AND 3: IMPROVEMENT SOLUTIONS AND NATIONAL DEPLOYMENT STRATEGY

- The MyVA Access Implementation Guidebook provides best practices regarding access improvement:
  - 23 high impact, high feasibility solutions
  - 5 longer term solutions

- Regular solution updates to ensure accurate information and resource materials
  - Last version (3.0) released Dec. 2017

- MyVA Access Implementation Guidebook is ava

https://www.vapulse.net/community/myva-access/implementation-gui

- National Deployment Strategy:
  - Field Support for national deployment of access solutions is relative to level of assistance needed

EVALUATION AIMS

- Develop criteria and metrics by which facilities and VHA leadership may assess progress on the adoption of the MyVA Access Initiative.

- Assess trends in access over time and identify facilitators and barriers to implementation (i.e., org factors such as policies, procedures, practices).

20 ACCESS METRIC BRIEF REPORTS

HTTPS://VAWW.INFOSHARE.VA.GOV/SITES/PRIMARYCARE/PCAT-ACCESS/ACCESS/VAC%20EVALUATION.ASPX

Wait times

- Wait Time for an appointment for New Patients
- Third Next Available
- Timely Care

Patient Perceptions

- SHEP Surveys
- Kiosk

Telehealth/Virtual Care

- Telephone Access
- Secure Messaging
- Home Telehealth

Mental Health

- PCMHI Penetration rate
- Percentage of new patients to PCMHI seen same day
- Chart Review - Patient Assessments for Call-ins
- Staffing Ratio
- Revisit Rate

Primary Care

- Extended Hour Encounters
- Staffing Ratio
- Panel Size Monitor

Other

- VA Community Care Trends
- E-Consult Utilization
- Travelling Veteran Coordinators
- Group Practice Manager

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Metrics that won't go away (for better or worse)

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THIRD NEXT AVAILABLE

- Definition: "*average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam*".
- Challenges when measuring in VA at the provider and clinic level.
- Theoretically should be 0 once "open access" or "open waters" is achieved.
- Does not take into account clinical indication.

Figure 2: Primary Care TNA (FY15-FY18)

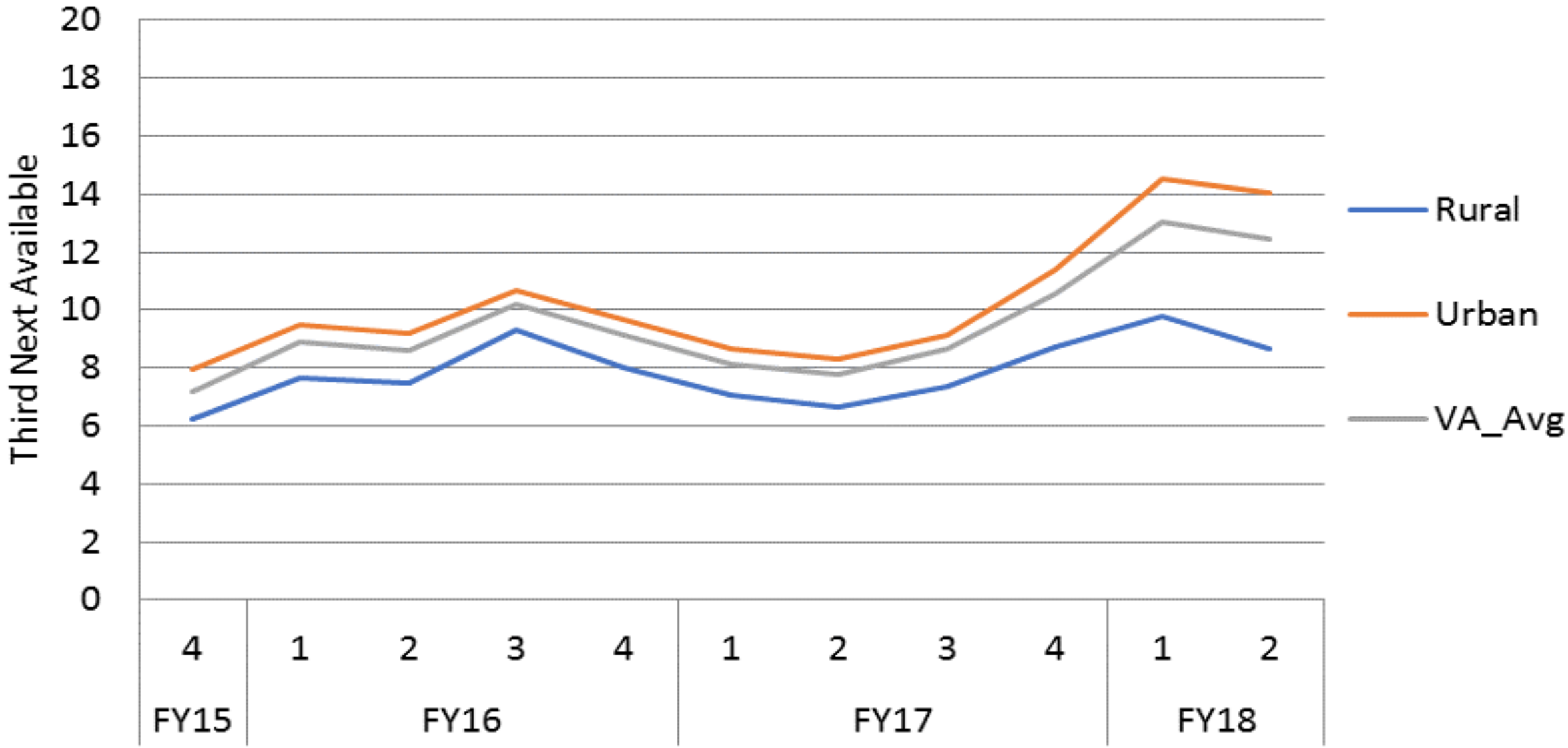
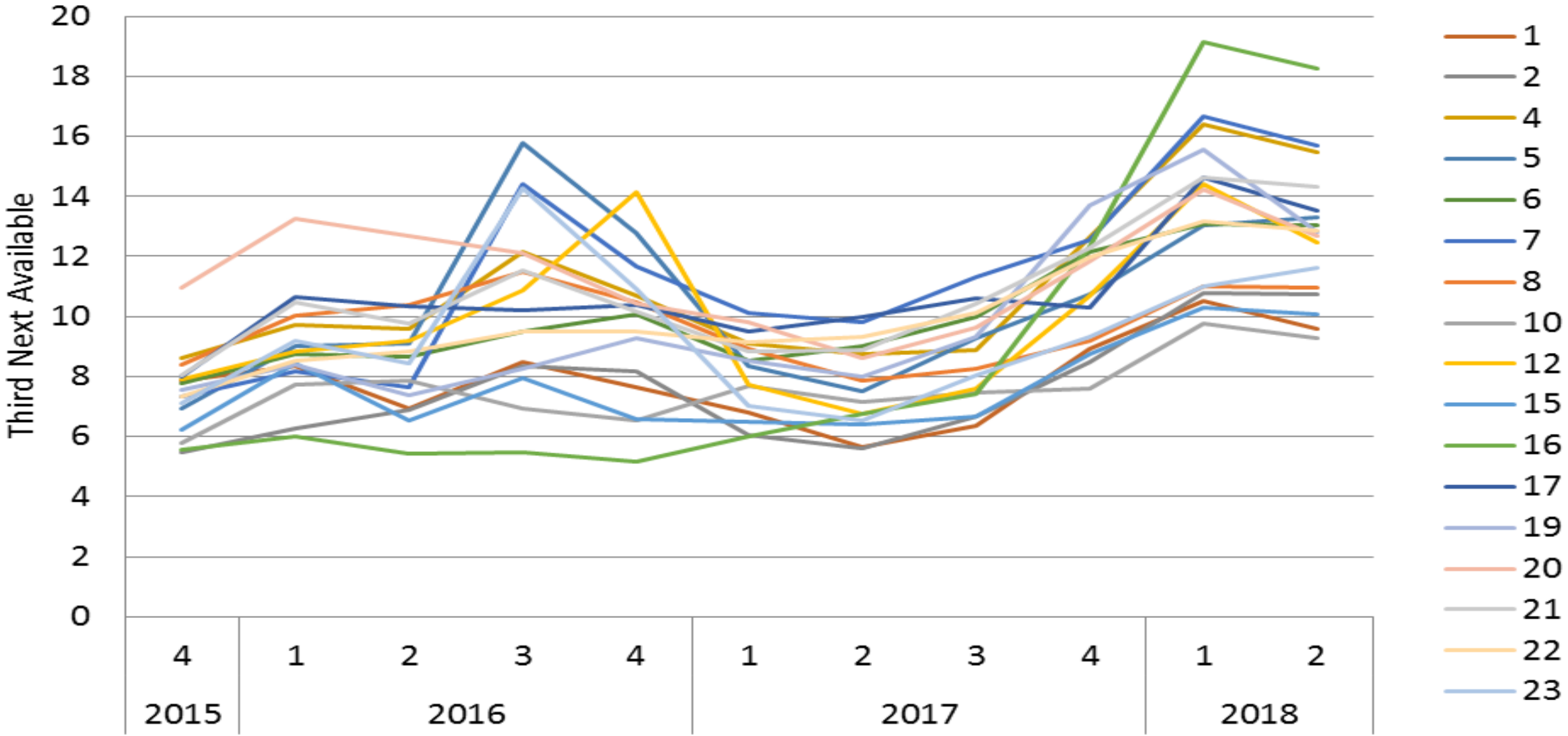


