

Fall 2015

Commentary

Listening to Veterans about Access to Care

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Contents

Director's Letter	2
Tracking Veterans' Perceptions of Access to Care	3
Distance and Access	4
Evaluation of Initiatives Designed to Increase Access to Patient Care: E-Consults and SCAN-ECHO	5
The Evolution of Veteran-Centric Access Metrics	6
Veteran Access to Health Care: A Conversation with VA Ann Arbor Healthcare System Director Robert McDivitt	7

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The “access” crisis that engulfed VA last year spurred significant changes in VA health care. Changes included increases in Veterans’ access to care, improvements in clinic scheduling practices, and new leadership. At a recent Congressional budget hearing, Secretary McDonald reported the following outcome measures: 7 million more VA clinic appointments this year, a 44 percent increase in VA care in the community, increases in net staffing by more than 12,000, increases in the number of primary care exam rooms, and increases in provider productivity. These outcomes reflect the traditional structural approach to measuring access. What they also reflect, however, is a missed opportunity to reinforce a multi-dimensional conceptualization that includes both “actual and perceived” access to care as defined in the 2010 VA State of the Art (SOTA) Conference on Access.

Over-reliance on the structure of VA health care, such as wait time metrics, distracts us from measuring patient-perceived access from a broader conceptual foundation that includes geographical, temporal, financial, cultural, and digital dimensions.¹ Some, but not all aspects of these access dimensions are addressed by the Survey of Healthcare Experience of Patients (SHEP), the single most important VA program to systematically assess patient perceptions of health care. Questions about the “ease of access to routine and urgent care” form the basis for key agency metrics tied to the Agency Performance Plan. During the early days of the VA access crisis, we observed that results from these standard access questions were already available and indicated wide variability across VA facilities

in patient perceptions of access to care. We also observed that lower access scores correlated with longer wait times. We should have been listening to the voice of our Veterans via the SHEP survey results rather than a singular dimensional focus on wait time metrics.

SHEP Program

The SHEP program, managed by the Office of Performance Management within the Office of Analytics and Business Intelligence (OABI), was initiated in fiscal year (FY) 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. We adopted the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology in FY09 when we launched two flagship surveys: 1) an outpatient survey which was later transitioned to the Patient Centered Medical Home (PCMH) survey that specifically focused on primary care; and 2) a hospital CAHPS survey of inpatient medical and surgical services. These instruments provided a standardized, validated, and tested mechanism for assessing patient experiences with health care that are used to systematically evaluate VA hospital performance. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys, the access questions were limited and did not evaluate the full scope of services used by Veterans.



Director's Letter

The crisis of the past year for VA over access will likely become an organizational case study about how *not* to use performance measures to drive system performance in a complex system. The problem of access was not a secret to VA leadership—while satisfaction with VA care was generally equal or above that of private systems, many facilities struggled to provide timely care especially for certain hard-to-recruit specialties, and especially in

places where the growth of the Veteran population had outpaced staffing increases. In efforts to focus attention on access and improve performance, VA made numerous errors: it chose the wrong measure (wait times for appointments rather than a more comprehensive patient-centered measure of access), set a uniform and unrealistic target (two weeks, without regard to capacity to meet that target), and tied performance to executive bonuses. The result was that in many facilities, lower level employees felt pressure to report misleading numbers. The irony was that VA had actually adopted many innovations over the past five years to improve access to care, but their success was not necessarily measured in shorter clinic wait times. Initiatives like video-telehealth, secure messaging, MyHealtheVet, SCAN-ECHO, and e-consult all improved the means by which patients, especially rural Veterans, could access their care team or engage the expertise of specialists.

The access crisis was a manifestation of deeper challenges for VA. The series of outside assessments of VA care that were commissioned as part of the Choice Act have recently been delivered to VA and a summary report integrating the separate findings has been made public.¹

Among the many shortcomings it calls out, the report highlights a lack of strategic vision and systems thinking as a fundamental failing, reflected in a tendency to tackle each issue as an isolated problem without thinking of its relation to the entire system. The greatest contribution of research in helping VA respond will be to examine and test the multiple system effects of different solutions being offered to improve access. While timely access is essential, it cannot be viewed alone without considering its relation to other important VA goals: high quality of care; coordination and communication across sites of care; sustainable costs to both the Veteran and VA; a robust mission of education, training, and research; and most importantly, an improved patient experience. There is enough work to keep many researchers busy while VA continues to address access and works to carry out a new transformation.

