# Engaging Stakeholders in Identifying Access Research and Evaluation Priorities: A Foundation for the Access Research Roadmap

Drs. Karen Albright and Demetria McNeal

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VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

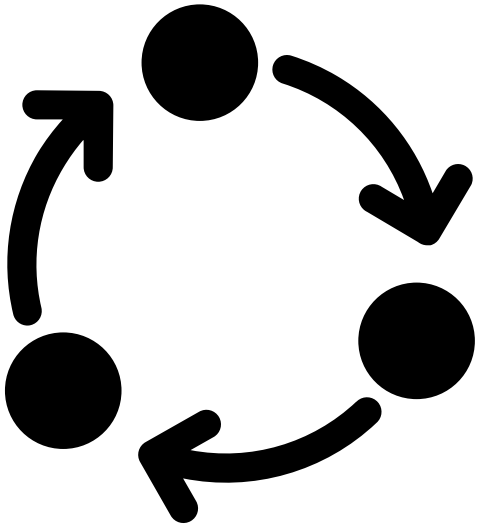
ARC NETWORK
HSR&D VETERANS ACCESS RESEARCH CONSORTIUM

# INTRODUCTIONS

- **The Veteran Access Research Consortium (VARC)**
  - Housed across Ann Arbor, Bedford MA, Denver, Iowa City
  - Part of the ARC Network, comprised of researchers interested in access research (VA and non-VA)
- **Demetria McNeal, PhD**
  - Communication scientist with VARC
  - Assistant Professor, Division of General Internal Medicine, University of Colorado School of Medicine
- **Karen Albright, PhD**
  - Social scientist with VARC; focus on social determinants of health
  - Associate Director, VA Denver-Seattle Center of Innovation (COIN)
  - Associate Professor, Division of General Internal Medicine, CU SOM

# POLLING QUESTION #1: WHAT IS YOUR PRIMARY ROLE IN VA?

- Student, trainee, or fellow
- Clinician
- Researcher
- Administrator, manager, or policy-maker
- Other (within VA)
- Other (outside VA)

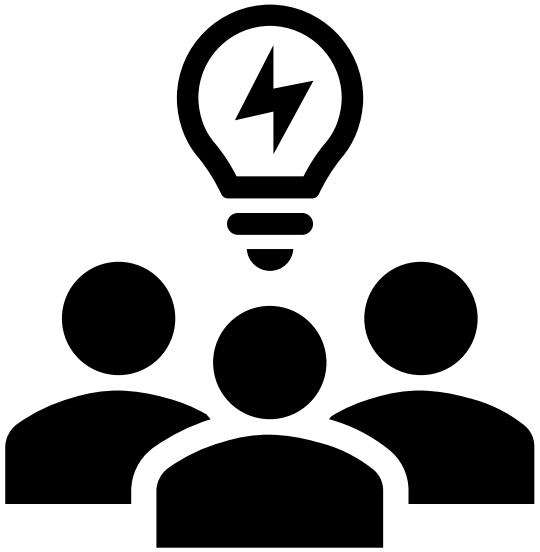


# ADVANCING ACCESS-RELATED RESEARCH IN VA

- VARC received funding from VA Health Services Research and Development (HSR&D) to advance access-related research within VA
  - Assessing the current state of VA access research
  - Compiling and developing metrics used to measure access
  - Soliciting access researchers' opinions about directions for future VA research
- Today's cyberseminar focuses on the activities of VARC's Stakeholder Engagement Workgroup
  - Mission: to identify high-priority access-related research questions on which HSR&D should focus in the coming years

# STAKEHOLDER ENGAGEMENT WORKGROUP

- Activities led by the Denver site:
  - Michael Ho, Karen Albright, Demetria McNeal, Kelty Fehling, Joe Simonetti, Evan Carey, and Erica Valdez
- Has engaged access researchers within and outside VA, operational partners, and Veterans to solicit their perspectives about the most important access-related research domains for VA to address in the next 5-10 years
- Ultimate goal: to inform VA HSR&D's funding priorities for access research and help shape the direction of the field



# WHAT IS ACCESS RESEARCH?

- Access to health care means having "the timely use of personal health services to achieve the best health outcomes“ (IOM, 1993).
- Access to health care includes:
  - Coverage: Insurance facilitates entry into the health care system.
  - Services: Having a usual source of care is associated with adults receiving recommended screening and prevention services.
  - Timeliness: The ability to provide health care when the need is recognized.
  - Workforce: Providers are capable, qualified, and culturally competent.