Figure 3: Primary Care TNA by VISN (FY15-FY18)



THIRD NEXT AVAILABLE

- TNA increased over time from 7.2 days (FY15) to 12.4 days (FY18)
  - Longer wait times in Urban than Rural clinics (14.1 vs. 8.7 days; $p<0.001$).
- Variation at VISN level
  - Highest increase in VISN 16 (271.2% increase from 5.2 days to 19.1 days)
  - Smallest increase in VISN 8 (45.8% increase from 7.9 days to 11.5 days).
- Variation at site level
  - 0-28.4 days in FY15
  - 0-59.4 days in FY18

- **Recommendations:**
  - IF measured, TNA should be measured at BOTH a provider and clinic level.
    - Some providers do not have daily clinic sessions (e.g., admin, research, or part-time).
    - Include clinic TNA as it reflects the ability of the clinic as a unit to provide timely care
  - Consider eliminating as a metric as questionable value and interpretation difficult.

VETERAN'S PERCEPTIONS OF ACCESS: SHEP SURVEYS

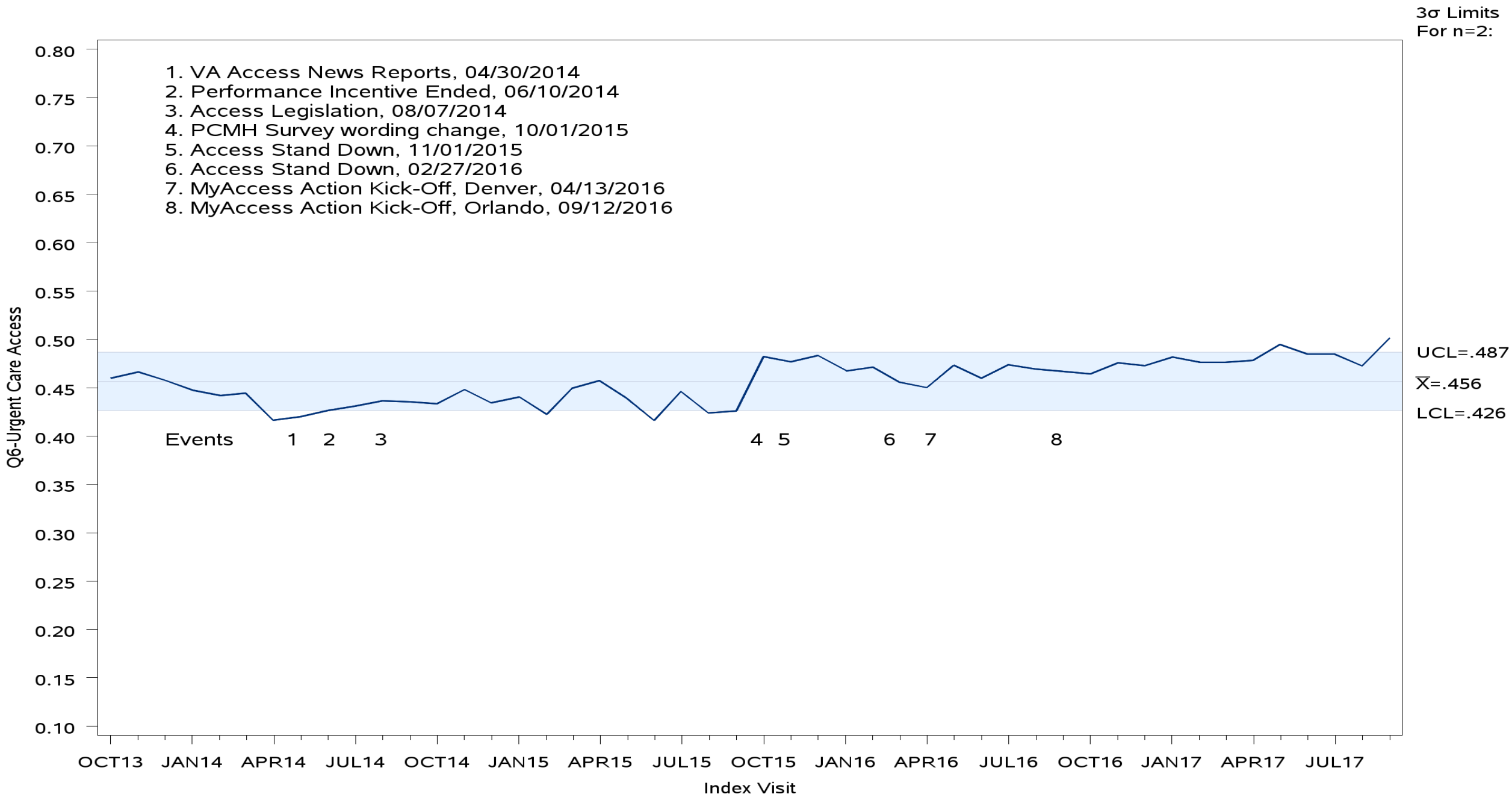
- Patient-reported perceived access (Qs 6, 9, 14, composite) stable since FY13
  - Special cause variation (i.e., change above the UCL), coinciding with the survey question changes in Oct 2015 and end of 2017

- Rural facilities had higher mean scores than Urban.
  - Although consistent across all measures, differences were small (1.3%-3.5% absolute difference)
  - Suggest that there was no significant Urban-Rural difference at a national level.

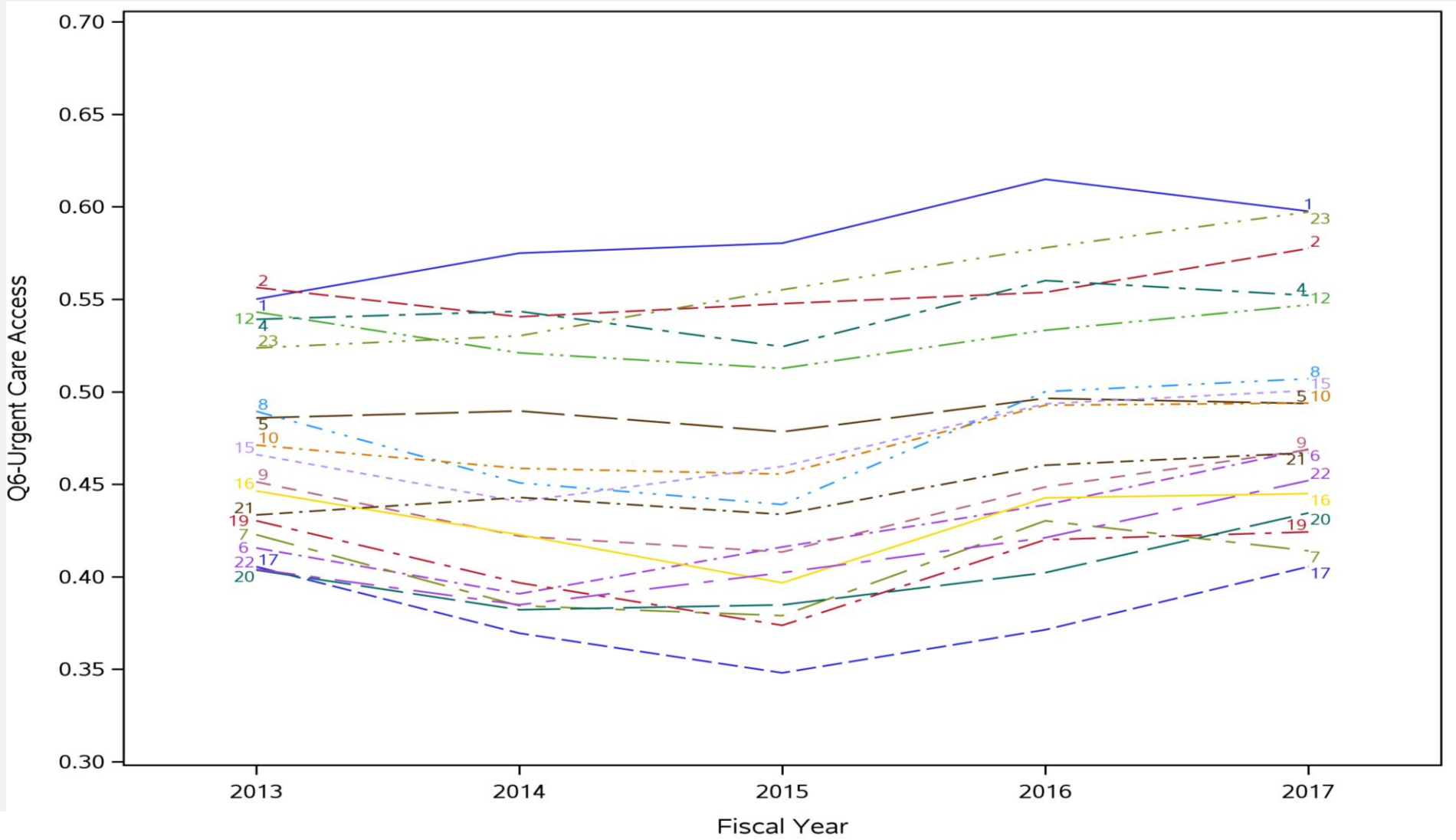
- While national aggregate SHEP metrics have been relatively stable, there is VISN level variation. Highest performing VISNs have SHEP scores 30-40% higher than lowest performing.
  - Differences have remained stable over the last 4 years.

