Cyberseminar Transcript

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Session: The Relationship between Routine Follow-Up Appointments and Access to Primary Care

Presenter: Megan Ellis Price, MS

**Rob:** I’d like to introduce our presenter today. Megan Ellis Price is with the Partnered Evidence-based Policy Resource Center, otherwise known as PEPReC, at the VA Boston Healthcare Center. Megan can I turn things over to you?

**Megan Ellis Price:** Sure. All right. Hi. I’m Megan Price. I’m here with Steve Pizer, the senior author for this project. Nicolae Done is a co-author. Thanks to the PACT group and the Cyberseminar team for having me here today. I work with PEPReC, the Partnered Evidence-based Policy Resource Center, as Rob said, at VA Boston. We are affiliated with QUERI, the VA Quality Enhancement Resource Initiative, OVAC, the Office of Veterans Access to Care. Office to Care is a co-sponsor of this project. I’d like to tailor this presentation to the audience so please answer the poll questions that show up later and send over questions that we can answer later. There will be a time for questions at the end.

So today I’m going to talk about some of our groups research showing that more frequent primary care visits are associated with greater patient satisfaction with access to care. We found that at facilities where, on average, successive primary care visits are spaced more than 4.6 months apart, patients are 20% less likely to report that they can access routine care when needed when compared to facilities where patients come in the more frequently. Essentially facilities where patients have more frequent return primary care visits have more satisfied patients. On average, facilities have patients come back just under every four months. We saw the strongest association with satisfaction with access to care in facilities with longer than average follow up times.

This has implications for VA scheduling practices. VA facilities have limited capacity. There are only so many clinicians and so many spots in the schedule and meanwhile there are a lot of Veterans seeking care. Facilities face a trade-off between prioritizing these primary care appointment spots for new patients with urgent issues or follow up appointments for returning patients with chronic conditions. Our work shows that if facilities space follow-up primary care visits too far apart then patient satisfaction with access to care may be lower. This is based on a metric that measures for each facility how many times and how often patients make return visits to primary care. Facilities concerned with patient satisfaction with access may wish to think about follow up frequency. This primarily applies to facilities with longer than average intervals between primary care follow up visits. Our results showed only a small association between visit frequency and satisfaction for access for facilities with more frequent than average primary care return visits. So the associations really comes into play for places where there are unusual [unintelligible 3:12] primary care follow up intervals especially where average follow up intervals are further than 4.4 and a half months apart.

So before I get into the details and nitty gritty of this presentation, I’d also like to know a bit about you so that I can spend more time on what you’re interested in. Our first poll question is what is your primary role in the VA? I’ll give you a few minutes to respond.

**Rob:** Thank you Megan and that poll is up and running. Megan has already given you the question, what is your primary role in VA? Answer options being student, trainee, or fellow, clinician, researcher, administrator, manager, or policymaker, and other. And things have leveled off around 85% Megan so I’m going to go ahead and close the poll and share the results out and let you know that only 4% of your audience say that they are student, trainee, or fellow, 36%, the largest number, say clinician, 29% the next number down say researcher, and 11% administrator, and 21% say other. Now back on your slides.

**Megan Ellis Price:** Thank you Rob. So next I’ll tell you a bit about our group PEPReC to give you some context. PEPReC which stands for Partnered Evidence-based Policy Resource Center focuses, not surprisingly given our name, on evidence-based policy. PEPReC staff has a mix of economists, data analysts, and policy experts. We design metrics to evaluate policies, help with program implementation, and randomize program evaluations and monitor the results of VA programs and policies. It’s a lot of data analysis and policy work. Much of our work partners with operation groups at the VA and we also do some research projects.

Some of our projects include identifying underserved facilities as required by the MISSION Act, evaluating VA programs including the Medical Scribes pilot and opioid risk stratifications, and finally helping research consortia match projects to what’s needed in VA operations groups through the Community Care Research Consortium and the Access CORE.