# DIMENSIONS OF ACCESS: OBSERVABLE MEASURES

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

Fortney JC et al. 2011. A Re-Conceptualization of Access for 21st Century Healthcare. *J Gen Intern Med* 26 (Suppl 2): 639–647.

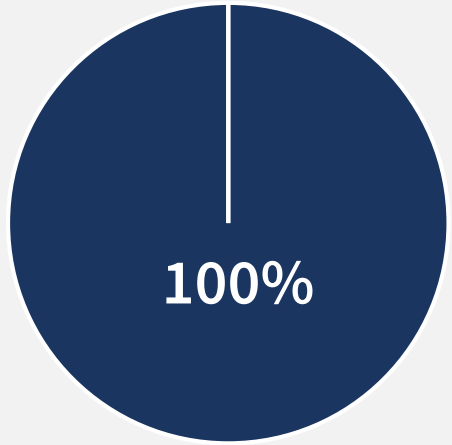
# DIMENSIONS OF ACCESS: VETERAN EXPERIENCE AND PERCEPTIONS

| | |
|---|---|
| Geographical | • Ease of travel |
| Temporal | • Time convenience |
| Cultural | • Understandability, Trust, Self-stigma |
| Digital | • Connectivity opportunities, Usability and privacy |
| Financial | • Eligibility complexity, Affordability |