https://www.va.gov/qualityofcare/apps/shep/barchart.asp
https://www.accesstocare.va.gov/
http://vaww.car.rtp.med.va.gov/programs/shep/shep.aspx

Q6. In the last 6 months, when you contacted this providers office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?



SHEP Q6: URGENT CARE ACCESS BY VISN



NEW PATIENT WAIT TIME

- Current metric does not take into account acuity or patient preference
- Goal <30 days
  - 91% of facilities meet the goal (128/141)
- Regional variation
  - 13 facilities had wait times >30 days
  - 4 facilities <10 days
  - Little urban vs. rural differences
  - Local variation due to slot availability (e.g., provider vacation, departures)

Figure 1a: Historical Trend for New-Patient Primary Care Appointment Wait Times

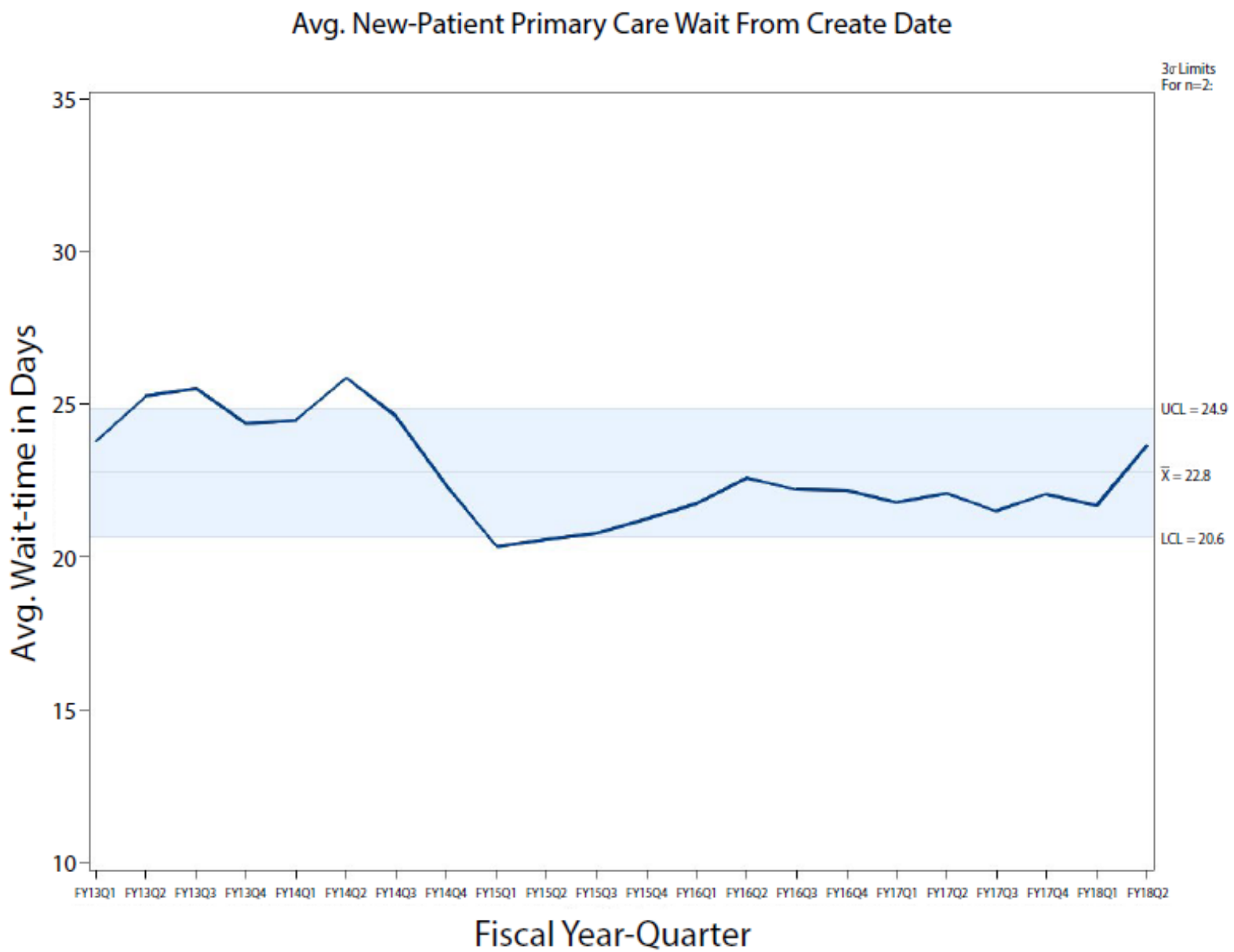
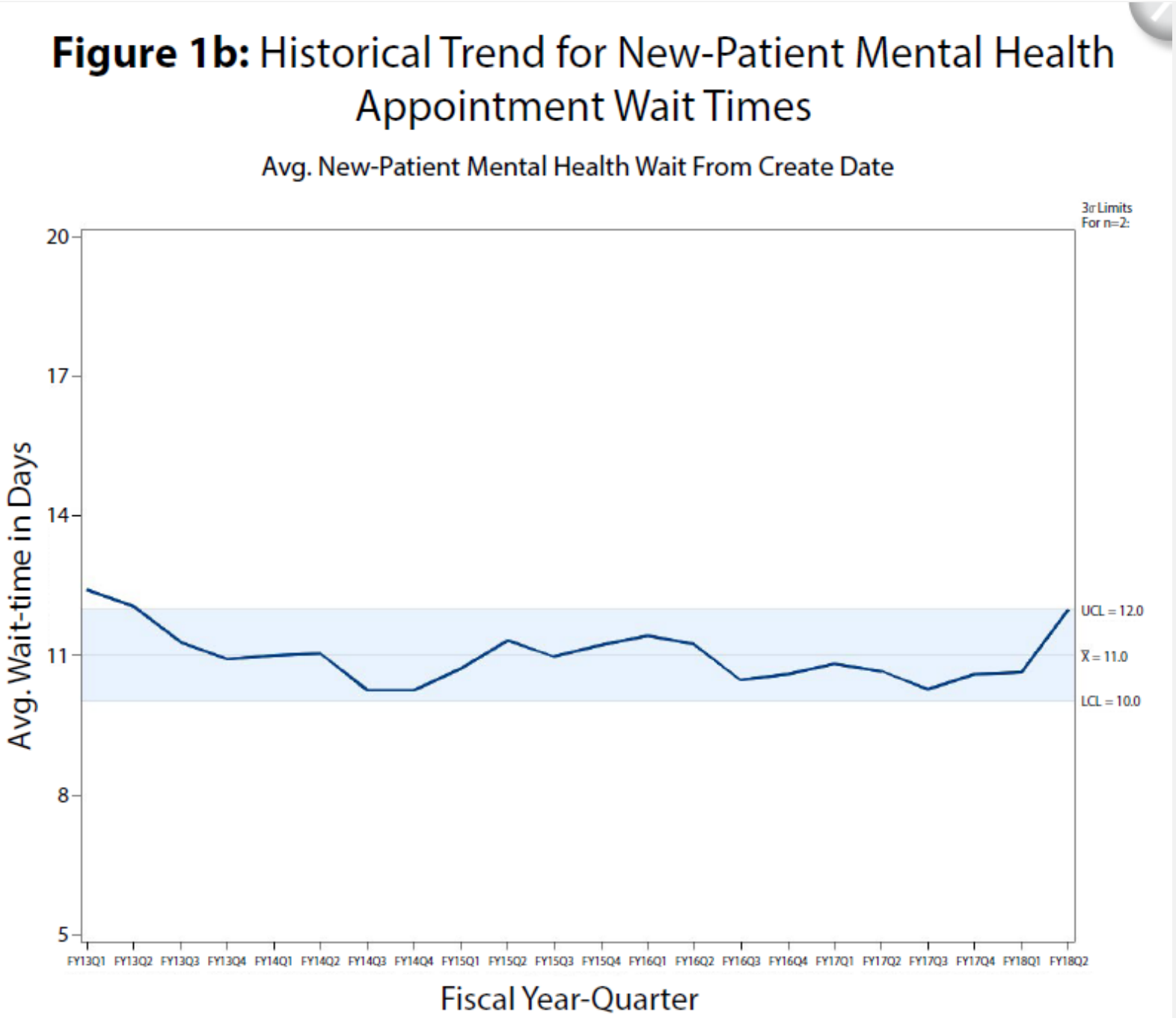