Now let’s get to it. This project combined data from several different sources. We used a mix of facility level and individual level data. We got our satisfaction with access to care data from the SHEP survey of patient satisfaction. This is our dependent variable in our analysis. We used VA CDW data to create facility level indicators of scheduling practices including mean appointment length, the ratio of primary care clinicians to enrollees at each facility, the average number of months between successive primary care visits at the facility which is our follow up time metric, the percent of visits that are overbooked, and the percent of visits that are unscheduled also called walk-ins. We also controlled for local area economic indicators as in common other economic variables are related to Veteran’s choices to use VA care or care in the community. Veterans with higher economic status are more likely to have private insurance and thus use non-VA care. Demographics such as age, sex, race, and education level are also correlated with Veteran satisfaction so we controlled for these. Finally we controlled for HEDIS healthcare quality indicators which include questions on facility level care indicators such as the percentage of diabetics with controlled blood pressure.

So my next poll question is, again, I’d like to know how to tailor this presentation. It’s what should this presentation spend extra time on? Choices are the implications of results, the details of data sources, quantitative methods, or other. And if it’s other, please write in and Rob will give you instructions on that.

**Rob:** All right. Thank you. Attendees if you want to write in regarding other please use that questions pain that I referred to in terms of questions earlier. We can use it to get a little more detail on what you mean by other. Megan, we have over 60% of your viewing audience making their choices so far. We’ll give people a few more moments to make their choices. Nobody’s written in in terms of other yet. And things have leveled off a little over 75% so I’m going to go ahead and close the poll and share out the results. And Megan 52% would like you to spend extra time on implications of results, 13% details of data sources, 32% quantitative methods and, only 2% say other but nobody wrote in. So now we’re back on your slides.

**Megan Ellis Price:** Thanks everybody. That makes sense given that I saw a strong number of clinicians in the audience so I’ll spend a bit of extra time talking about implications but I’ll still go through the other things as well.

So sample group for this project include patient’s seen in primary care between October 2013 and June 2016. And we only included patients who completed the SHEP survey of patient satisfaction which is given to a random sample of Veteran’s who have completed visits at the VA. SHEP is a mailed survey and, as far as survey’s go, has a pretty good response rate, around 40% for the year 2015. We ended up with 94,496 patients in our sample. This is a small portion of the 6.6 million patients who received VA care in fiscal year 2014. But it’s still a pretty big sample and it’s more than large enough to yield very statistically significant results.

SHEP is a nationwide survey of VA patients and it asks a variety of questions about patient experiences at the VA. It’s a random sample of patients with completed appointments. Patients can be surveyed up to one time a year. Our dependent variables for this analysis patient satisfaction with access to care came from this survey. For routine care, we used the question in the last 12 months when you made an appointment for a checkup or routine care with this provider, how often did you get an appointment as soon as you needed? For urgent care we used the question, in the last 12 months when you phoned this provider’s office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

As you can see here, on slide 11 titled Access Satisfaction Baseline, the VA has room for improvement on patient satisfaction with access to care. 40% of patients said they could get urgent care in one day or less. 68% of patients said they could usually or always get routine care. Improving access to care is a current priority for the VA and is the focus for a lot of our work at PEPReC.

The demographics of our patient sample reflect the demographics of the VA as a whole. The mean age is 66-years-old. Only 3% of patients are under the age of 40. Almost two-thirds are between 60 and 79 and 13% are 80 or over. It’s very overwhelmingly male, 93% are men. The majority, 80% are white and 73% have some college but have not completed a bachelor’s degree. I was struck by the high proportion of Veterans in this sample with some college education and believe that it likely reflects the GI bill. The last variable mentioned here, priority 7 and 8 indicate Veterans who pay a copay for inpatient care at the VA. Many Veterans do not pay copays for VA inpatient care. They can be excluded from copays due to medical issues that are related to their time in military service known as service connected disabilities, or for economic status. Veterans in priority groups 7 and 8 are Veterans that pay copays and thus have higher economic status. We controlled for this variable because economic status is associated with the Veterans likelihood of using the VA as their primary source of medical care. Higher income Veterans are more likely to have private insurance and thus do not use the VA as much as lower income Veterans.

