HSR&D

# Interventions to Improve Veterans' Access to Care: A Systematic Review of the Literature

EXECUTIVE SUMMARY

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Department of Veterans Affairs
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Prepared by:
Evidence-based Synthesis Program (ESP) Center
Minneapolis VA Health Care System
Minneapolis, MN
Timothy J. Wilt, MD, MPH, Director

Investigators:

Principal Investigator:
Shannon M. Kehle, PhD

Co-Investigator:
Nancy Greer, PhD

Research Associate:
Indulis Rutks, BS

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## BACKGROUND

Recently, researchers within the Department of Veterans Affairs (VA) have begun to develop an updated conceptualization of access which takes into account the impact of new technology on access and places a greater focus on outcomes beyond increased access.[1] Specifically, the new conceptualization acknowledges post-access outcomes such as satisfaction, symptom levels, and functioning. As such, we sought to conduct a review of the literature that would clarify the current state of knowledge regarding the link between access to healthcare and system-level (e.g., utilization, satisfaction with care) and patient-level (quality of life, symptoms, mortality) outcomes. Given VA's continuing commitment to improving access for veterans,[2,3] we also examined the efficacy of interventions designed to improve access, with a focus on access, system-level, and patient-level outcomes (Figure 1).

The Key Questions addressed in this review are:

KEY QUESTION #1: What is the evidence that variation in veterans' ability to obtain needed health care (i.e., access) contributes to variation in system level (e.g., utilization, satisfaction) or patient level (e.g., quality of life, functional ability, mortality) outcomes?

> KEY QUESTION #1A: Does the effect of access on system and/or patient level outcomes differ by patient (e.g., demographics, overall health, illness severity), treatment (e.g., mental health, physical health), or setting (e.g., rural, urban, community, VA) characteristics?

KEY QUESTION #2: What interventions have been successful in improving access for patient populations with reduced health care access?

> KEY QUESTION #2A: Have interventions that have improved health care access led to improvements in system level and patient level outcomes?

## METHODS

We searched OVID MEDLINE, CINAHL, and PsycINFO for English language articles related to access and veterans' care published in peer-reviewed journals from 1990 to June 2010. Data were abstracted from 23 articles related to Key Question #1 and 26 related to Key Question #2. We constructed evidence tables with patient characteristics, outcomes, and study quality for each study included. Due to heterogeneity in study design, patient characteristics, and outcomes, pooled analyses were not feasible.

## RESULTS

KEY QUESTIONS #1 and #1a: We identified 23 studies that focused on the association between access and system-level or patient-level outcomes. Most commonly studied was the association between distance from a VA facility and utilization, primarily outpatient health and/or mental health service use. Across a variety of patient needs (e.g., treatment for substance abuse or spinal cord injury, primary care), we found fair to good evidence that increased distance from a VA

facility was associated with decreased utilization. Other factors studied in relation to outpatient utilization included ability to pay for care, social support, and comorbidities. Distance, ability to pay for care, and comorbid conditions also influenced utilization of inpatient care including choice of VA or non-VA facilities. Five studies reported patient-level outcomes including two that addressed mortality. We found limited evidence that increased distance from a VA facility (one study) and longer wait time for an appointment (one study) were associated with increased mortality. We found fair evidence from six studies that identified significant interactions with the majority focused on distance and other explanatory variables such as age and diagnosis.

KEY QUESTIONS #2 and #2a: We identified 26 articles (24 unique studies) that examined the efficacy of interventions designed to increase access. Only five were randomized trials. We categorized these interventions as Community Based Outpatient Clinics, Mental Health Integration into Primary Care, Intensive Case Management, Telehealth, Outreach, CoPayments, and Other. Changes in medication copayments had the strongest evidence base with four studies. We found fair strength of evidence that increases in medication copayments decreased access / adherence to needed medications. Community Based Outpatient Clinics and Primary Care Mental Health Integration were evaluated in 6 studies each, but the studies were of low quality. There were fewer studies that evaluated other interventions (e.g., primary care mental health integration, intensive case management, telemedicine, outreach). Nineteen studies reported system-level outcomes, most often satisfaction with care and use of primary care. The majority of studies that reported satisfaction found veterans were more satisfied with care following the intervention. All but one of the studies on primary care and general medical visits found that the intervention was associated with increased utilization. Six studies reported patient-level outcomes: three found that access did not impact outcomes and one found that veterans with increased access had worse outcomes.

## CONCLUSIONS

The data suggest it is possible to improve access to healthcare, although there was a lack of high quality evidence supporting the efficacy of any one intervention. There was fair evidence that increases in medication copayments decrease access / adherence to needed medications. However, future research is needed to determine if decreasing copayments increases access / adherence. There was fair evidence of a relationship between improved access and better system-level outcomes (satisfaction and primary care utilization). There was a lack of data regarding the link between access and patient-level outcomes. Future research should focus on the quality and appropriateness of care and patient-level outcomes.