Figure 1b: Historical Trend for New-Patient Mental Health Appointment Wait Times



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Promising New Metrics

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TIMELY CARE: BACKGROUND/OBJECTIVE

- Limited methods for assessing access to care for walk-in and urgent, unscheduled needs.
- Industry standard for wait-times is “Third Next Available”
- VA standard was set at 14-days, with no distinction between new and established patients and urgency of request.
- Current goal is <30 days for all clinics, again without distinction

Objective: develop a novel metric to assess the provision of timely care, determine the extent to which timely care was provided by VA, and correlate timely care with patient perception of access.

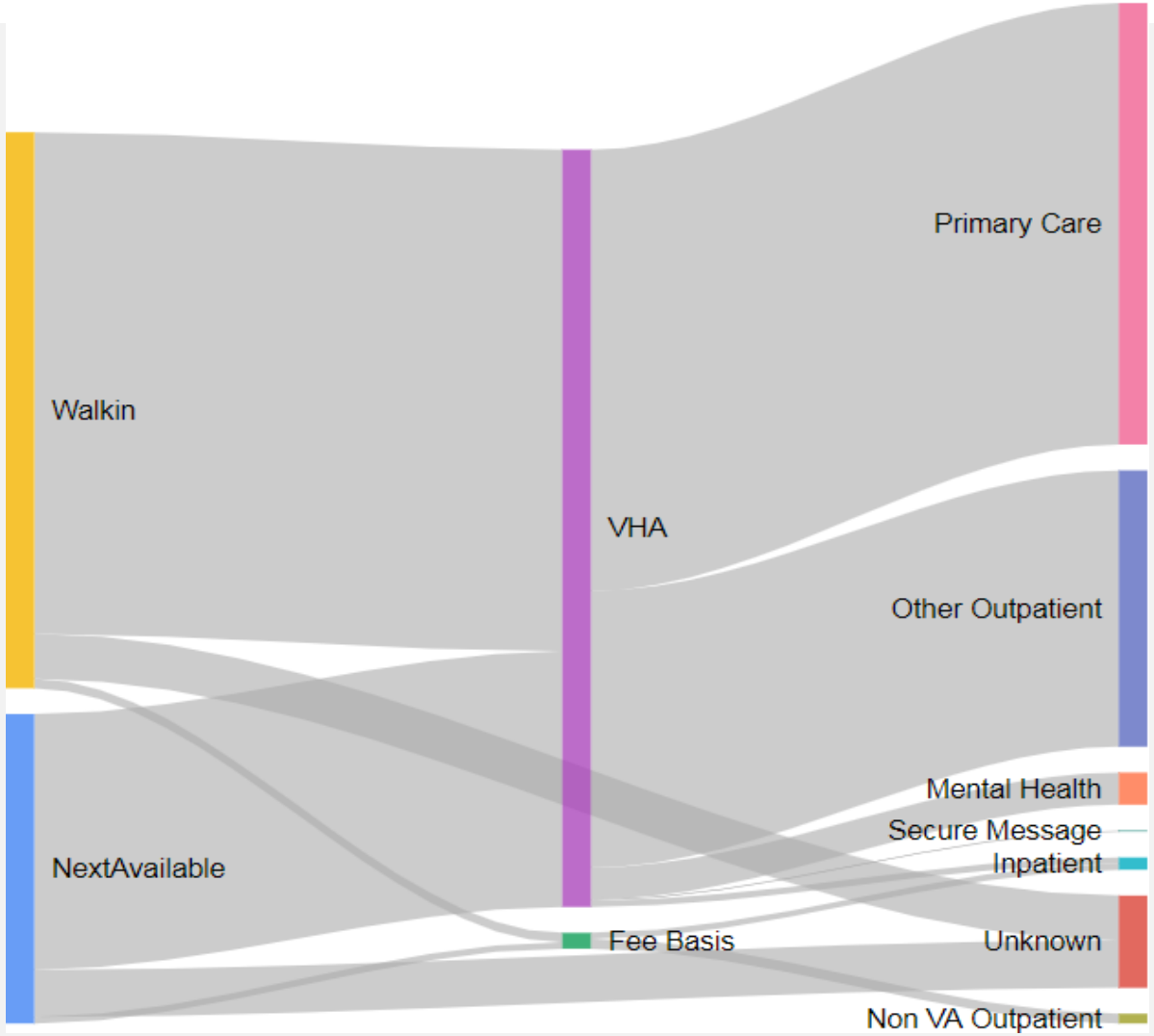
TIMELY CARE

- *"If you need care right away during regular business hours, you can receive services the same day, or if after hours, by the next day from a VA Medical Center or Health Care Center.*
  - *Options for how that care might be provided include:*
    - *in person*
    - *via telephone*
    - *smart phone*
    - *through video care*
    - *secure messaging*
    - *or other options*
  - *This care may be delivered by your provider or another appropriate clinical staff member based on availability and your care needs."*