Next we’ll go over our facility operations variables. These were all calculated on the facility level for each month of our study periods. We used VA CDW data to create facility level indicators of scheduling practices including mean appointment length, the ratio of primary care clinicians to enrollees at each facility, the average number of months between successive primary care visits at the facility which is our follow up time [unintelligible 12:38], the percent of visits that are overbooked, and the percent of visits that are unscheduled, also called walk-ins. For the most part, facilities can adjust these scheduling practices to respond to appointment demand. The exception is appointment length which VA policies sets at 60 minutes for new patients and 30 minutes for returning patients. We wanted to make sure that we are using past data to predict future data and thus will reduce the likelihood of endogeneity, also known as reverse causation. For this reason, we lagged these facility variables by one month which means that we used June facility scheduling data to predict July’s survey responses and so forth. The mean appointment length is just over 30 minutes. On average there’s around one full time primary care clinician per 2000 enrollees but this varies significantly by VA facility. On average, patient’s return to primary care around every four months. This also varies a lot between facilities. 11% of visits are overbooked and 32% of primary care visits are unscheduled walk-ins.

I’d like to delve a bit more into the follow up time metric as that popped out as the main result of this project. When we started this project, we created five facility operations measures and wanted to learn which, if any of these were associated with patient satisfaction with access to care. Follow up time, the number of months between return primary care visits, popped out as a strong association. The others not so much. Looking at this graph, I am struck by how much this follow up time measure varies by VA facility. These numbers are facility averages. Some facilities have their average patient come in to primary care every two months while others have patients come in just under every six months. On average, patients return roughly every four months. Yes patient demographics and the concentration of different health conditions that may require frequent follow up varies between facilities but not by enough to explain this. There’s also some correlation between the clinician to enrolled patient ratio and follow up times but it’s not a very strong correlation. There are differences between facilities and how much Veterans rely on the VA versus other sources of healthcare in the community which are probably related to this. But I think this graph, even so, is a lot of it is about differences and practice patterns. Some of it may be individual providers adjusting their scheduling practices to account for demand for appointments but we just don’t know. Exploring the reasons for the wide variation between facilities in follow up time is [unintelligible 15:29] avenue for further work. The VA is working to improve access to care and how often patient’s come in is a component of that. It’s clear that there is no one right answer here. Every patient is different, every physician is different, and each facility has a unique set of constraints and trade-offs. Physician judgement is very important, can’t be minimized, and needs to be preserved but it’s clear from this that physicians and facilities have very different patterns with regards to how often they have their patients return for primary care visits and it would be good to have a better understanding of why and what is driving this why variation here.

Economic factors definitely come in to play. Their related to Veteran choices to utilize VA healthcare and thus need to be control for when we do work relating to access to care at the VA. Higher income Veterans are more likely to have access to private healthcare coverage and are less likely to utilize the VA as their primary source of healthcare. Since Veteran utilization of VA care impacts how much demand there is for VA healthcare in a given area, we control for economic characteristics when developing models related to access to care. In this model we are using local area income levels, house prices, the Veteran unemployment rate, Medicare Advantage Penetration, and facility level priority 7 and 8. I’d like to spend a bit of time discussing the Medicare Advantage Penetration and facility level priority 7 and 8 as they are less intuitive than the other measures. Medicare Advantage Penetration is a measure of a portion of people with Medicare in a given local area who use Medicare Advantage. Medicare Advantage are Medicare plans managed by private insurers. They are an alternative to traditional Medicare. We use Medicare Advantage Penetration as a proxy variable for measuring the availability of private insurance coverage in a given local area. Some geographic areas have more private insurers competing for business than others. The degree of private insurance availability is associated with Veterans choices to use the VA. I discussed priority 7 and 8 earlier but I’d like to define it again. Veterans with priority 7 and 8 are the Veterans who pay copays for inpatient care at the VA due to their relatively higher economic status. The measure on this slide is a facility level average measure. It thus differs from the individual level measure shown on slide 12. The facility aggregation is higher than the individual average because smaller facilities on average have a higher proportion of Veterans with priority 7 and 8. In this model we control for both individual and facility level priority 7 and 8 Veterans because community economics and the economic status of individual Veterans relative to their community have differing relationships with a choice to utilize the VA for healthcare.