David Atkins, M.D., M.P.H.
Director, HSR&D

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New Era for SHEP

SHEP was awarded additional resources to significantly expand the inventory of surveys to more comprehensively assess Veteran access to care. Award of these additional resources was prompted by the widespread recognition that clinic appointment wait times were inadequate measures of access to care. This year we are introducing the following

new surveys, multiple survey modalities, and new analytic reports designed to measure access to—and experience with—a wide range of VA health care services, including VA care in the community.

PCMH Survey Addition of Specialty

Care Item-Set. For those Veterans who responded to the PCMH survey and who also had an encounter with a specialist, they are

asked additional questions about the ease of getting specialty care appointments and the Overall Rating of Specialists. Data collection began in October and facility-level results are being reported to the field.

VA Specialty Care Survey. Veterans with visits to high volume specialty care clinics are sent a specific specialty care survey that includes questions about ease of access to VA specialty care clinics, overall rating of VA specialist, and CAHPS domains such as communication and coordination of care. The survey utilizes more timely and effective modes of survey administration including email invites, an online survey (mobile device enabled), and traditional mail-mode administration. Data collection began in May and results will be available in late August.

VA Care in the Community. This survey will address the requirements of the Choice Act by evaluating Veteran perceptions of access to—and experiences with—all VA care in the community. The survey addresses experience with both choice care and traditional fee care. Just as with the Specialty Care Survey, multiple modes of administration will be utilized in implementing this survey. Extensive focus group work was completed to support the development of this survey to be launched in late FY15.

New Enrollee Survey. This survey will address Veteran experiences with initial enrollment and access to first clinic appointments. Extensive focus group work was recently completed to support the development of this survey with an anticipated early fall launch.

Finally, we have established a **Veteran Insights Panel** composed of over 3,200 Veterans that are representative of users of VA health care. We are engaging panel members in direct discussions about important themes and issues. We interact with the panel through email notification and a special access website (mobile device enabled). We are engaged in real time feedback via live chat discussion, qualitative and quantitative surveys, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our Veterans.

Measurement of access is complex because the understanding and definition of access mean different things to different people. We need to embrace a patient-centered view of

Continued on page 8

Response to Commentary

Tracking Veterans' Perceptions of Access to Care

John Fortney, PhD, HSR&D Center of Innovation for Veteran-Centered and Value-Driven Care, Seattle, Washington; Susan Kirsh, MD, MPH, VA Office of Clinical Operations, Washington, DC; and Jeffrey Pyne, MD, HSR&D Center for Mental Healthcare and Outcomes Research and VA South Central Mental Illness Education and Clinical Center, Little Rock, Arkansas

Last year's access crisis compelled VHA to rethink how access to care is measured, resulting in new opportunities for HSR&D investigators to work with operational partners. Participants of the VHA 2010 *State of the Art (SOTA) Conference on Improving Access to Care* envisioned a new conceptualization of access that emphasized patient centeredness and assessing how well the VA health care system fit the needs and preferences of individual Veterans.¹ The reconceptualization of access developed at the SOTA Conference also highlighted the importance of measuring how Veterans *perceive* their access to care. While VHA has traditionally relied on structural measures of access (e.g., number of providers) or objective measures of access (e.g., days to first available appointment), the time has come to track Veterans' perceptions of access to care and use that as the primary yardstick for measuring success.

