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Presenter: Peter J. Kaboli, MD, MS

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Doctor Peter J. Kaboli: I’m Peter Kaboli and I’m going to try and set things up over the next 10 to 12 minutes for Adam who is really going to present the more interesting work that we’ve been doing on evaluating access and timely access in primary care. And some of the things I’m, I’m presenting are just background that many of you already know and hopefully will just be a setup for what he’s going to be talking about. So I’m going to go fairly quickly so that we can get to the more interesting work.

So our objectives for today are to review current metrics for timely access in VHA and the private sector for primary care. Describe the intent and definition of the Same Day Access metric in VHA and propose new methods for measuring timely care.

So as far as the definition of access, this is a definition that was proposed in 1993, that was fairly specific about, you know timeliness of personal health services. Some work that we did a number of years ago through the VA, came up with a new definition and said, 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. And we broke that down into actual which represents those directly-observable and objectively measurable dimensions of access and perceived which represents those self-reported and subjective dimensions of access. And in this paper, we outlined a set of specific dimensions that could characterize the fit between the patient and the healthcare system. So as health care is evolved, there’s been less of a focus on patient-to-provider face-to-face encounters. And the VA has obviously been a pioneer in that. Because the private sector as you all know, you know billing is driven primarily by a face-to-face visit and difficult to bill for nonface-to-face encounters. That’s changing fully, the private sector, but not anywhere near what is at the VA. So we have this perceived or subjective measures of access and then actual or objective measures. And of the dimensions that we came up with, you know temporal was one of the key dimensions. And in the model that we’ve developed and in my highlighting actually, it probably doesn’t look very good on the screen. But it’s supposed to be a highlight over the temporal part of this where you, it could be measured in time to get a next appointment or waiting time or just the convenience of time for the patient.

This also came up recently in an Institute of Medicine Report called Transforming Health Care Scheduling and Acess. This was a, this came out in the wake of the Phoenix issues at the VA and they had of I think a very important point in there. They said the IOM report Crossing the Quality Chasm 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. And I think many of you that are familiar with what happened in Phoenix, there was a lot of misunderstanding, there. And if we had had better measures and a better understanding of what timely care was, I think much of that could’ve been averted. So a few different ways to measure care depend on the perspectives. So I’m going to give a brief review of, of a number of perspectives and sort of talk about what the problems are with them and you know ultimately by the end hopefully we’ve come up with some better ways to measure timeliness.

So in the VA, you know if you go for the patient perspective, there’s an attempt to have this used to be called the patient preferred date it became the desire date. And that’s just that, to point to how long the patient has to wait from when they desire to have an appointment. Now the problem with that is patients don’t always know the urgency of their issues. So it can swing both ways, one that they will put off care that needs to be moved up sooner. Or they will perceive that they need care sooner than medically indicated.

From a provider perspective, there was an attempt to do the clinically indicated date or the CID and from that point to the appointment date. The biggest problem with that is the provider, for those of you that are providers on the phone, know this when you put in the clinically indicated date. Well it depends on a lot of things and it also depends on the patient's schedule. So it asks you to put in a single date as opposed to just a date range of saying, well within three months or within six months. And so, the default for a lot of providers is just to default it to today or tomorrow and then have the scheduler schedule it whenever’s next available.

For the schedulers, is the create date to the appointment date. But that doesn’t even allow for the wait time is, I’m sorry, what the wait is based on the patient preference.

In the market, I’m going to talk briefly about use of, basically, a secret shopper type phone call. That gets at you know calling the clinic and saying, how long until the next visit? The problem with that is it’s time intensive. If, and time is money. And so, you gotta funds to be able to do that sort of work.

And, an industry standard, and we’ll talk briefly about the pros and cons of third next available. But one of the biggest problems is it requires access to a scheduling grid. It depends on whether it’s your own provider or any provider and it doesn’t work at all when you have open access. Because you could have a three, third next available is zero or one day. But does that represent you know, the timeliness of care?

So another way that was, the VAs looked at access management is through this systematic review that was performed at RAND. And what they did was review the literature found about 50 pubs, about 29 assessed primary care access interventions. And they had five key questions. So the first question is, what definitions and measures of intervention success are used, and what evidence supports use of these definitions and measures? And the overwhelming majority used third next available. And this could, has a fair number of issues especially for the VA. There was some look at continuity in patient satisfaction. But in the end none of them were linked to health outcomes. So why was third next available, or why is it currently being used frequently? Well one is that it’s more stable than other choices like first available, and that’s one of the things people argue for. For a paper that Don Berwick wrote a number of years ago said, this statistic is used to measure the number of days the patient has to wait to get an appointment. The TNA is featured because the first and second available appointments may reflect openings created by patients canceling appointments and thus does not accurately, accurately measure true availability. So they felt like it serves as an anchor metric to more reliably reflect when the schedule actually has substantial capacity.