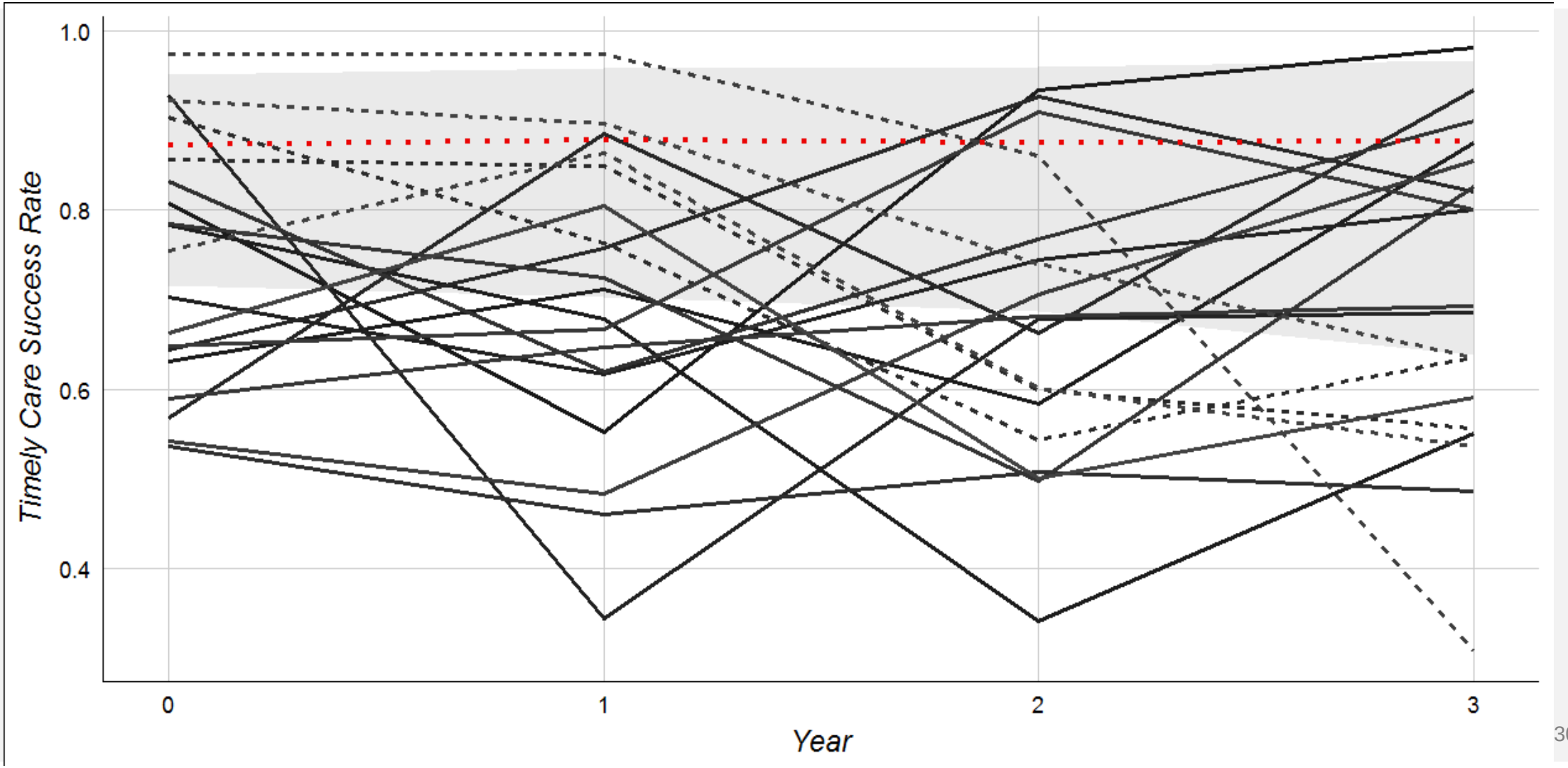
TIMELY CARE RATES IN 174 VA CLINICS

	2013-14*	2014-15*	2015-16*	2016-17*
Requests	267,276	310,124	352,675	318,634
Success, N (%)	240,191 (90)	272,181 (88)	298,049 (85)	280,874 (88)
VA Fulfillment, N (%)				
Primary Care	149,162 (62)	166,788 (61)	185,526 (62)	180,657 (64)
Other Service Line	78,058 (32)	88,616 (33)	91,408 (31)	85,898 (31)
Mental Health	8,321 (3)	9,906 (3)	11,646 (4)	11,187 (4)
Inpatient	1,532 (1)	1,814 (1)	4,034 (1.3)	1,800 (0.6)
Secure Message	190 (0)	234 (0)	159 (0)	89 (0)
Non-VA Fulfillment, N (%)				
Outpatient	2,369 (0.9)	4,180 (1.5)	4,556 (1.5)	**796 (0)
Inpatient	90 (0)	177 (0)	156 (0)	213 (0)

“RIVERPLOT” OF TIMELY CARE REQUESTS AND FULFILLMENT LOCATION (N=1,396,077 REQUESTS)



19/174 CLINICS WITH TIMELY CARE BELOW 95% CREDIBLE INTERVAL (CI)



SUMMARY & NEXT STEPS: TIMELY CARE METRIC

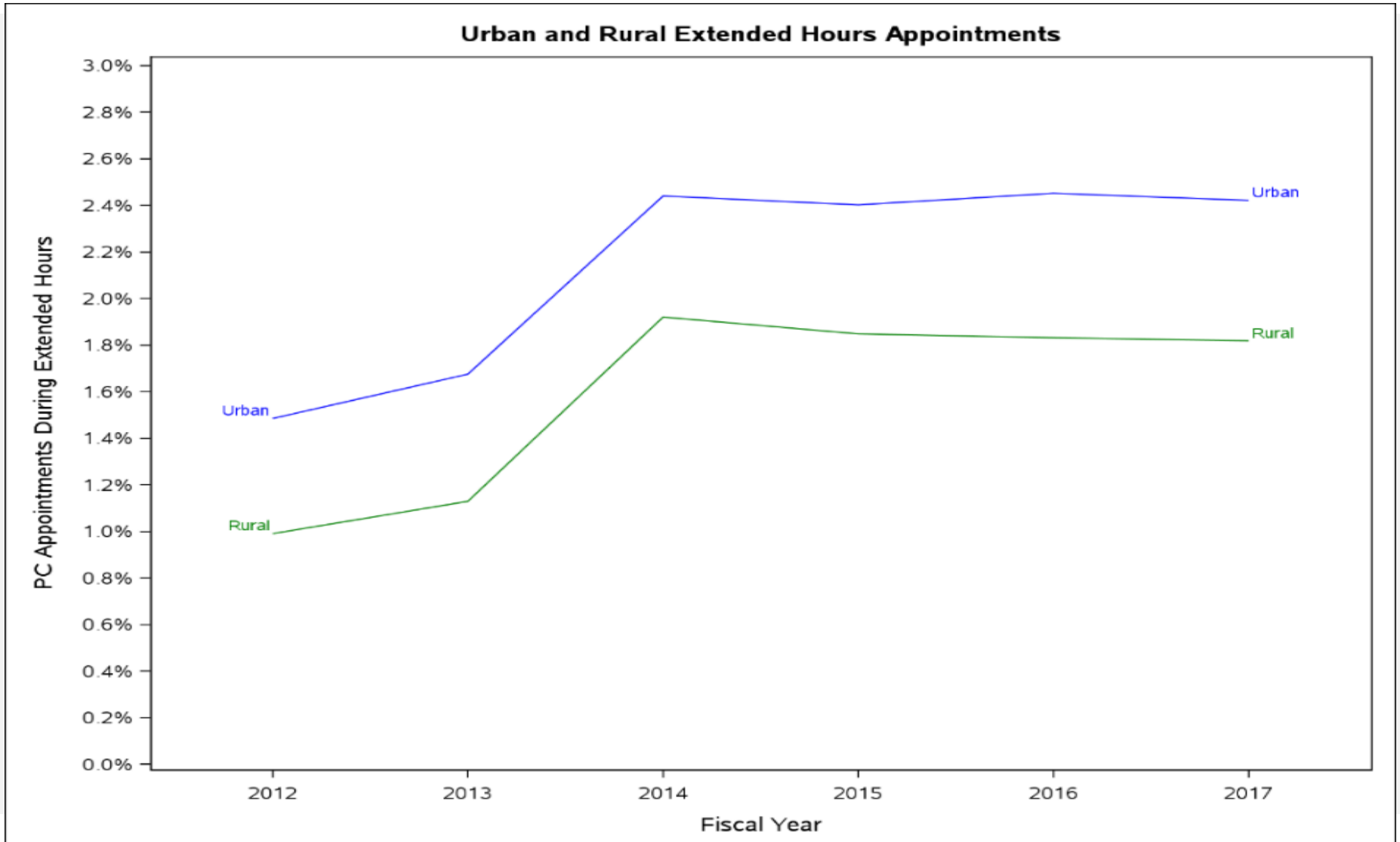
- 30-40% of patients are requesting “timely care”
  - Number is increasing: concerns for change in perception of walk-in vs. appointment
- VA fulfilling ~90% of requests, with 98% by VA
  - What is the future role and impact of CHOICE
- 11% of clinics (19/174) were outliers
  - Potential to use to identify clinics in need of improvement

- Analyze all VA clinics to identify clinics below the 95% CI.
- Correlate with other measures of Access.
- Explore whether Group Practice Managers and clinic staff would find this metric useful in monitoring Access.