Shift to Perceived Measures of Access

Shifting the emphasis away from structural and objective measures of access to perceived measures of access has many advantages. First, focusing on patient experiences ensures we measure what matters to Veterans. If VA is going to make structural and process investments in improving access, success should be assessed according to whether Veterans perceive these improvements. Second, research conducted by Drs. Prentice, Davies, and Pizer has shown that Veterans' perceived access to care (e.g., timeliness of care) is highly correlated with actual measures of access (e.g., days to first available appointment).² Thus, perceived access to care is not too distal an outcome to assess the impact of structural and process improvements in health

care delivery. Third, assessing system performance by measuring Veterans' perceptions of care is much less "gameable" than other metrics that are based on data routinely collected by local VHA staff who bear the negative consequences of poor performance. Perceived access is a patient-reported measure that can be collected in an unbiased manner by centralized VHA staff who operate independently from the local VHA staff who are responsible for clinical operations.

As described in Dr. Wright's commentary *Listening to Veterans about Access to Care*, the Survey of Healthcare Experience of Patients (SHEP) represents an ideal mechanism to monitor Veterans' perceptions of access to care, including both care delivered by VHA and private care paid for by VHA. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) instrument is embedded within the SHEP and provides a nice comparison to the private sector. However, the CAHPS does not necessarily measure all the domains of access that are important to Veterans. HSR&D investigators now have an opportunity to contribute to the development of a Veteran-centered survey instrument designed to measure perceived access to care. For example, the objective of Dr. Pyne's HSR&D-funded project is to generate survey items that measure perceived access to VA mental health care based on the conceptual framework for access developed at the SOTA Conference.

Perceived Access Inventory: A New Survey Instrument

Eighty Veterans diagnosed with a mental health disorder living in Veterans Integrated Service Networks 1, 16, and 21 have

participated in semi-structured qualitative interviews specifically designed to uncover what dimensions of access are most important to them. Based on qualitative analysis of these interviews with Veterans and in partnership with the VHA Office of Performance Management within the Office of Analytics and Business Intelligence, Dr. Pyne and his colleagues plan to develop and validate a new survey instrument, the Perceived Access Inventory. A key goal of this project is to provide VHA operations with a patient-centered and psychometrically validated survey instrument that can be used to monitor changes in perceived access associated with changes in VA policy or resource allocation. In addition, the project will identify geographic areas or facilities with low perceived access to care and measure changes in perceived access in randomized controlled trials evaluating interventions designed to improve access.

Evidence clearly supports the need for a standardized program designed to improve timely access to outpatient care.³ To this end, VHA is currently embracing the use of an outpatient clinic practice management program. One aim of this program is to incorporate findings about perceived access to care and satisfaction from the SHEP. In addition, facilities will have an opportunity to employ the use of VetLink (kiosks), ICE, and Truthpointe, all products designed to assess Veterans' experience with care in real time. This emerging emphasis on Veterans' experience with care is a high priority of MyVA in the Secretary's Office.

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Research Highlight

Distance and Access

John F. McCarthy, PhD, MPH, Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC), Office of Mental Health Operations, HSR&D Center for Clinical Management Research, Ann Arbor, Michigan

Ensuring Veterans' access to health services is a national and Veterans Affairs (VA) priority. Delayed or missed encounters may increase risks for adverse outcomes. Concerns about distance effects on access are not new. In this article, I discuss distance and access, noting relevant findings and outlining the concept of access and implications for research.

Responding to widespread concerns regarding wait times, Congress passed the Veterans Access, Choice, and Accountability Act of 2014. The Act directs VA to establish the Veterans Choice Program to furnish services through qualified non-VA providers for eligible Veterans who cannot be seen within 30 days or whose driving distance to the nearest VA medical facility exceeds 40 miles.

Geographic Factors and Distance Barriers

Planning for mental health services has long considered geographic factors. In 1850, Edward Jarvis noted, in the language of the period, that “an insane asylum is, and must be, to a certain extent, a local institution. People will avail themselves of its privileges in some proportion to their nearness to it.”¹ Whereas New Yorkers had considered locating a “grand... establishment” centrally, in Utica, to “offer equal advantages to... all parts of the State,” Jarvis reasoned that although the facility might receive all who needed care from Oneida county, it would not serve “more than a fifth or a fourth of those of Rockland and Clinton.” Jarvis described an early “law” of health services: a distance-decay relationship, whereby the likelihood of utilization diminishes at greater distances from providers.