# CURRENT STATE OF VA ACCESS RESEARCH (2015-20): VARC PORTFOLIO REVIEW WORKGROUP

## Web-based review

**211**
Total projects identified




**266** of 266 projects **coded with rubric**

## Operational Interviews

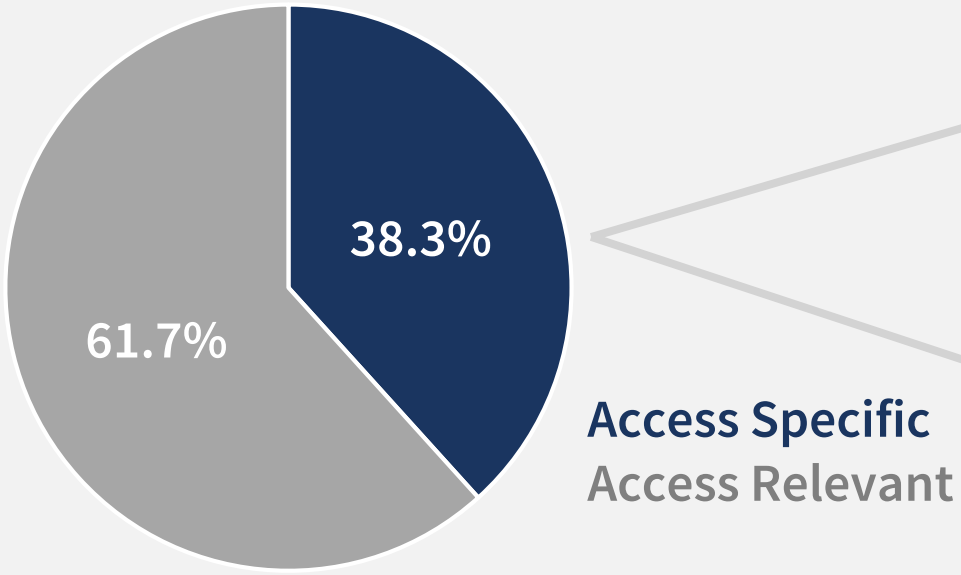
**11** Interviews completed

**55** Operational projects identified

# CURRENT STATE OF VA ACCESS-RELATED RESEARCH

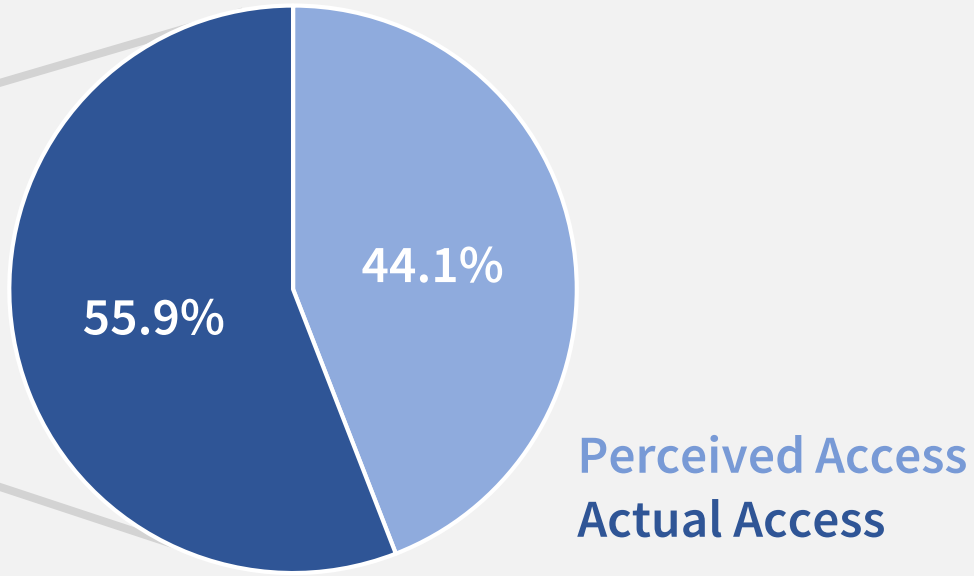
About half of access-related projects **directly measured access** (were access specific). N=266

*Access specific* projects measure actual or perceived access, whereas *access relevant* projects do not incorporate specific measurements of access.




More projects tended to directly measure **actual patient access** as opposed to **patient perceptions** of access. N=102