Slide 16 shows a HEDIS healthcare quality measure we controlled for in this project. We use healthcare quality indicators with a goal of accounting for differing practice patterns between different VA facilities. Looking at the standard deviations shown in parenthesis on our chart you can see that there is substantial variations in these measures between VA facilities. The set of variables include the percent of diabetics with controlled blood pressure, the percent of diabetics with poorly controlled HbA1c, the percent of patients age 50 to 75 with colonoscopy screening, the percent of patients immunized against pneumonia, the percent of patients aged 18 to 64 immunized against influenza, and the percent of patients age 65+ immunized against influenza. For a sense of comparison I also glanced at, it’s not shown in this slide, but the national Medicare HMO data and although only the VA sample data was included in our model. On average the VA does well on most of these measures compared to the Medicare means. Flu vaccinations are the exception. Of course I suspect the low-average flu vaccine numbers are related to many Veterans being dually eligible for Medicare, private insurance, and VA coverage. So thus Veterans are receiving flu vaccines from non-VA clinics which doesn’t show up in VA data. The standard [unintelligible 20:28] for the two influenza vaccine measures are very wide which shows that some VA facilities have very high flu vaccination rates and some have very low flu vaccination rates.

Finally, we can get to our main results. You’ve already heard the punchline but it doesn’t hurt to repeat it again. Follow up time matters. In facilities where, on average, patients come back less frequently for return visits, patients are less satisfied with their access to care. The results shown here are from logistic regression models. They reflect two different models with differing dependent or left hand side variables. For column one, the dependent variable reflects satisfaction with access to urgent care specifically if the patient could get urgent care within one day. Column two is about routine care. If the patient could usually or always get routine care when needed. These are both binary outcome variables uncoded as zero or one. These results don’t include every variable in our model. The results for additional controls including age, gender, race, first language, and education level are on the next slide. The notation 1M lag reflects that in our model the variables noted was lagged by one month. For example, using June appointment length data to predict July satisfaction with access data. The models also have facility, month, and year fixed effects. The results here are odds ratios with Z-scores below in parenthesis. Stars reflect the level of statistical significance with more stars being more significant. Odds ratios can be interpreted as follows. Let's use the first result mean appointment length for urgent care for example. A 10 minute increase in the facility mean appointment length is associated with 0.99 times the odds of a patient reporting that they could get urgent care within one day. This result has two stars next to it, so rather significant at the 95% level. And odds ratio of one indicates no relationships. Greater than one indicates an increased or a positive ratio and less than one reflects a decrease or inverse relationship. The Z-scores shown in parenthesis below the odds ratio are another measurement of significance. They show the number of standard deviations that a given odds ratio differs from the mean. So for example, the urgent care and appointment length odds ratio is about two standard deviations away from mean. Looking at statistical significance [unintelligible 23:12] two things pop out; the average follow up time and if the individual patient is priority 7 or 8. Let’s do follow up time first. Since this work is focused on access to care, it’s what our group is most interested in exploring. A one month increase in follow up time defined as the facility average interval between successive primary care appointments over the last year is associated with the patient seen in primary care to be 10% less likely to report that they could access urgent care within one day. This could also be said as having 0.9 x the odds and 13% less likely to report that they could usually or always get routine care when needed. The Z-scores here are large especially for urgent care where the Z-score showed an almost four standard deviation difference from the means so a fairy[sic] highly[sic] statistically significant result. It’s worth discussing the individual priorities 7 and 8 variable too. Veterans with priority 7 and 8 designations indicating that they pay copays for healthcare at the VA due to their relatively higher economic status are more likely to report that they are satisfied with their access to care. I hypothesize that this is because Veterans in the priority 7 and 8 categories are more likely than other Veterans to have access to alternative forms of healthcare coverage and thus they use the VA because they like the VA rather than because they have no other alternatives. The Z-scores and P values shows that this relationship is highly statistically significant.