Jarvis's work has guided analyses specific to individuals with mental illness who receive VA care. For example, studies indicate that living farther from VA providers is as-

sociated with having fewer outpatient visit days; less treatment retention; less receipt of psychotherapy and greater receipt of antidepressant medications following initial depression diagnosis; and less initiation of mental health intensive case management services among eligible patients.

Analyses also document other responses to distance barriers. When individuals with schizophrenia and bipolar disorder relocate, they are more likely to move closer to VA providers. And among individuals with serious mental illness, clinic trip chaining or coordination is greater for those who live farther from VA providers, as indicated by greater average number of clinic encounters per visit day. Similar findings have been documented for other VA patient populations. Distance is also associated with less timely follow-up after myocardial infarction, less receipt of needed liver transplants, less specialty care among patients with HIV, and less receipt of VA care among Medicare-eligible Veterans. Increased VA travel reimbursement is associated with greater receipt of medications and outpatient encounters.

Access is often poorly conceptualized in the research and policy literature. My understanding of access builds from the writings of Avedis Donabedian, and Penchansky and Thomas's “Five ‘A's of Access.”^{2,3} To begin, it is understood that the health care process is situated in a sociocultural, organizational, and physical context. Access may affect utilization in terms of contact with providers, volume of services, and continuity of care. Access is conceptually distinct from utilization and outcomes, although these may offer helpful validators of access.

Most essentially, access represents a general concept that refers to specific dimensions of the fit between characteristics of potential clients and providers. Penchansky and Thomas validated a taxonomy of ac-

cess with these dimensions: affordability, availability, acceptability, accommodation, and accessibility. Distance to care represents a measure of geographic accessibility, what Rashid Bashshur has called “the friction of space.”

John Fortney and colleagues recently proposed an update to this framework. This updated view includes discussion of fit in terms of the “ease” of having virtual or face-to-face interactions. This update may focus health system efforts. It remains important for our understandings of access to consider provider responses to potential clients.

Several points follow from this conceptual understanding of access. Access should be understood in terms of multiple specific dimensions. People can have different degrees of access; access is not all-or-nothing. And individuals may differ in their “fit thresholds” as a function of their resources, preferences, and experiences. This approach is at the core of patient-centered care.

The concept of access as “fit” can guide researchers to consider varied influences on treatment seeking and continuation behavior; the importance of client preferences and circumstances; the role of clinicians' perspectives and behaviors; and the impact of services organization and delivery practices.

Over the past 20 years, VA has advanced substantially as an accessible health system. Notable examples include the expansion of contact points, services integration, enhanced travel reimbursement, expansion of telehealth, and provision of outreach and home-based services. The Veterans Choice Program presents important new opportunities to further enhance access and meet the needs of Veterans.

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Research Highlight

Evaluation of Initiatives Designed to Increase Access to Patient Care: E-Consults and SCAN-ECHO

Katherine Williams, MPH, and Leah Haverhals, MA with the VA Eastern Colorado Health Care System, Denver, Colorado and Sherry Ball, PhD, Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio. The authors are affiliated with the Virtual VHA Specialty Care Evaluation Center.

Specialty care services in the Veterans Health Administration (VHA) are commonly concentrated in urban medical centers, with fewer specialty care services offered in suburban and rural areas. In May 2011, the Office of Specialty Care (OSC) rolled out initiatives aimed at expanding access to specialty care, resulting in the development of two new consultation approaches: Electronic-Consults (E-Consults) and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). This article presents findings from an evaluation of these new approaches conducted by the Specialty Care Evaluation Center (SCEC) in collaboration with OSC.

E-Consults allow primary care providers (PCPs) to consult with specialists through the electronic medical record and to receive responses and recommendations without necessitating a Veteran face-to-face specialist visit.

SCAN-ECHO uses video-conferencing to hold monthly or bi-weekly scheduled sessions between a multi-disciplinary specialty care team at urban medical centers and PCPs, many of whom are at Community-Based Outpatient Clinics (CBOCs). Sessions begin with a didactic lesson and end with a case presentation, usually given by a PCP, followed by real-time discussion. Thus, all participating PCPs can gain expertise applicable to specific cases as well as to future patients.