The other questions that were asked in this brief were, I’m sorry, this systematic review are, what samples or populations were studied? Not well described. Some of it was in VA, but mostly, you know in general primary care clinics. What are the salient characteristics of local and organizational contexts studied? Also not well described in any of these studies. But of them, it was either academically-affiliated clinics, the National Health Service in England or the VA.

The fourth question was, what are the key features of successful and unsuccessful interventions for organizational management of access? And all described O advance or open access. And you’ve all heard that, you know NDA for many years under different monikers. But that’s been a, a general theme that the VA has, has been pushing. And the last was, are relevant, tested tools, toolkits and other detailed materials available? And there are some, including VA.

So Merritt Hawkins is an, or a company that does secret shopper calls. What they basically do is every few years they do these secret shopper telephone calls. About 10 to 15 offices in large cities, they’ve added metro areas recently. They go through five medical specialties. They randomly select physician names from internet-based office listings and then they make phone calls based on a newest person to the community. So they have a script and they call. One of the flaws of this is a, if a, if the individual physician that they call to ask for was booked out or no longer taking patients the wait time defaults it to one year. So they didn’t ask if somebody else in the clinic could see you, it was that physician. I think that’s a problem with their methodology. But anyway here are their findings that in large metro markets it’s about 24 days for a new appointment, and that’s gone up since 2014. Mid-sized market’s a little longer, about 32 days and that’s also gone up. Now the area with the highest wait time was Boston. I guess there’s not enough physicians in Boston so that’s about 50 days. With Dallas being the lowest. And in mid-sized cities that they surveyed Yakima, about the same, 50 days. And Billings, Montana at the low end. So their conclusion was wait times in this survey have gone up since 2004. And they say that a two-week wait is considered a tipping point to hire new providers, and big part of what Merritt Hawkins does. And that mid-sized markets had longer wait times.

Finish up here. RAND recently came out with a few reports that were in the wake of the Phoenix issues and the Choice Act. And I think it’s important for everybody to remember that you know the Veteran population is declining, but the number of VA patients has increased that are getting care, and it’s expected that that’s going to increase until about 2019. So we’ve got another year and a half and then the predictions are that it will stay level or decline.

So the wait time, and what they said in their report for primary care. The wait time measure used by VA, the number of days following the preferred date, makes it difficult to compare it with other healthcare systems. And that’s true because no other health care systems measure wait times that way. Most use third next available, and we’ve, that’s come in and out of favor in the VA over time.

And if you look at the figure on the right, it gives an idea that, you know about 83% of new primary care patients are able to get an appointment within two weeks. And overall compared to Merritt Hawkins that’s much faster, and we would love to look at individual markets, but those data aren’t available.

One of the last things they said and this leads right into what Adam’s going to talk about. Is that the VA should consider alternative strategies of timely access to care. And this is right out of the report and a main recommendation. VA should examine the utility of alternative benchmarks of timeliness, such as those related to appointment availability. VA should develop methods to routinely compare the timeliness of VA care with non-VA benchmarks and publish these comparisons for transparency. And speaking of time, time is gone. And I thought I had more to say, but I’m going to pass this onto Adam so he can take it from here.

Moderator: Thank you. Are\_

Adam J. Batten: Thanks Peter.

Moderator: \_you ready to share your screen?

Adam J. Batten: I sure am.

Moderator: Excellent. You should have that pop-up now.

Adam J. Batten: Okay. Can you see my screen?

Moderator: We can. It looks good, thank you.

Adam J. Batten: All right, great. So following up [unintelligible 12:11] in your, good morning, everybody. Thanks for attending this seminar and everybody’s that tuning in here at the archives. Appreciate your time. So I’m going to get into a talk about timely care of what the My VA Access Evaluations kind of conceptualize at timely care. So brief overview of what I’m going to talk about. Our goal, some necessary definitions about what SDA same-day access versus timely care. This design and method that we’re using to evaluate these metrics. And we’re going to do quick data view of what we’re actually seeing in the CDW. And then get into some real results from our preliminary models.