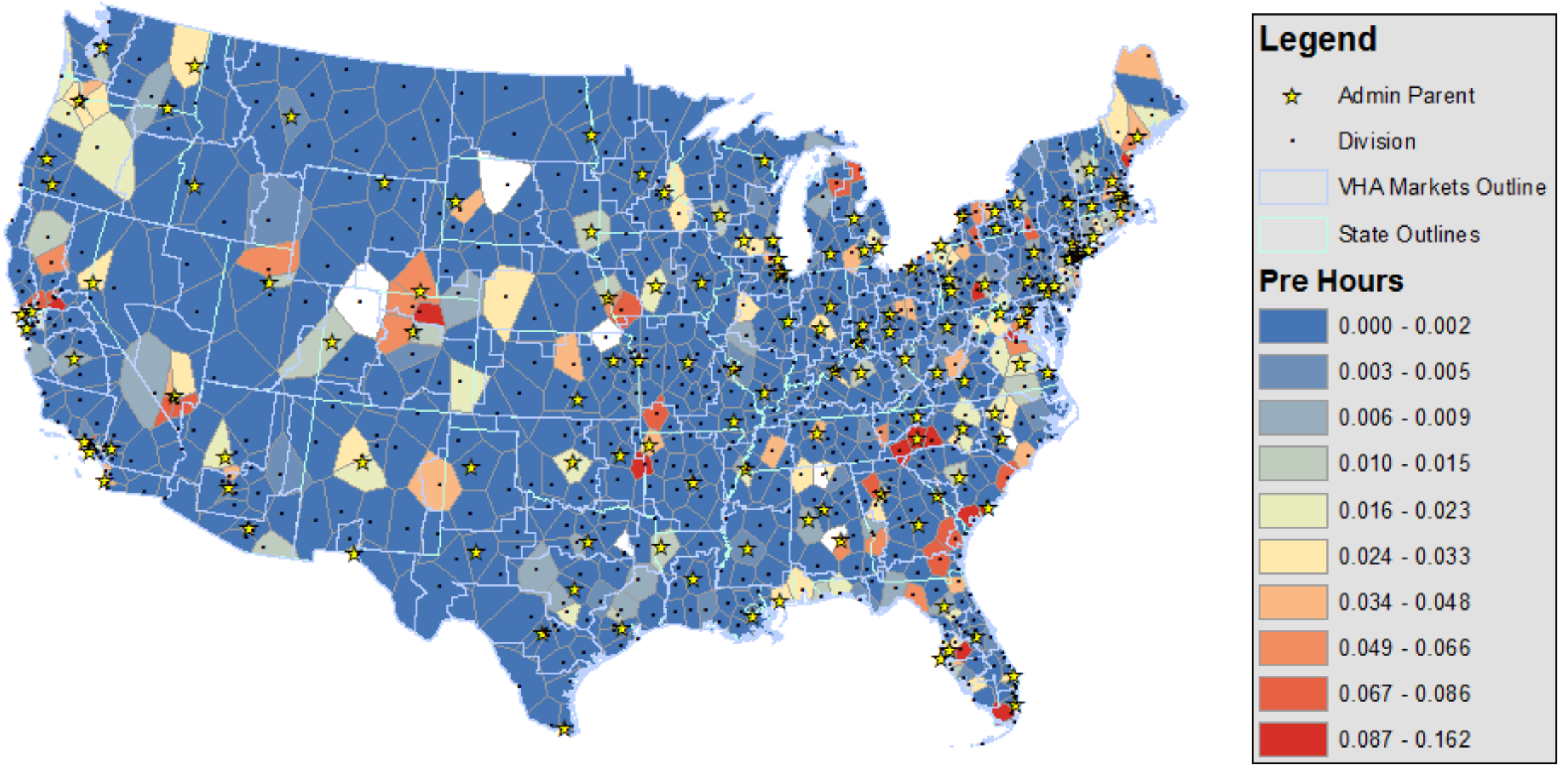
PRIMARY CARE (PC) EXTENDED HOURS

- PC Extended hours encounters increased 83% from 114,000 (FY12) to 208,657 (FY17), representing 2.4% of all Primary Care encounters.
  - Much of the increase occurred in FY13 and FY14, increasing by 71%.
  - Early morning hours represent most extended hours encounters
  - Weekends increased the most over this period, increasing roughly 6X from FY12-14.
- Since FY14, extended-hours encounters continue to modestly increase by 7%.
  - Encounters during morning hours increased by 26%; however, encounters during weekends and evening declined by 13% and 14%, respectively.
- Morning hours correlated with improved patient experiences with after-hours access (Q12, SHEP survey)

NATIONAL TRENDS OF EXTENDED HOURS ENCOUNTERS AS PERCENTAGE OF TOTAL ENCOUNTERS FOR CLINICS SERVING RURAL OR HIGHLY RURAL AND URBAN PATIENTS



REGIONAL DISTRIBUTION OF THE USE OF MORNING APPOINTMENTS



SUMMARY & NEXT STEPS: EXTENDED HOURS

Summary:

Increase in morning hours and decline in evening/weekend hours questions whether this is in response to patient preference or provider convenience. The correlation of morning hours with patient experience suggests patient preferences; however, this finding may be simply due to the higher availability.

Next Steps:

- Are Extended Hours working and for whom?[1]
- Increasing access and improving outcomes?
  - After-hours SHEP and reduced hospitalizations for chronic ACSC[2,3]
- Decreasing access?

1 Augustine et al, JACM, 2018
2 HSR&D Cyber seminar, 07/16/2016
3 HSR&D Cyber seminar, 06/20/2018

VETERAN'S PERCEPTIONS OF ACCESS: VETLINK KIOSK SURVEY

- Single question on getting appointment at check-in:
  - "*How satisfied are you that you got today's appointment when you wanted it*?"
  - Similar to SHEP Q6 on getting an appointment for care as soon as needed, but asked at the time of appointment instead of weeks afterwards.

- VA kiosk surveys correlated with all six SHEP questions assessing access; Correlations (r= 0.46 to 0.58) suggest only 21-33% of SHEP variation may be accounted for by Kiosk data at the HCS level.

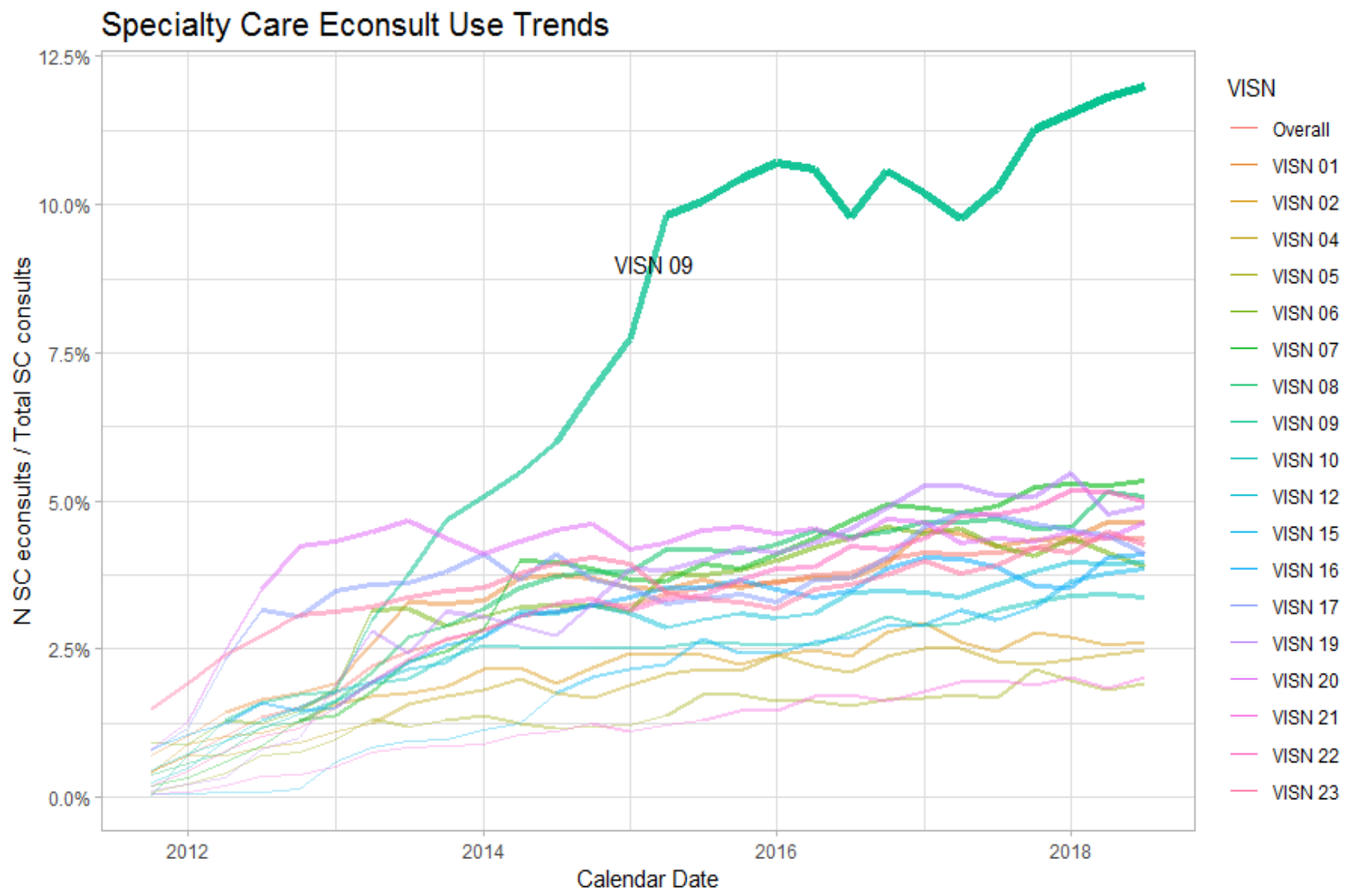
VETLINK/KIOSK QUESTIONS: RECOMMENDATIONS

- Questions should be used locally to identify dissatisfied Veterans and perform real time service recovery and monitor clinic performance.
- Due to highly positive correlation between Kiosk and SHEP, Kiosk questions have potential to track early indications of positive or negative changes in patient's perceptions of access, but should not replace SHEP.
- Vsignals/Medallia has potential to be incorporated into Veteran Perception of Access.