It’s not the main focus of our analysis but you may be wondering what other controls in our model matter. Well here they are. Females are more satisfied than males with their access to urgent care but females are less satisfied than males with their, females are more satisfied than males with their access to urgent care but less satisfied than males with their access to routine care. Older patients are more satisfied with their access to care than younger patients. In this case the age 80+ category is the reference category which the other categories are compared to. White patients are more satisfied with access to care than other races. Hispanic Veterans are particularly less satisfied with their access to urgent care. Veterans who report being in very good or excellent health in their SHEP survey responses are much more satisfied with their access to care than Veterans who report being less healthy. Finally, Veterans with at least some college report being slightly less satisfied with their access to care at the VA. Our [unintelligible 26:00] include that HEDIS healthcare quality results in this slide because they brought significant to the model although we still controlled for them.

When we saw these initial follow up time results we wanted to know if the results differed between facilities with especially long or especially short average follow up intervals between successive primary care visits. In other words, is there a break point somewhere along the distribution beyond which extending the follow up intervals had an especially strong relationship with patient satisfaction with access to primary care. To assess this, we broke the follow up time variable into sextiles and then re-ran the analysis with each sextile as a dummy variable. Dummy variables are a term used in the common metric score primary variables that enable categories to be separated out. This slide, slide 19, has the results. As with the previous result slides, results are in odd ratios. The number of stars reflects statistical significance and the Z-scores are in parenthesis below. The first textile is the reference group by which other groups are compared to and that’s the group where Veterans come in the most often in facilities where the average follow up interval is less than 3.2 months. Column one lists the sextiles. Column two lists the range of months to follow up time the sextile references. Column three shows the result for the urgent care model. And column four shows the results for the routine care model. There is a consistent trend throughout the distribution of the longer than mean primary care follow up interval, the less patients are satisfied with their access to care. Remember that the reference group for these odd ratios is sextile one where the facility average interval between successive primary care visits is less than 3.2 months. Looking at a highest sextile, we see that in facilities where average follow up times are greater than 4.6 months patients are 14% less likely to report that they could get urgent care within one day when needed when compared to patients in facilities where patients on average have follow ups more often than every 3.2 months. For routine care, the relationship is even stronger. Patients in facilities in the highest sextile are 20% less likely to report that they can usually or always get routine care when needed when compared to the first textile. The implication for facilities and practitioners is primarily for facilities with longer than average primary care follow up intervals. If these facilities want to improve patient perception of access to care, they may want to take into account how often they are scheduling return primary care visits. Of course, the clinical indication for each individual patient needs to be first and foremost when deciding when to have a patient come back for their next visit.

So this study, like all studies, has its limitations. First and foremost this is an association study. There is a potential for endogeneity. What if patients schedule more follow up visits because they are more satisfied with the VA? We used two statistical techniques to try to control for and measure endogeneity. First we lag the facility operations and economic variables so that prior facility operational decisions data predict future patient satisfaction. Secondly we tested for endogeneity by running a model specification with lagged variables as instruments. This did not show a problem with endogeneity. However, facility operations don’t change that much from month-to-month. In other words, there is a lot of serial correlation. This makes the lag variable approach less meaningful and, thus, we are unable to make a causal determination. And an avenue for future work is to develop an instrumental variable model with the goal of conclusively or not that identifying causality.

So I’d like to close out this presentation with acknowledgements. We, meaning me, Nicolae Donae and Steve Pizer, want to thank Dr. Michael Davies, Mary Fields, and Manny Alvillar for helpful comments on prior versions of this work and for logistical assistance. This project was supported by the VA’s Quality Enhancement Research Initiative (QUERI) and by the VA Office of Veterans Access to Care (OVAC). So I welcome your comments and suggestions. Thank you and Rob will now have a question and answer period so please send in your questions.

**Rob:** Thank you Megan. At this time we don’t have an pending questions. Audience members if you have a question you’d like to submit please use that questions pane in the GoToWebinar dashboard, that’s the white piece of software that came up on the right hand side of your monitor when you joined. There’s a section labeled questions in the gray bar. You can click on the triangular shaped icon and it will open up and you can even pull that whole thing out and make it bigger. Make it easier to submit your questions and to read other peoples.