So our goal, so this is a busy slide. But basically, our goal is to build a, a kind of a process where we can quickly extract information from the CDW or other data sources. And model them in such a way that we can actually start to build up some kind of insight into what’s, what successful facilities are doing to implement access. So the, the key domains that we’ve kind of targeted here we’re calling patient demand. So a lot of that is enrollment growth, reliance, demographics, et cetera. Facility supply, so getting into the characteristics of the facility. And in staffing, so how, how full the panels are, what the turnover rates are like within the facility. And this is really, we’re sending this out to kind of work hand-in-hand with our site visit teams who are actually, have gone around to a lot of the clinics and interviewed some of the clinicians and GPNs to really, try to find out locally what’s happening. So we’re kind of backing up that analysis with that we’re seeing at [inaudible 14:07].

So this is our goal. Where are we now? So let’s get into some definitions, oops, okay. So same-day access, this is the original SDA. Which when I first saw this I thought my [unintelligible 14:21] was done. It started in, it’s fine they’ve already got all of the basic units, you know defined in simple ratio. This, the create date equals desired date equals appoint date plus walk-ins. And then divide that by the, those dates that, the desired date equal to the create dates. So very simple ratio. When I first took up this project, this was the current definition. And as we, as we kind of started to build up the, the matrix and actually start to measure this. There was a revision to the, to the My VA Access implementation. And SDA was dropped entirely and replaced with this new concept of which they’re calling timely care. So this, this is a long complete definition and I’m just going skip through this to get to the essential ingredients here.

So these are, this is a big kind of the main, the main points of the primary care concept. So, service is, service is focused on patient need. And how that service is provided, it can happen anywhere that service can be provided by any clinician and by any means necessary. So basically, by any means I mean face-to-face, or CVT, or secure messaging, et cetera. And there’s a small caveat it says based on availability. So the based on availability we’re really trying to measure that with the staffing and facilities the range that I talked about earlier. So the, the primary question is this concept, can it be measured in the CDW? So the short answer is yes. And we, we really hit VSSC and CDW architects for a lot of information when we first got started. And they pointed us towards, of course, the appointment domain in CDW which has all of the ingrediments, ingredients used in the SDA. So it has the, the actual scheduling request type which tells you if the patient either walked in or they requested the next available appointment. Or if they requested some other appointment that’s not the next available, but sometime you know within the next two to three weeks. It’s also what the desired date is, we’re going to use that for established patients when we’re measuring timeliness of care or SDA. And as I go [inaudible 16:53] use timely care in the VA pretty much [unintelligible 16:56] timely care. And then appointment mandates, so those are, those are primarily used for the new patients. So patients are considered new if they haven't been seen in the parent facility Vista System for 24 months or they’re actually bonafide new patients. So for those we’re working on assumption that they didn’t really have an established, haven’t established themselves in the appointment scheduling domain. So we’re using appointment made date for that. And it’s actually where and when the patient was seen. We looked into the utilization data. So we’re looking at these outpatient workloads, inpatient and fee basis and eventually Medicare. So the 2016 Medicare just came out. We’ve got a request in so we’re waiting on that data, and we should have that pretty quickly. Okay so that’s, getting into some of the nitty-gritty of what we are using, the CDW elements that we’re using to define timely care.

So now we consider this a successful fulfillment of timely care to be when a patient has a completed appointment within 48 hours from requesting next day or walking in and that care can be received in any of the following locations. So I’m, I’m just going to walk through some examples of how that, that request can be fulfilled and what we, we are considering a success. So the patient can request next day or walk-in and receive care in the same clinic stop with or without their primary PCMM provider. They can have, they can request in the clinic stop but then be seen in a different clinic stop with the same [inaudbile 18:47] sta6a. And by sta6a I mean division. They can be seen at a different division within the same parent network or even community care or of course via virtual.

And then the failure is patient not seeing within, of course. The clinic cancels so we’re going to penalize clinics who do a lot of clinic cancellations. Especially for these next day requests. And then a patient seen in the emergency department or urgent care if the need is not an emergency or if the need is emergent but it could be treatable in primary care. And for those few last definitions, we’re using an NYU EDUC classification those, there’s links in the appendix of this slide deck if you’re interested.

Moderator: Adam, I apologize for interrupting.

Adam J. Batten: Yeah.\_

Moderator: \_I just had a quick clarifying question from the audience.

Adam J. Batten: Sure.

Moderator: Can you define what is meant by virtual care?

Adam J. Batten: Oh, yeah. So that’s any clinic video telehealth or secure messaging is essentially what we’re considering to be. Is that\_

Moderator: Yes. That’s perfect. Thank you.

Adam J. Batten: Okay. So exclusions, the standard kind of health services exclusions, so age between 18 to 100. A hundred’s probably little bit high. Death before appointment, cancellation due to them actually being in hospital at the time of the request. The patient either no-shows or they cancels. And we’re excluding mobile units because we don’t know how to measure those. Those are predominantly in Seattle in this, in this intake that I’m going to show.