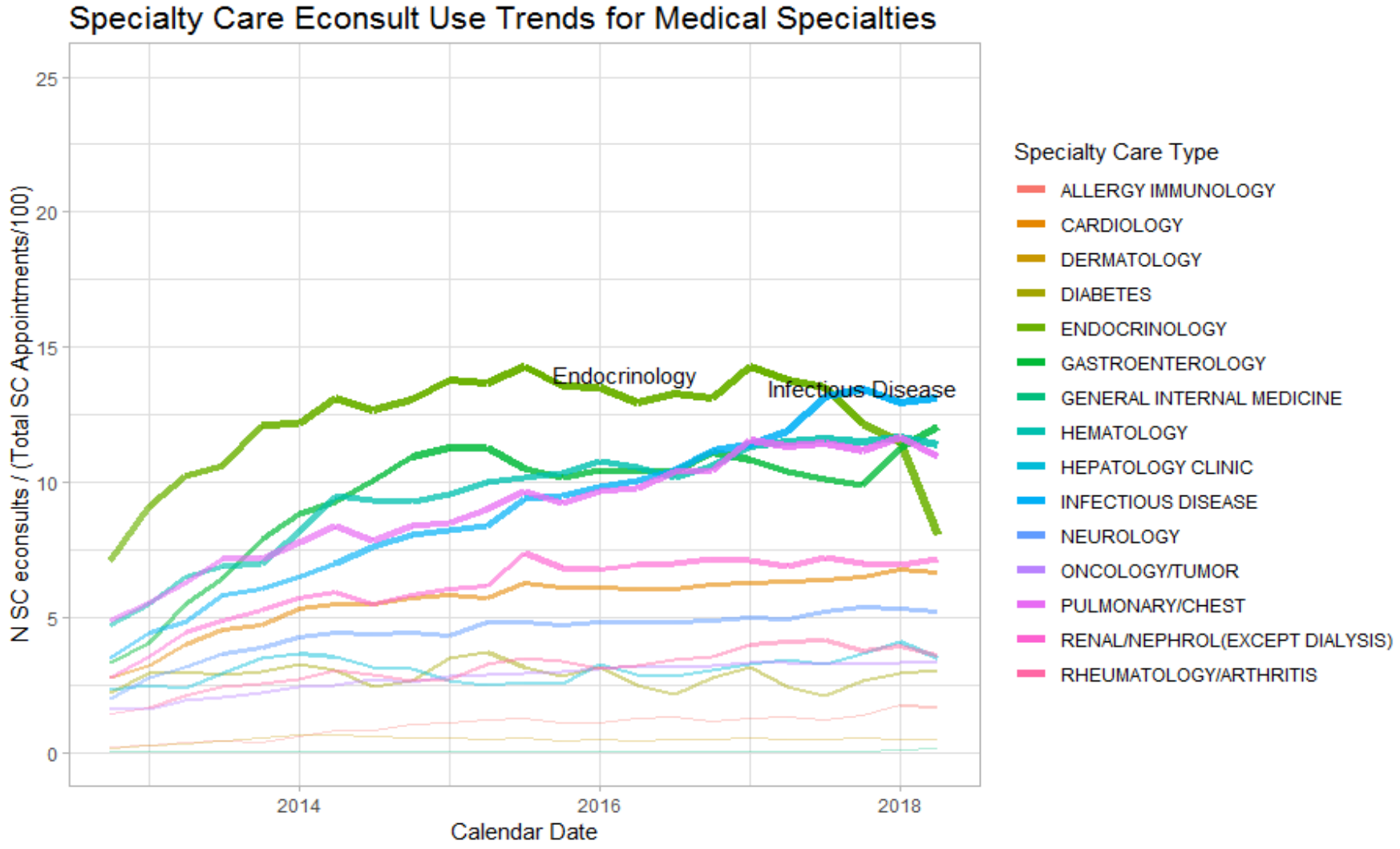
E-CONSULTS

- Since inception (2011), rates have plateaued in most VISNs, but VISN 9 has a significantly higher rate suggesting higher rates may be possible.
  - VISN 9 had more than 2X the rate of use of E-consults (12.0%) than the rest of the VISNs (1.92%-5.33%), with higher adoption of E-consults beginning in 2014.
- 5 Medical Specialties >10% (ID, GI, Endo, Heme, Pulm)
- 2 Surgical Specialties >10% (Neurosurgery, Vascular)
- E-consult adoption was similar stratified by urban/rural residence

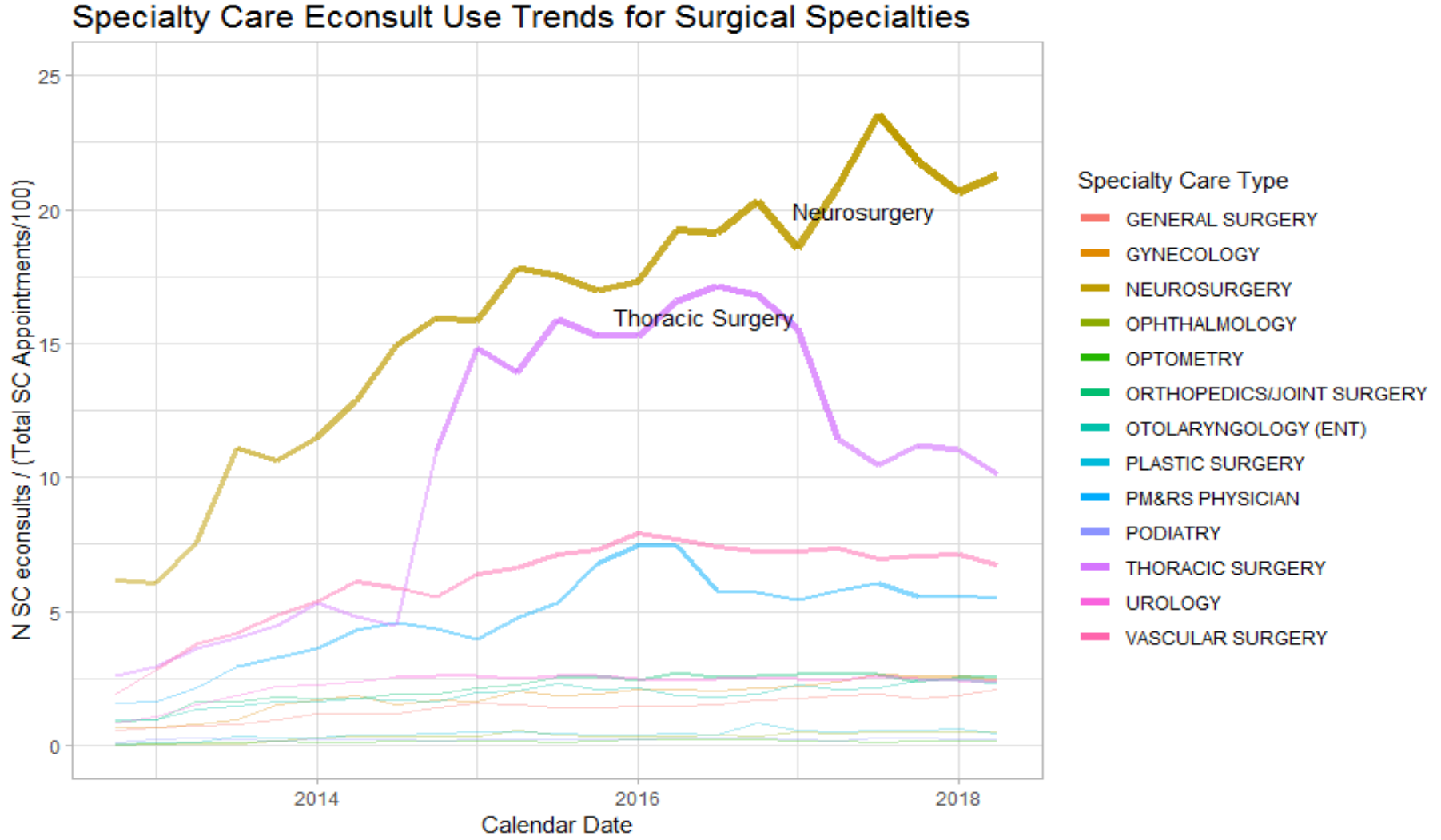
E-CONSULTS: PROPORTION OF TOTAL CONSULTS



E-CONSULTS: MEDICAL SPECIALTIES



E-CONSULTS: SURGICAL SPECIALTIES



E-CONSULTS: RECOMMENDATIONS

- Optimal E-consult use should be explored to establish benchmarks.
  - Mandatory E-consult option or provider choice?
- Determine factors associated with use and between E-consults and clinical outcomes.
- Determine proportion of E-consults that substitute for F2F visits, assist in triage of eventual F2F visits, and/or expedite the consults.
- Miles of travel saved by Veterans should be included in future analyses.
- Consider regionalization of high use/highly specialized E-consults (e.g., Hematology, NSG).