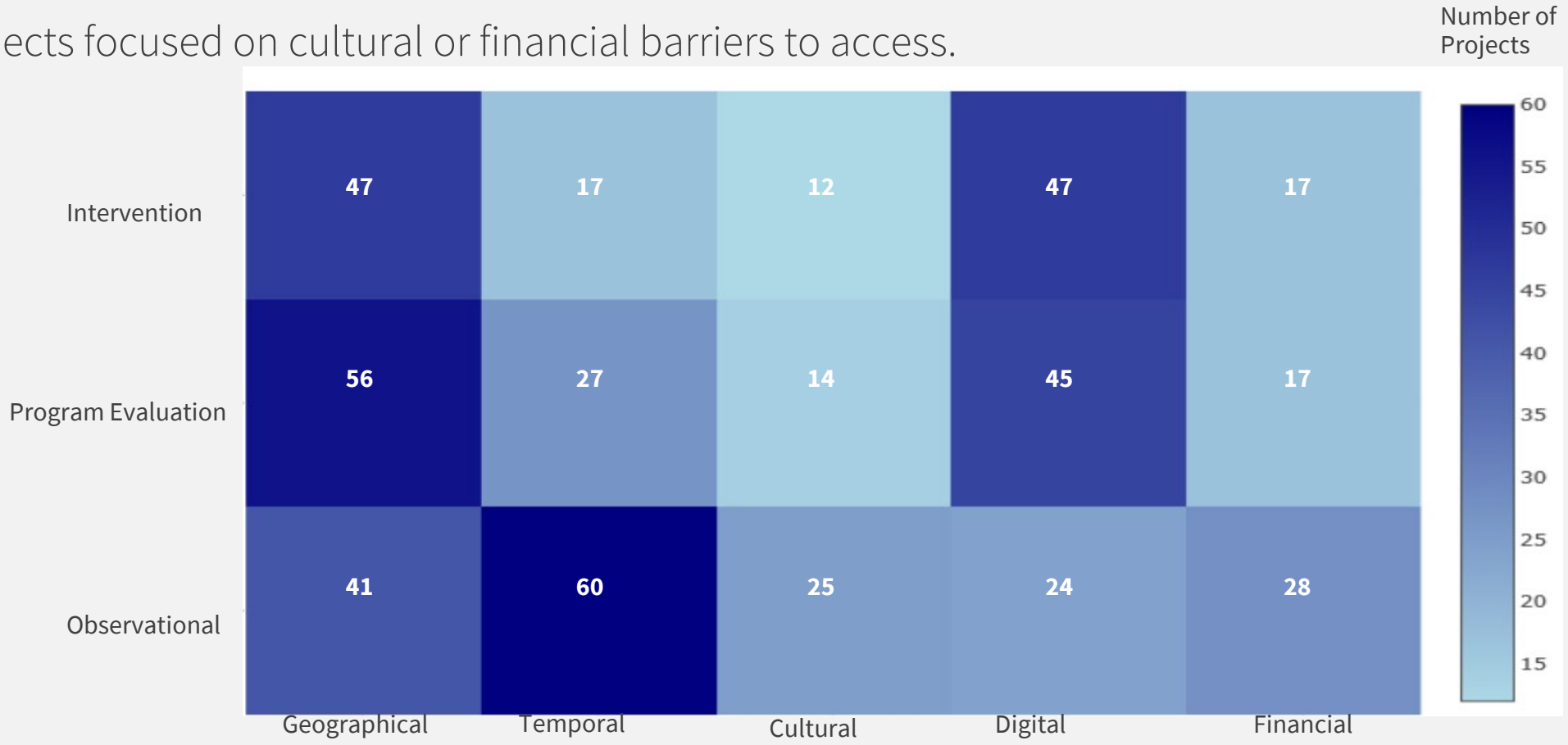
Access type (i.e., actual or perceived access) are subsets of *access specific*.



# CURRENT STATE OF VA ACCESS-RELATED RESEARCH

Relatively few projects were **interventions**, but those that were interventions focused on **geographical** and **digital** barriers to access.

Few projects focused on cultural or financial barriers to access.



# SUMMARY OF CURRENT RESEARCH

Over the last 5 years, VA has developed a robust access portfolio with research and operational work across clinical domains.

Much of the intervention / evaluation work has focused on digital and geographical barriers.

A substantial proportion of interventions show promise and engage in pre-implementation work but fail to be translated / operationalized.