So the key assumptions here that the data capture, of course, is timely, accurate and complete. So the requests we’re really assuming that the schedulers and whoever’s entering the data that they’re really being accurate about whether or not the patient is actually requesting next day, they’re walking in, et cetera.

Cancellation types. So again, assuming the, you know the scheduler’s are really being accurate about who is canceling the appointment. The desire date, so when the patient or clinician wants to see the patient. We’re assuming that’s accurate and of course, it’d be the date when they were actually seen. And then patients needs, we’re, we’re using the Nosos from the Health Economics Resource Center as a proxy for patient need. So it’s a, it’s a risk adjustment variable. And then the biggest, probably the biggest assumption in this, this current concept is that the VA primary care governs treatment across both VA and non-VA.

So getting into, moving, moving from the actual data model into that conceptualizing, conceptualizing more research-oriented question. Are rural facilities or divisions less likely to provide timely care? And the corollary are rural, rural patients less likely to receive timely care? So this, this primary setup is really just to assess the feasibility of the data model. So how accurate the queries and ETL and how long it takes. Looking into a lot of the features that you know did the standard kind of univariate, multivariate assessment of the D, the columns that we’re interested in. And then looking in the, to see if there really is any significant variability and at what a level of is, at what level we have the most significant variability.

So here are the methods. So pre/post for expected cohorts. We’re using the, the end of the performing incentives in June, 2014 as our start point. And we’re going one year prior, we’re using that as the baseline year. And then we’re following the, following everybody for three years after that. So standard hierarchical regression. Primary exposure is urban/rural and we get that from PSSG. If you don’t know what a lot of these acronyms are there’s, there’s links in the appendix. For risk adjustment or need, need assessmen, we’re using the Nosos from HERC. Tested random intercept, random slopes and then levels of, different levels of nesting. So division with compare and patient within division within parent, et cetera. And then we do a quick subset analysis in primary care and mental health. And then those are the, those are the R packages that are under [unintelligible 23:48] my work.

So data views. So that’s the concept, let’s actually look at what this, this data looks like. So I took, we’re, we’re actually as part of the evaluation we’re looking at 23 parent facilities. So I just, I took out a random three mostly rural parents so Sioux Falls, Butler, and Iowa City. And then three urban parents so Seattle, Chicago, Baltimore. And so we’re going to look at a, a couple of plots of what the actual, this a, this timely care concept looks like next.

So here we got a panel plot. So the top panel is the actual parent aggregate timely care success rate. So starting in 2014 and going all the way up to 2017. So you can see that there’s a little, good amount of variability at the parent level. And they’re all, they're all pretty much increasing for the most part over the, over the time periods. And then in the bottom panel we have the separate parents. And within the parents, we have their, the divisions that are assigned to those parents, their separate timely care success rates. So you can see there is extreme and significant variability within division in parent. And it looks like the, the more rural facilities have a slightly better success rate. So this is, this is looking at all possible appointment requests. So this primary care, mental health specialty, labs, pharmacy, everything. So in, in total it looks like that those are doing pretty good but there’s, parents are doing pretty good but there’s extreme variability within division.

Okay. So subset within primary care. So now, now we only consider requests within primary care and it looks like there’s a couple of facilities that are, couple of parents that are actually decreasing over the time period. And then, but we’re still seeing the same kind of behavior within the division. But the rural facilities look they're in aggregate doing a little bit better than the urban facilities.

And then last, last we have the mental health success rate. A little bit lower start points and they don’t really seem to be increasing that much over the time period. And what we’re seeing down here is that, is there’s a bit of a click where the urban divisions and aggregates seem to be doing a little bit better than the rural divisions.

Okay. So that’s, that’s what timely care is looking like under these, these definitions. Let's get into the full, the full Table 1. So any, any health service analysis you have to have a Table 1. So here we have the patients, both patients in our 23 divisions 2014, 2015, 2016, 2017. It’s about in-patients or about 20% of the entire PCMM population in any year. See if I can check the time here. On average the population is around 63, predominantly male, of course, predominantly white and then about 30, 34% rural population throughout the time period. So Table 1B now is the, just the people who are making next day requests or walking in. So it’s about half of our sample population and in a year. There a little bit younger and a little bit more diverse so 74 versus 80% white. And there tend to be a lot more urbans so 70 versus 62, 73 versus 65. And also their, their risk scores are a bit higher. That the distribution a little bit wider, to. So that, that’s what the population of people making same-day requests and walking in looks like. It’s a little bit, a little bit younger a little bit more urban, a little bit more racially diverse.