The SCEC, which includes five VHA sites—Denver, Cleveland, Seattle, Ann Arbor, and East Orange—collaborated with OSC to achieve operational and research objectives with regard to these two new consultation approaches. Researchers combined elements from a formative evaluation, including administrator/provider cross-sectional interviews and surveys, with quantitative data on patterns of use from a summative evaluation.

Impact on Retention and Recruitment of Providers

From September 2011 to October 2013, VHA facilities reported 740,149 E-Consults across 121 VHA sites for 58 specialties. Providers reported that patients received timely treatment, traveled less for specialist appointments, and were more satisfied with their care after E-Consult implementation. One PCP stated, “E-Consults fit very well with this [pain program] because answers to questions can come quickly.”

Since 2011, specialty care teams at 12 VHA sites have developed SCAN-ECHO curricula based upon local expertise and need. From these sites, specialty programs were developed including, but not limited to, cardiology, diabetes, gastroenterology, geriatrics, hepatology, pain management, pulmonary, surgery, and women’s health.

PCPs from over 280 CBOCs regularly participate in SCAN-ECHO sessions, with over 3,000 patient cases presented from 2011 to 2013. Ninety-three percent of participating PCPs and 87 percent of specialists agreed SCAN-ECHO has increased PCP knowledge and competencies. One specialist said, “We have empowered PCPs to do more at their level... and therefore the complexity of patients they are referring is more [complex] because they are handling the lower complexity [patients].”

The impact of SCAN-ECHO participation on provider retention and recruitment in providing adequate access to care was apparent from the evaluation. Participating PCPs reported high levels of satisfaction with SCAN-ECHO and only quit attending SCAN-ECHO sessions to meet urgent patient care demands. Many providers reported that SCAN-ECHO increased job satisfaction and some described it as critical to avoiding

burnout. One PCP noted, “I love it. It’s the face of the future. I was getting burned out in PC (primary care), but this has given me new life.” Further, one PCP stated, “What’s most important [about SCAN-ECHO] is that providers feel more satisfied in their career, it keeps them here. The turnover of PCPs is a huge upheaval.” Results also suggested stronger professional relationships were fostered between PCPs and specialists, facilitating improved knowledge sharing.

Patient Access Implications and Future Evaluation

Eighty-eight percent of surveyed SCAN-ECHO PCP participants agreed it has improved their ability to manage and treat patients. One PCP noted, “I feel empowered by the knowledge I learned at the SCAN-ECHO session. We receive detailed recommendations, and I can ask specialists anything. Sometimes during traditional consults we may not completely understand the reply. I think my quality of taking care of patients has improved dramatically.” While it was apparent that providers felt both initiatives were beneficial, providers stressed the importance of protected time to participate in these new consultation approaches. Providers reported that a lack of protected time was a significant barrier to participation. In fact, only 16 percent of SCAN-ECHO PCPs surveyed stated they had protected time to participate.

The SCEC has worked closely with OSC and has provided feedback on evaluation components that have been incorporated into guidance documents for subsequent rollout of both initiatives. For example, the SCEC has suggested further analytics for E-Consults and SCAN-ECHO (e.g., travel distance averted by using E-Consults instead of face-to-face consults) to support participants with emphasis on meeting the needs of individual VHA sites and OSC. Additionally, the SCEC has incorporated geospatial information systems mapping to analyze spread of E-Consults.

These evaluation findings suggest initiatives such as SCAN-ECHO and E-Consults show much promise in improving access to care for Veterans. However, providing protected time for participating providers to be involved in these initiatives is critical for sustainability and success.