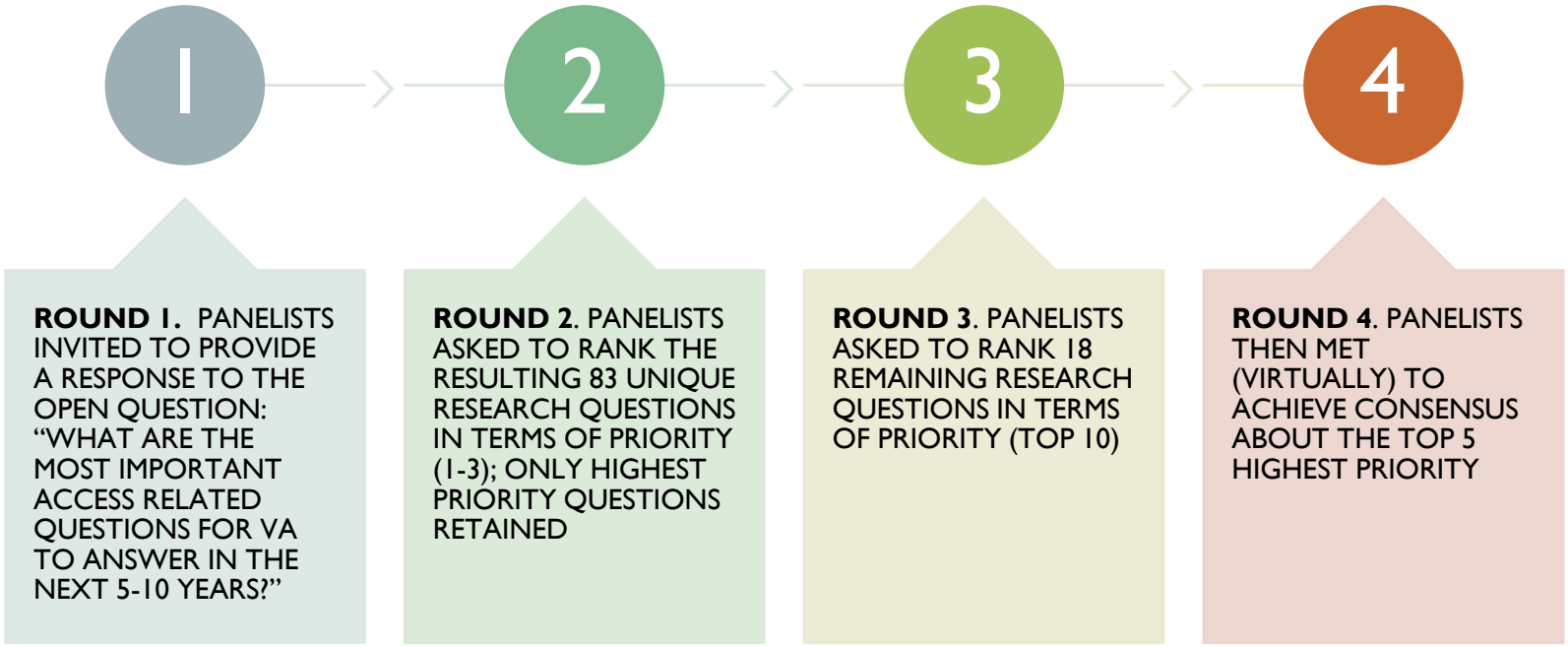
# SO… WHAT IS NEXT?

- To solicit perspectives about the most important access-related research domains to address next, the Stakeholder Engagement Workgroup conducted:
  (1) A modified Delphi panel
  (2) A series of dialogues with Veteran Engagement Boards
- The Delphi process involved a multi-round engagement of 22 access researchers and VA operational partners, in which these experts identified important access related questions and then ranked them in terms of priority for VA support
- Veterans' perspectives on those questions and relevant access-related issues were then solicited from Veterans in Iowa City, Ann Arbor, and Bedford/Boston

# WHAT IS THE DELPHI METHOD?

- RAND developed the Delphi method in the 1950s, originally to forecast the impact of technology on warfare
- The Delphi process aims to determine the extent to which people (often experts) dis/agree about a given issue and, typically via multiple rounds, to ultimately arrive at a consensus opinion
- Delphi has been described as a qualitative, quantitative, and mixed-methods approach
  - Anonymous collection of opinion + the tightly structured nature of the process + the often quantitatively described results = difficult to situate in a single methodological category

# SOLICITING OPINIONS VIA MODIFIED DELPHI METHOD



DELPHI PANEL PARTICIPANTS:

9 VA + 4 NON-VA RESEARCHERS
+9 OPERATIONAL PARTNERS

# RESULTS: TOP 10 RESEARCH QUESTIONS

| | |
|---|---|
| 1 | Are there specific groups of enrolled Veterans who encounter barriers to care (e.g., language, literacy, transportation, lack of telehealth capacity, discrimination, harassment at facilities) and could targeted interventions enable these groups to overcome these barriers? |
| 2 | How can we ensure equitable and effective access to services for Veterans who are underrepresented or experience disparities in the VA (e.g., racial/ethnic minorities, LGBTQ, women, those living on tribal lands)? |
| 3 | What access barriers are interfering the most with Veterans getting the care they need? |
| 4 | How can non-face-to-face modalities (i.e.,telehealth/virtual care) be most effectively used to improve access in primary/specialty care? |
| 5 | How should veteran access to care be defined and measured in the VA and in the community (e.g., best variables, data sources)? |
| 6 | How do we incorporate patient preferences in our questions about access to care? |
| 7 | How should we determine what the VA builds (provides) vs buys (community care) in order to most effectively improve access to timely, high-quality care for Veterans? |
| 8 | How are each of the various dimensions of access (the 5 As: affordability, availability, accessibility, accommodation, and acceptability) related to functional outcomes and value for veterans? |
| 9 | What are the unintended consequences of addressing access to care (e.g., exacerbate disparities)? |
| 10 | Does increased access lead to improved care quality, care coordination, patient satisfaction/preferences and manageable costs? |

# FINAL SUGGESTIONS FROM THE DELPHI PANEL

| Access Research Domains | Leading Research Questions for Each Domain |
|---|---|
| **Measurement of access** | **How should actual and perceived access be defined and measured so it is understandable, uses the best possible data (surveys, electronic, etc.), and has meaningful implications for Veteran outcomes, both in VA and the community?** |
| **Barriers to access** | **How do structural, logistic, personal and organizational barriers to access vary across subpopulations and interfere with veterans getting the care they need and/or desire?** |
| **Equity and subpopulations** | **How can we ensure equitable and effective access to services for Veterans who are underrepresented or experience disparities in the VA (e.g., racial/ethnic minorities, LGBTQ, women, those living on tribal lands)?** |
| **Effective interventions to improve access** | **What are the most effective and scalable interventions that improve access, considering different modalities (e.g., in person, virtual care), settings (e.g., VA, community), and targets (e.g., patients, providers, system)? How does this vary for subpopulations?** |
| **Consequences of poor/better access** | **Does (a) increased access and/or (b) better access lead to improved quality care coordination, patient satisfaction, clinical outcomes, care continuity, and cost? What are the systemic consequences?** |

# POLL QUESTION #2: OF THE FIVE ACCESS-RELATED RESEARCH QUESTIONS IDENTIFIED BY PANELISTS, WHICH DO YOU THINK IS MOST IMPORTANT FOR VA TO PRIORITIZE FIRST?

- How should actual and perceived access be defined and measured so it is understandable, uses the best possible data (surveys, electronic, etc.), and has meaningful implications for Veteran outcomes, both in VA and the community?
- How do structural, logistic, personal and organizational barriers to access vary across subpopulations and interfere with veterans getting the care they need and/or desire?
- How can we ensure equitable and effective access to services for Veterans who are underrepresented or experience disparities in the VA (e.g., racial/ethnic minorities, LGBTQ, women, those living on tribal lands)?
- What are the most effective and scalable interventions that improve access, considering different modalities (e.g., in person, virtual care), settings (e.g., VA, community), and targets (e.g., patients, providers, system)? How does this vary for subpopulations?
- Does (a) increased access and/or (b) better access lead to improved quality care coordination, patient satisfaction, clinical outcomes, care continuity, and cost? What are the systemic consequences?

# VETERAN ENGAGEMENT SESSIONS

- October 2020 – Iowa City
  - Center for Access and Delivery Research and Evaluation (CADRE) Veteran Engagement Panel
- November and December 2020 – Ann Arbor
  - Center for Clinical Management Research (CCMR) Veteran Research Engagement Council
- November 2020 – Bedford/Boston
  - Center for Healthcare Organization and Implementation Research (CHOIR) Veteran Engagement in Research Group
- Mission: to provide Veteran perspectives and input on research studies
- Members range in age, service era, branch, race, education, and gender; approximately 7-12 Veterans at a session