So here’s our exclusions table. So we started with about 1.5 million requests in the 23 divisions or the 23 parents over every year. And in the end, we end up excluding about 10 to 11% of all these, due to the, due to the reasons that I stipulated above. And we’re still working on a lot of these exclusions. It’s kind of a work in progress here, so. And obviously the exclusions aren’t mutually exclusive. So a lot of the people who are actually in-patient and making same-day requests they’ll be canceled in the CDW. So you’ll have, you know both an in-patient exclusion and a, an appointment cancel exclusion. So these are not mutually exclusive.

So, fulfillment. So where, do you see where making the same day requests or walk-in where they actually doing that, where they, where they are receiving care. So for the most part for all, for all requests they’re being, they’re being treated in other places outside of primary care, mental health. So this VA other is VA specialty, it could be labs it could be pharmacy it could be anything except VA primary care and VA mental health. So on average in any year you’re seeing about 70% some are in specialty, nonprimary care and in primary you're seeing about 20% fulfillment on average throughout the year. Mental health’s seeing about six, six to seven. VA in-patients doing 2%, that’s gone up, almost doubled. And the fee in-patient so that’s around 1%, 2% that’s also increasing. Then fee out-patient is only down 2% or so of all visits. And then in the last year here’s we’re running into that, that problem with the, the missing Choice data in the fee basis domain which I, I have a link in the notes to the OIG report which gets into the details about that. So the, the stuff that I’m missing here is Medicare. So really would like to look and see, you know given the age of the population what type of, you know, if someone’s [unintelligible 31:03] in Medicare if any.

Okay. So here’s, here the model, the model results. So we’re considering the linear hierarchical regression in the first table. And then just for, just to be complete I’m including also the logistical results for those of you thinking probabilities scale. So the first table linear so, as you go down the rows that’s as denotes which level of aggregation we’re considering for our random effects. So the first, the first row is a random intercept, random slope of parents. The second row is random intercept, random slope of sta5a. And then the last the two rows are subset analysis. So the random intercept, random slope with any Sta5a for primary care and then for mental health. So as you can see on average we’re starting at about 70, 75 to 85% of the small positive time trend. And for rural, so rural here we’re saying it, that the proportion of Veterans who are classified rural within these levels of aggregation. So this right here would be the proportion of rural Veterans within Sta5a. So there’s a little bit of negative, it looks like for higher, for divisions with higher proportions of rural Veterans. And then the Nosos is [unintelligible 32:37] positive which you expect. So patients with higher risk tend to get, have a higher Sta [unintelligible 32:45] [clears throat] excuse me. Anyway\_

Moderator: I’m sorry, can you repeat that?

Adam J. Batten: Yeah, sorry. I just got, throat’s a little dry, but\_

Moderator: Oh, okay. No problem.

Adam J. Batten: Okay. So\_

Moderator: \_We do have another, I’m sorry. We do have another clarifying question before we get going.

Adam J. Batten:: Okay.

Moderator: Can you let us know what is included in other, is that specialty, emergency department?

Adam J. Batten: This [unintelligible 33:25]. Yeah. So that, that would be anywhere, so if it was the emergency department it would have to have been classified as truly emergent. So with it, you know prior to running this table we exclude anyone using data NYU algorithm who was truly emergent. So there could be EDUC in there but only if, only if it was truly emergent and they couldn’t be treated anywhere else. Does that make sense? I know\_

Moderator: \_Great. Thank you.

Adam J. Batten: But, so these I mean it’s fixed effect sure they’re interesting, but the best part about these models is the random effects, of course. So we can go in, as you see the bulk of these are not significantly different from zero. But we don’t, in average we’re not really interested in those. What we’re interested in are these guys down here. That seem to have, this, they have a low a negative effect for their, for their start point and they’re also, they’re also struggling to increase their timely care over time.

So the idea now is to take out these facilities in the tails and hone in on them. Pull out as much information as we can to feed into the, the site visit teams so that they have, they’ve got a good kind of assessment of what is happening in the facility as they, as they roll out their analysis also. So these, those kind of trouble divisions we’re going to pull into this full data model. Pull in all their enrollment rates, patient demographics, facility characteristics, complexity, et cetera. And work on kind of a joint analysis as to what the site visit teams are seeing. So that’s, that’s where we’re headed right now.