Research Highlight

The Evolution of Veteran-Centric Access Metrics

Julia Prentice, PhD, Steven Pizer, PhD, both with the Evidence-Based Policy Resource Center and Health Care Financing and Economics, VA Boston Healthcare System, Boston, Massachusetts

In 2014, VA underwent a widely publicized crisis in confidence as Congress and the public questioned whether appointment wait time metrics used by VA accurately reflected patient experience.¹ Our work validating VA access metrics has found a consistent relationship between longer waits for VA care and decreased self-reported satisfaction. Our research findings also highlight the importance of using diverse metrics when assessing self-reported satisfaction for different populations.²

Historical Context

Congress requested that VA begin systematically measuring wait times for outpatient care over a decade ago when concerns first surfaced regarding excessive wait times experienced by Veterans for VA care. VA initially measured access by calculating the number of days between an appointment request and the first next available appointment in the scheduling system. Despite similar measures being extensively used in the private sector, VA recognized that these metrics measured overall supply but did not take actual Veteran experience into account. For example, a Veteran may not want or need the next available appointment but, rather, may want to schedule a follow-up appointment months from today. The metric did not take such preferences into consideration, assuming every Veteran wanted the next available appointment. Consequently, when the Veteran actually scheduled and completed the appointment was not captured.

Beginning in 2004, VA policymakers moved away from this ‘first next available’ appointment metric and developed several different access metrics. One such metric used the initial appointment request date as the start-

ing point and then calculated the number of days until the appointment was scheduled or completed. Another metric used the ideal date that a patient wants to be seen—as interpreted by the scheduler—as the starting point (desired date). This metric was revamped in the Veterans Access Choice and Accountability Act of 2014 (Choice Act) that was passed in response to the VA access crisis.³ The clinically indicated date, also known as the patient preferred date, is now captured and used as the starting point. This date is the date that a provider requests to see a patient.

Past work has found new patients may want to be seen as soon as possible due to emerging health concerns. Returning patients may prioritize convenience of appointment times or continuity of care over how long they are waiting for appointments. Our work supports these conclusions. New patients who visited facilities with longer wait times using the ‘appointment request’ metric reported lower satisfaction with both their ability to access VA care and more generally with VA care. In fact, our research found no relationship between the ‘desired date’ metric and satisfaction for new patients. In contrast, there was no relationship between the ‘appointment request’ date metric and self-reported satisfaction for returning patients. We did find a consistent relationship between the ‘longer desired’ date metric and lower satisfaction for these patients.

Access to Specialty Consult Appointments

Preliminary recent work focusing on wait times for specialty consult appointments further supports these findings and expands the definition of Veteran-centric

metrics. Patients referred to specialty care are likely to have new concerns and want to be seen as soon as possible after the need for a referral is identified. Veterans visiting facilities with longer wait times for specialty consults report lower satisfaction when assessed using a metric with consult ‘appointment request’ date as the starting point. Notably, a metric that measured the time it took to complete behind the scenes administrative processes (e.g., transferring the consult) had no relationship with satisfaction. As VA continues to put a greater emphasis on the experiences of patients, these findings suggest that metrics should focus on measuring tangible processes that patients easily understand as action being taken on their behalf, such as scheduling appointments.

Our work confirms that appointment wait times are an important issue for Veterans. When there is not an emerging health concern, Veterans may prefer to wait longer and prioritize other aspect of their health care. Ongoing work is examining whether the new access metrics that measure wait times and were required by the Choice Act reliably predict patient satisfaction. As VA continues to reorganize and provide comprehensive services outside of traditional appointments, more comprehensive access metrics that reflect patient experiences with non-traditional encounters—such as telephone contacts and secure messages with members of their care team—will also be needed. Researchers will need to validate these new metrics by demonstrating that better reported performance is associated with increased patient satisfaction.

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Dialogue

Veteran Access to Health Care: A Conversation with VA Ann Arbor Healthcare System Director Robert McDivitt

FORUM Editors, Karen Bossi and Margaret Trinity, recently sat down with Robert McDivitt, Director of the VA Ann Arbor Healthcare System (VAAAHS) and Acting VISN 11 Network Director, to explore the topic of access—what access means in the context of the health care Veterans receive, as well as successes and challenges that VA Ann Arbor Healthcare System has experienced around access to care for Veterans.

What does access to VA health care mean to you?