# STRENGTHENING EXCELLENCE IN RESEARCH THROUGH VETERAN ENGAGEMENT (SERVE) TOOLKIT

https://www.hsrd.research.va.gov/for_researchers/serve/serve-toolkit.pdf

**Table 1: Levels of Engagement in Research**

| | Participate | Consult | Involve | Collaborate | Lead/ Co-Lead |
|---|---|---|---|---|---|
| **Veteran's Role** | To act as a participant in a research study | To provide feedback or input on specific research activities | To work directly with a research team throughout a study | Partner with researchers on all aspects of a research study | Leadership role with decision-making authority on studies |
| **Researcher's Role** | To conduct research in a respectful, ethical manner | Veteran(s) asked for input on specific aspects of a research study | On-going engagement of Veteran(s) throughout a research study | Veteran(s) join research team and act as team member | Shared leadership and decision-making |
| **Examples** | Quantitative, qualitative, mixed methods research | Meeting with existing or ad hoc groups; priority setting activities | Standing group dedicated to providing input on studies | Members of research steering committee | Veterans are research partners or co-investigators |

*Levels of engagement in health research figure was adapted from the International Association for Public Participation's Public Participation Spectrum under the fair dealing provision of the Canadian Copyright Act for research. https://sustainingcommunity.wordpress.com/2017/02/14/spectrum-of-public-participation/*

# APPROACH AND BEST PRACTICES

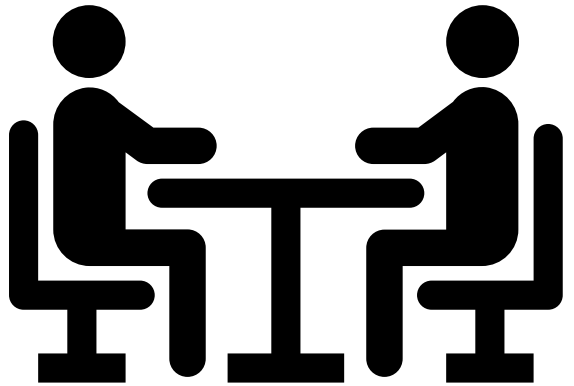
- **Introductions, backgrounds**
  - *Important to establish our personal relationships to service*
- **Explained VARC's mission and goals for the session**
  - *Context critical: Alignment with HSR&D's goals and intention to provide optimal care*
- **Described Delphi process and results**
  - *More helpful to focus on final results, rather than get too mired in the methodological weeds*
- **Invited reactions and feedback**
  - *More fruitful to avoid broad overarching questions (e.g., "What are your reactions to this list?") and instead translate academic abstraction to engage meaningful Veteran experiences*
  - *Focus on barriers, equity, and interventions*

# DISCUSSION: BARRIERS TO ACCESS

- *How do structural, logistic, personal and organizational barriers to access vary across subpopulations and interfere with veterans getting the care they need and/or desire?*
- What are some of the things that you think act as barriers to access to care through the VA?
- Why or how are they barriers?

# DISCUSSION: EQUITY ACROSS VETERANS

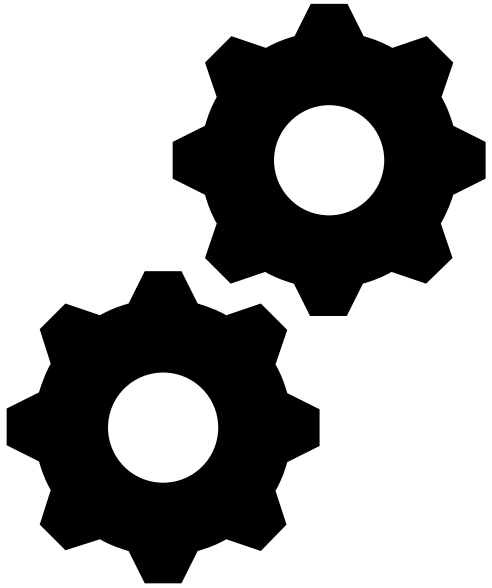
- *How can we ensure equitable and effective access to services for Veterans who are underrepresented or experience disparities in the VA?*
- Do you think there are differences in access to care across the Veteran population?
- What are those differences and why do you think those differences exist?
- Which differences should be addressed immediately?