The ideal system. So the ideal system for timely care you know the first test of the, the people who are assessing what the patient needs that has to be spot on. One way we could, perhaps, you know, increase our accuracy there is utilizing wearable tech. Or even developing some better predictive analytics to kind of anticipate need and what, what the patient actually might need before they even need it, right? And that’s, that’s kind of the, the new push with a lot of the IBM Watson and Google Deep Learn approaches to health care analysis. We really need active time stamps so currently we’re working with this, desire date versus clinically indicated date. We really need to separate like who’s, who is making the request? Is it the clinic or is it the patient, you know? And then also I think we need to do a little bit of a patient education. Make sure that the patient knows where and how they can access services. So I mean it, do they need to come into the medical center or can they be seen at the neighborhood drug store to get that flu shot? And then ideally clinic staff of course, are educated to the condition of the patient prior to arrival. And then others so we’re, well this is really a, a work in progress. So if you have any comments or questions, please enter those into the chat box. And then, that’s it. Thanks, everybody.

Moderator: Excellent. Well, thank you both. We do have several pending questions. So we’ll get right to them. If anyone joined us after the top of the hour and is looking to submit a question or a comment you can do so in writing using your GoToWebinar control panel on the right-hand side of your screen. Just click the arrow sign next to the word questions. That will expand the dialog box and you can then type or question or comment in there.

The first one came in. Would this include telephone appointments and unscheduled interactions with patients or services to patients?

Adam J. Batten: That’s a great question, so. I mean we’re really assuming with this model, we’re really assuming that that the, all appointments are captured in the appointment domain. So, for that kind of interaction, unless whoever you know instigated the call went into CPRS and entered that, we wouldn’t know about it. But hopefully the site visit teams will be able to kind of get to take the temperature on how, how often that happens and then we can, we can potentially add that to the, the information about the division.

Moderator: Thank you. The next question. Does patient need mean from the time, I’m sorry give me one second. Does patient need mean from the patient’s perspective? In other words, this isn’t a determination based on objective clinical need.

Adam J. Batten: Well in a sense, right now since we’re using the Nosos it’s based on, which is a regression which includes several, several elements captured from the Diagnostic ICD-10, ICD-9 codes. It also includes pharmacy utilization, co-costs. So in a sense we’re using, we’re not even really considering what the patient perceives is their need. We’re, we’re using a kind of well-proven measure of patient risk as a proxy for that.

Moderator: Thank you.

Dr. Peter J. Kaboli: This is Peter. And I’m going to answer that in another way too. I think that’s a great question about what, what is the need and who determines it, you know when we talk about timely care. And in the, there’s some proposed legislation called the Veterans Coordinated Access and Rewarding Experience Program or CARE. And the CARE Program is, is supposed to be sort of the next version of Choice, if it’s, if it’s passed by Congress. But basically what they say and I’m reading from a summary that says, in mark contrast to the Veterans Choice Program the pair, Care Program is designed to rely on the clinical assessment in parenthesis or in italics the clinical assessment of each Veteran by a primary health care professional in the VHA to assign the eligibility of a Veteran for community-based care. And I think the reason that’s relevant in, with this discussion of timely care is, you know who makes that decision? Is it just the, is it the 40 mile and 30 day rule? Is patient-driven? Is it provider driven? And I think the intent here is to make it sort of an informed patient-provider interaction. But ultimately it’s the provider that decides what’s the medical need. And if somebody’s needs to be, get care faster than the VA can provide they can get it in the community. And we need to have a way to measure that.

Moderator: Thank you, both. The next question, was your work initiated by OVAC?

Adam J. Batten: Peter, you want to take that?

Dr. Peter J. Kaboli: I’ll take that, yeah. So, and that’s a good question and I had just for the sake of time at the beginning I didn’t give too much background on some of this. So some of this work is funded by the Office of Rural Health in collaboration with the Office of Veterans Access to Care (OVAC). And this came in the wake of, you know the Phoenix issues and then the establishment of the MyVA Access initiative to improve access in VA. And probably many of you are on the phone you know were involved with that and the development of the Group Practice Manager model the GPMs. And so part of our role is to, is to assess access using the existing metrics that we have and propose new metrics that can be incorporated into the current metrics system that we use at the VA. So that we have better ways to say, you know what? Our access is pretty good and here is objective data to show it. Or identify areas where access is not good or at least areas that we could improve on.

Moderator: Thank you. The next question, will this include primary care, oh you might have already touched on this, but we’ll see. Will this include primary care provided through VA Choice or community care?

Adam J. Batten: Yes, yes it does. So that, I mean up to, at least up until Q, quarter four 2015, when the lump sum payments started happening with Choice. So up until then yes we do, we do include in fee basis. If you want additional details, I would highly recommend that you read the OIG reports that just came out regarding the, the Choice implementation and data capture.

Moderator: Thank you. The next question, are these patients making same-day requests or merely request for an appointment?