SIMULATED PATIENTS: (AKA-SECRET SHOPPERS)

Original Investigation | HEALTH CARE REFORM

Primary Care Access for New Patients on the Eve of Health Care Reform

Karin V. Rhodes, MD, MS; Genevieve M. Kenney, PhD; Ari B. Friedman, MS; Brendan Saloner, PhD; Charlotte C. Lawson, BA; David Chearo, MA; Douglas Wissoker, PhD; Daniel Polsky, PhD

JAMA Intern Med. 2014;174(6):861-869. doi:10.1001/jamainternmed.2014.20
Published online April 7, 2014.

MERRITT HAWKINS
an AMN Healthcare company

2017 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES

And Medicare and Medicaid Acceptance Rates

A survey examining the time needed to schedule a new patient physician appointment in 15 major metropolitan areas and in 15 mid-sized metropolitan areas, as well as the rates of physician Medicare and Medicaid acceptance in these areas.

RHODES RESEARCH METHODS

- Calls to MD offices in 10 states (8 Medicaid expansion/2 not)
- Primary Care only
  - Medicaid vs. Private Insurance
- Script of someone new to the community
- Reported:
  - appointment availability (yes/no)
  - <7 day wait
  - >30 day wait

MERRITT-HAWKINS MARKET RESEARCH

- Calls to 10-20 MD offices in 15 large metro and 15 mid-sized markets
- Primary Care and 4 specialties
- Script of someone new to the community
- Reported:
  - mean wait time
  - If not taking new patients, default to 365 day wait

RHODES: NEW APPOINTMENT AVAILABILITY IN MASSACHUSETTS AND IOWA

Table 1. Appointment Availability Rate of Primary Care Appointments for Simulated New Patients[a]

State	Medicaid, %		Difference in Medicaid		Private Coverage, %		Difference in Private Coverage	
	2012-2013	2016	Percentage Points	*P* Value	2012-2013	2016	Percentage Points	*P* Value
Arkansas	48.7	49.7	1.0	.84	88.1	83.0	−5.1	.02
Georgia[b]	67.9	64.3	−3.6	.23	88.1	86.4	−1.8	.47
Illinois	49.8	69.8	20.0	<.001	89.6	88.1	−1.5	.43
Iowa	68.5	76.6	8.1	.02	88.6	86.8	−1.8	.45
Massachusetts	51.7	55.3	3.6	.37	66.5	69.0	2.5	.47

- **Medicaid** new appointment availability improved in every state (except GA)
- **Private Coverage** new appointment availability overall no change, with some variability (OR worse, PA better)

RHODES: SHORT AND LONG WAIT TIMES IN MASSACHUSETTS AND IOWA

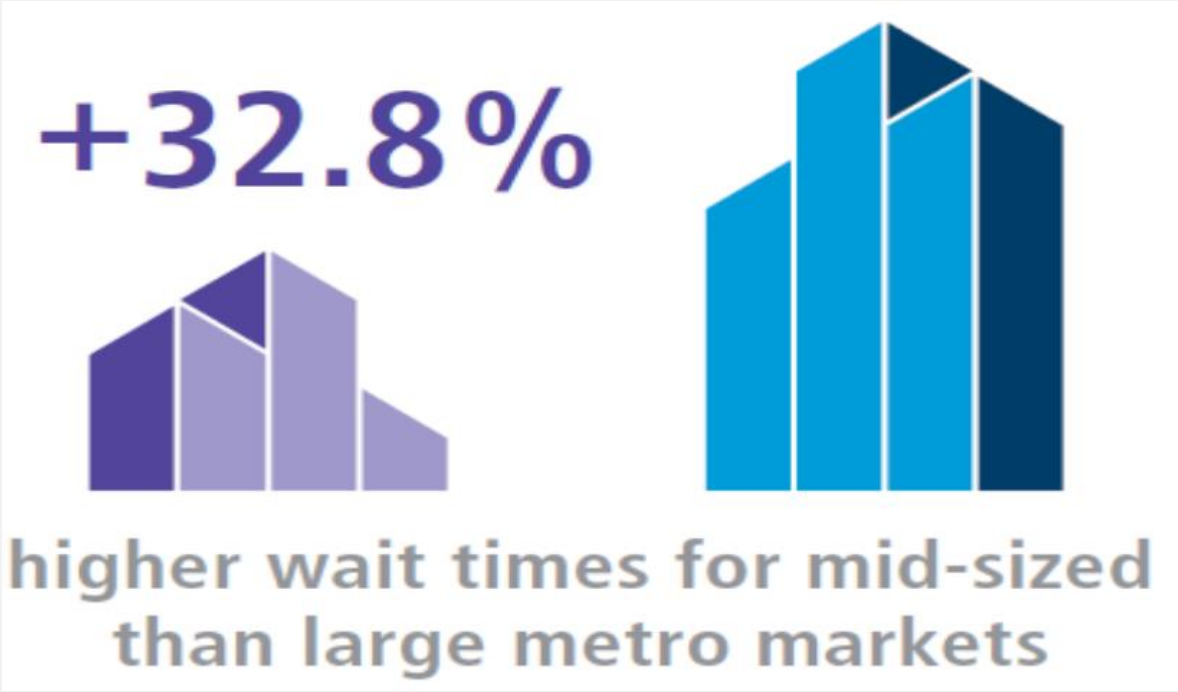
Table 2. Share of New Simulated Patients With Short and Long Wait Times for Primary Care Appointments[a]

State	Medicaid, %		Difference in Medicaid		Private Coverage, %		Difference in Private Coverage	
	2012-2013	2016	Percentage Points	*P* Value	2012-2013	2016	Percentage Points	*P* Value
Short Wait Times (≤1 wk)								
Arkansas	56.1	54.0	−2.1	.77	64.9	57.3	−7.6	.008
Georgia[b]	60.4	55.0	−5.3	.10	58.0	56.5	−1.5	.61
Illinois	59.1	52.3	−6.8	.11	62.6	58.4	−4.3	.16
Iowa	64.6	56.7	−8.0	.048	59.3	62.0	2.7	.51
Massachusetts	30.5	37.6	7.0	.04	34.8	37.3	2.5	.47
Long Wait Times (>30 d)								
Arkansas	4.4	6.9	2.5	.48	4.9	7.8	2.9	.12
Georgia[b]	7.6	10.1	2.5	.26	6.2	12.8	6.6	.006
Illinois	8.1	9.9	1.8	.51	4.9	8.4	3.5	.08
Iowa	5.1	4.7	−0.5	.86	3.2	3.6	0.4	.81
Massachusetts	32.2	21.2	−11.0	.049	21.7	20.1	−1.6	.46

- **Medicaid** short wait times worsened and long wait times no change
- **Private Coverage** short and long wait times worsened

MERRITT-HAWKINS: AVERAGE WAIT FOR NEW APPOINTMENT

- Large Metro Markets: 24 days
- Mid-sized Markets: 32 days



MERRITT-HAWKINS: HIGH AND LOW WAIT TIMES

- Highest Large Market: Boston
  - Dallas lowest at 14.8 days
- Highest Mid-sized: Yakima, WA
  - Billings, MT lowest 10.8 days

FUTURE OF SECRET SHOPPERS IN VA

- 3 site pilot contracted and starting soon
- May offer best way to determine wait times from the patient perspective
- Provides objective metric for public reporting and local improvement

FUTURE ACCESS-RELATED ISSUES

- Mission Act (401/403)
  - Access Standards for when to refer to community for care
  - Criteria for “underserved facilities” designation with annual definition
    - Implement mobile deployment teams, residency program pilot, and scribes
- Electronic Health Record Modernization
  - Impact on access and efficiency (20-30% reduction?)
- Reduce no-shows (currently 11%)
- Provider and staff recruitment and retention and access
- Continued expansion of virtual care to improve access (e.g., E-consults, specialty care telemedicine, tele-hospitalists)
- Access-related marketing/satisfaction
- Inpatient access/bed availability

THANK YOU

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Metric briefs and other access-related materials

- **OVAC VA Pulse:**

https://www.vapulse.net/community/ovac/content?filterID=contentstatus[published]~category[veteran-access-to-care-evaluation]

- **Access SharePoint:**

https://vaww.infoshare.va.gov/sites/primarycare/PCAT-Access/Access/VAC%20Evaluation.aspx