# DISCUSSION: EFFECTIVE INTERVENTIONS

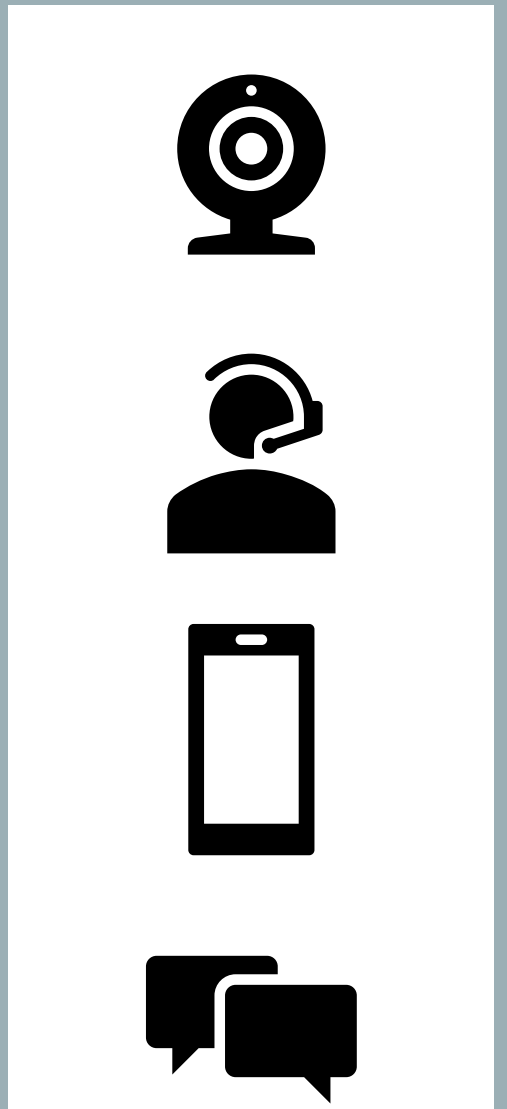
*What are the most effective and scalable interventions that improve access, considering different modalities (e.g., in person, virtual care), settings (e.g., VA, community), and targets (e.g., patients, providers, system)?*

What ideas do you have for how access issues within the VA might be addressed?



# SIGNIFICANT NEEDS FOR ACCESS TO CARE IDENTIFIED BY VETERANS

- **Dissemination of VA services**
  - Services and resources disseminated consistently and equally across VA system
  - Details of services should be easily available
- **Communication of services**
  - Need for widespread marketing and individualized contact
  - "This is like showing where the doors to services are. If you don't show people where the door is, there's no access!"
- **Connection and relationship to local communities/health care facilities**
  - Partnership with community organizations to connect with Veterans
  - Relationship with community-based health care clinics/hospitals
- **Telehealth support**
  - Education on technological resources and available options for telehealth care (e.g. tablet distribution)



# OTHER ISSUES IDENTIFIED BY VETERANS

- **(Dis) Trust of VA system/health care professionals**
  - Perception of "poor quality of care"
- **Military Culture**
  - Recognition of diverse health care needs by Veteran cohort (e.g., Vietnam, Iraqi Freedom)
  - Recognition of health care needs aligned with time since disconnection from service (e.g. active duty, reservist)

# WHAT'S NEXT

COMPLETE 5-YEAR RESEARCH ROADMAP

PRESENT FINAL RESULTS TO HSR&D, OPERATIONAL PARTNERS, AND OTHER STAKEHOLDERS

INFORM FUNDING PRIORITIES FOR 2021 AND BEYOND



- Karen Albright, PhD
  Karen.Albright2@va.gov
- Demetria McNeal, PhD
  Demetria.McNeal@va.gov
- Veteran Access Research Consortium