Adam J. Batten: No. So they’re, they’re, they are classified as making next day requests or they walk into a clinic. Predominantly these are walk-ins, walk-ins have doubled over the last several years. We, we’re hearing information, anecdotal information on the ground that patients are being told to basically just walk-in whenever they need something. So, by and large these are, these are, we’re modeling walk-ins here.

Dr. Peter J. Kaboli: Yeah. And I can comment more on that in terms of the roles that walk-ins have. And I’m sure every single person on this call has their own opinion about it you know and the value of having carved out slots and you know starting the day with open slots you know but that’s balanced against you know criticism later for having wasted slots. So, you know one hand is telling you well, have open slots in the morning so that people can walk in. And you know if by the end of the day if they’re not filled it’s like, well you wasted these slots, why didn’t you fill them? So I think this whole walk in issue is a challenge for everybody. You know in a perfect world, you know people that model this say well, you should get to the point where anybody can walk in at any time and be seen, and then you perfectly match supply and demand. And you know, the problem with that is that you know, supply and demand are not you know static over time. Your supply can change if a provider leaves or you know people are on vacation. And demand can go up or down based on Holidays and weekends and flu seasons and things like that. So, we don’t live in that perfect world. But, you know we want to balance the ability for people to walk in for you know semi-urgent needs versus just walking in anytime for routine care and then expecting somebody to see them in 15 minutes.

Moderator: Thank you. Next question. Did these appointments include provider telephone contacts with patients?

Adam J. Batten: Yes.

Moderator: Thank you. It still seems strange to me that 70% of successful timely care was delivered outside of primary care. How is that possible when specialty has far less availability than primary care?

Adam J. Batten: Well this is more utilization outside of, at least clinic stop wise. So what I, keep in mind we’re measuring clinic stops here. So any, any classification that’s not primary care. So that includes you know lab visits, pharmacy draws, all those kind of, you know day-to-day deluge of clinic stop visits just overwhelms the count to primary care visits. [Unintelligible 46:42]\_

Dr. Peter J. Kaboli: \_Yeah for, for lack of a better term, I mean it’s, it’s a touch with the patient, I mean they’ve touched the system, where the systems touch them in some way. And so we know there’s been contact you know and that may or may not have met the need that they have or it may start the, you know the ball rolling. I mean a lab visit maybe a, you know the first step in whatever the, the, you know same day need was.

Moderator: Thank you.

Dr. Peter J. Kaboli: I think that is, I’ll also add onto that, I mean that’s unique about you know the VA and our ability to measure. I mean, we can measure all the different ways that people connect with the system, and you know, we don’t know yet whether adding on more ways for them to contact us whether it be through secure messaging, you know text messaging, phone calls you know other forms of apps you know where people can just you know use another form to contact the system. Does that improve their access overall? You know does it triage people to the right access you know or does it just create more care? I mean it may just be that, you know you make it too easy for people to get care they get more care than they need.

Moderator: Thank you. Forgive me if I mispronounce this statistic word. What is the beige and probability or reasonable expectation for timely care? It will never be 100%, but what is a reasonable expectation?

Adam J. Batten: I would say, I mean if you just look at, you look at how in, in total when I run all these facilities. It looks like everybody’s regressing toward this mean of about 84% within primary care. I haven’t looked in mental health, yet. But I think, I think that’s probably the upper limit of plus or minus about 2 to 3% on how, how successful this entire system can be at providing same-day access.

Dr. Peter J. Kaboli: Yeah and I, I think that is, that is the million dollar question, you know. Because if you, if you create a metric, you know you gotta give somebody or give, you know the system, you know benchmarks of what’s considered sort of adequate response or adequate you know performance you know and what’s considered really good performance. I mean, you know having it being 100% is not reasonable. Reminds of a study that was done looking at patients, actually parents because it was a pediatric study. Parents calling into a, a like a nurse triage line about you know a question that they had after hours for their child. And when the nurse triage line told them to go to the emergency room for whatever their problem was, 25% of the time they still didn’t go. So people make choices about different things. So they were told to access the sytems by a healthcare professional and still didn’t access it. So I don’t think you can ever have a 100%.

Moderator: Thank you. In the modeling model, in the modeling and models have you considered the use of non-regression models such as system dynamics?

Adam J. Batten: I’m not familiar with systems dynamics. I did consider doing a GAM model. But were, were not really interested in, you know coming out with the most insanely accurate prediction model we can. We’re really trying to come up with a concept, a way to analyze that’s easy to interpret and kind of disseminate to decision makers.