For the past 35 years, I've worked in a variety of positions across six medical centers and three corporate assignments within the VA health care system. I am also a Veteran and view access issues from a patient perspective.

Across VA, I've witnessed an evolution from a system that once focused on inpatient care to a system focused on outpatient

care, then primary care, and now, health and wellness in partnership with Veterans. The focus has shifted to providing care when it is needed by Veterans and where Veterans are located. Today, Veterans have access to care on a real time basis via smartphones. And most Veterans have experienced at least one virtual encounter—whether telehealth, videoconferencing technology, or an e-consult. At the facility level, I have seen a pronounced increase in telephone communications between clinicians and Veterans. So, in fact, VA is a leader in access to care, although it has not always been portrayed as such.

What is an example of a success you've had addressing access issues?

Over the last few years, the VAAAHS has focused on increasing capacity in both its primary care and specialty care clinics, which led us to hire an additional 60 clinicians as a result of implementation of the Choice Act. One of our priorities has been to expand evening and weekend clinics. As a result, we've seen a 10 percent increase in outpatient visits from FY 14 to FY 15.

We've also worked hard to improve wait times for specialty care referrals. One example is the endoscopy clinic, where in the past we had hundreds of Veterans on the wait list for an appointment. Today, we do not have any Veterans on the electronic wait list and, for routine screening, we are well within the 30-day guideline for securing an appointment. To accomplish these improvements in access, we expanded staffing in the endoscopy clinic, and we also redesigned clinic workflow. The next phase is for us to expand the physical space within the endoscopy clinic itself.

Another prime example is improved access to dermatology consults. We now have a

teledermatology initiative whereby our outpatient clinics have dermatoscopes so that images can be forwarded to University of Michigan faculty physician and a diagnosis provided within 48 hours. This is just one example of a telemedicine technology that VA has aggressively rolled out in the last decade.

What is an example of a challenge you've experienced in ensuring access to Veterans?

Looking ahead, one of our strategic goals is to roll out the Patient-Aligned Care Team (PACT) concept in several specialty clinics. We feel that the PACT concept has been successful in primary care in terms of surrounding Veterans with a team of providers, and using communication tools that do not necessarily require the Veteran to physically travel to the clinic. We anticipate translating the successes that we saw in primary care PACT into specialty care.

What should the next steps be for VA in addressing access?

Our job is working in partnership with Veterans. At VAAAHS, we are continuously engaged in a conversation with the Veterans we serve. We involve Veterans in myriad ways across our facilities. We recently designed a new Veterans Welcome Center and we have Veterans who serve on our governing board. We've conducted several Veteran Tele-Townhalls via Facebook with hundreds of Veterans in virtual attendance. Last year, VAAAHS conducted a Tele-Townhall with a congressional representative who was available to answer questions, much like a call in radio show; we had 700 Veterans participating. The Facebook Townhall has become an important listening post for us.

As a health care executive, my goal is to take evidence-based research results and implement them in a way that works in a given environment. The excellent work undertaken by HSR&D researchers in the area of access as well as many other critical topics has allowed facility leaders such as myself to roll out best clinical practices from health system to health system and from VISN to VISN.

VA Ann Arbor Healthcare System At a Glance

The VA Ann Arbor Healthcare System (VAAAHS) provides state-of-the-art health care services to Veterans living in a 15-county area of Michigan and Northwest Ohio. In 2014, VAAAHS served more than 65,000 Veterans.

The main hospital campus located in Ann Arbor serves as a referral center for specialty care and operates 109 acute care beds and 40 Community Living Center (extended care) beds. VAAAHS experienced more than 800,000 outpatient visits in fiscal year 2014 and also provided nearly 6,000 inpatient episodes of care in its hospital and extended care center.

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Translating research into quality health care for Veterans

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Continued from page 2

access that encompasses both the structure of our health care system and the preferences of our Veterans. We need help from the research community to better understand what is most important to our Veterans so that we can systematically assess how well the system is performing to meet

those needs. Our commitment of providing accessibility to high quality care for our Veterans deserves no less.

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Karen Bossi and Margaret Trinity, Co-Editors

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