Moderator: Thank you. We do have a couple of comments that came in. [Clears throat] Pardon me. One is a recommendation for an article that Dr. Shulkin wrote and that can be found in Politico magazine. So you can just, I’m sure just Google VA, David Shulkin, Politico magazine and you can find that there. It’s titled Trump Veterans Affairs, VA, David Shulkin.

And we have another comment that came in. Can I suggest someone asking panels of patients to help define what timely care means to them? I mean sometimes when I call for an appointment I am in pain or if you feel acutely ill and want to be seen that day. Other times I’d want to follow up with primary care and I’m satisfied with seven days. Other times I need specialty and I’m satisfied with two to four weeks depending on how concerned I am. Maybe if we could ask the patient which category they feel like they’re in and record that, it would be more meaningful.

Adam J. Batten: Yeah. Totally [inaudible 51:48]. Sorry, go ahead.

Dr. Peter J. Kaboli: No, you go ahead Batten and then I’ll follow up.

Adam J. Batten: Well, I was just saying this patch is crucial, right? So that’s the preliminary assessment of what patients needs. Yeah, that I, that’s like irreplaceable.

Dr. Peter J. Kaboli: Yeah, and, and there is some work going on right now to get at that. It’s going back to you know, what I mentioned at the beginning. This whole concept of perceived access and are you meeting the need of the patients. You know, somebody at one point may fill like getting their toenails, you know cut. You know is an absolute emergency they’ve put it off too long and they want it done today. And that’s their perception, it’s probably medically indicated, but that’s their perception. There’s a group led by Jeff Pyne in, in Little Rock whose developing a perceived access inventory. So it’s a basically a scale to, you know get a sense of patients, you know what is their perceived need for care. That the primary focus is on mental health but as they study this better and sort of refine their methods, you know our hope is to able to use that in primary care, specialty care, you know procedures, you know urgent care. So you get an idea from the patients perspective what they feel is appropriate access. I can tell you one other thing we, we were looking at yesterday was just the wait time data. Get us through SHEP or the CAPS data through SHEP saying, that actually, Veterans look over the last year, you know their wait times that they perceive have gone down. You know the time that sit in, in the waiting room has gone down. You know, if that’s how they feel that’s great, that’s a good sign.

Moderator: Thank you. The next question. Where can we find the OIG reports?

Adam J. Batten: Well you can just Google OIG VA Choice. It’s, it came out in, what is this January, I believe of this year. December of last or January this year. I believe I had a link in the slides. If you downloaded the slides I have a link on the slide with the table.

Moderator: Thank you. Do you have an estimate of the proportion of successful SDA were not face-to-face? For example, virtual.

Adam J. Batten: We, I haven’t actually, you know built a slicer for that but we could relatively easily do that. We should do that. Yeah, thanks for the suggestion.

Moderator: Thank you. Are more site visits scheduled?

Dr. Peter J. Kaboli: No. We did 22 site visits and the analysis of that work is going on right now and we’ll have something, certs, data start to come out over the next few months. We do have a request into the OPS Management and Budget for doing 50 Veteran interviews. And this gets back at,you know your, the question about the patient's perceptions. And, you know we're hoping that through a series of interviews from the Veterans from the sites that we visited we can start to get at what their perceptions are. And I think that’s really important. You know when you have events like Phoenix and other bad press that hits, hits the airwaves. You know it has a negative effect on peoples perceptions. You know, but when you get at the data looking at their, the current Veterans who seek care in the VA you know their satisfaction with care is very high. So, so there’s a bit of disconnect. So we want to get, get to know better what the Veterans think.

Moderator: Thank you. The next question we have. Many of these factors that are modeled seem to interact with one another such as rurality. Will you consider modeling these interactions in the future?

Adam J. Batten: Yeah, definitely. So we, I mean, you know part of the standard modeling procedures, so we look at, you know interactions, square to square roots, all kinds of stuff. But we wanted to just keep, for this display, this presentation just to keep a simple, kind of just additives, additive effects currently.

Moderator: Excellent. Well, that is the final pending question at this time. But I would like to give each of you the opportunity to make any concluding comments you would like. Dr. Kaboli, we can start with you.

Dr. Peter J. Kaboli: But, I just want to say thanks for everybody. You can contact Adam or myself if you have other suggestions or ways that we can do this better. I mean we’re, you know we don’t have it all figured out yet and hopefully over the next six months to a year we can have a better metric that we believe can measure timely care. Adam?

Adam J. Batten: Yeah, I agree. We’re, we’re just definitely a work in progress. So if you have any comments or suggestions, please do feel free to email me or Peter. And, yeah. Thanks again for showing up.

[END OF AUDIO 57:42]