**Dr. Steve Pizer:** Rob can you hear me?

**Rob:** Yes I can. Steve?

**Dr. Steve Pizer:** Yeah this is Steve. While we’re waiting for people to submit some questions, this is Steve Pizer. I might comment briefly on the implications of the research. So one of the reasons that we were motivated to investigate this topic is that we saw a lot of variation in the frequency with which various clinics schedule follow up appointments and we have heard anecdotally from service chiefs that one of the ways that individual providers and service chiefs sometimes try to balance supply and demand is through variations in follow up time. So this is a subject, as far as we know, hasn’t been investigated by anyone else and if you’re an individual clinician and you’re waiting times are getting longer and maybe somebody suggests to you or maybe you just consider that you might be able to get your waiting times down for new patients by extending the follow up time for some of your established patients we wanted to know what consequences that decision would have. So as is often the case with research, we did this a lot of different ways and we got a variety of different results as we were doing it. Our current set of results with a lot of controls and a lot of sensitivity analyses suggests that there isn’t a big drop off in patient satisfaction, you know, within three months. As you get to four months, we start seeing some more effects and longer than four months those affects get bigger. So that might have been what you might have guessed if you’re a provider. There are a lot of guidelines that suggest sort of three month follow up for patients with chronic conditions but, you know, those are, I think there’s a big difference between clinical guidelines for the proper care of patients with the appropriate follow up time as to keep patient’s stable and the patient’s perception of whether they have adequate access. So we’re hoping that these results can provide some guidance to providers in the field and service chiefs as they continue their ongoing efforts to balance supply and demand and maintain access for patients. So those are my thoughts on the implications of the results. And certainly one could do research like this looking at follow up intervals related to clinical outcomes for specific populations of patients. Like patients with diabetes or patients with heart failure or patients with hypertension and you’d be looking at the appropriate outcomes for those groups of patients and then seeing whether the follow up interval has an effect on those, or association with those outcomes. So I’ll pause there and see if we have any questions from the audience.

**Rob:** We do. We have a few questions queued up. Megan do you want to comment on Steve’s comments or should we just launch into the questions?

**Megan Ellis Price:** Well Steve, I agree with what you said so please do launch in.

**Rob:** Okay. First off why is the information not less than two years old?

**Megan Ellis Price:** Thank you. That was due to, we would love to be able to do this with more recent data. We were limited to particularly the HEDIS measures. We don’t have very recent data for that.

**Dr. Steve Pizer:** Yeah there also it takes a bit of a lag to get the SHEP responses. I think now that we have done this analysis once and found not very strong relationships with the HEDIS measures that will free us a little bit on that.

**Megan Ellis Price:** I think when we started this relationship, this work, we only had SHEP data through fiscal year 2016, which was what we included in this analysis. And now we have it through fiscal year 2017 so we could potentially add another year of data if we removed the HEDIS variables but, because of the lag with SHEP data, we would not be able to update it into the current time.

**Dr. Steve Pizer:** Right.

**Rob:** Thank you. Next question. How does this research effect the National See Recommendations for 1.6 appointments a year, i.e., only seeing patients every seven months?

**Dr. Steve Pizer:** Umm I think,

**Megan Ellis Price:** Well,

**Dr. Steve Pizer:** Go ahead Megan.

**Megan Ellis Price:** Okay. Well on average patients are clearly coming in more often than that. I think on average patients are coming in every four months but really a lot of that it’s clearly, the recommendations we looked at facility level information, and clearly these are an individual patient average. Individual patients are coming in more often so I think it’s, I think that there really a different optimal follow up interval between a very healthy patient where maybe every seven months is okay and a patient with chronic conditions who is coming in more often.

**Dr. Steve Pizer:** I think that’s right. No. I think that’s exactly right. You know, this is a first look at it and so we’re seeing satisfaction effects, sort of overall satisfaction effects, but clearly the population here is highly heterogeneous and so future work could be to add more data and then split up the types of patients by health condition and see if there’s a relationship there. But the very short answer is I think these findings, you know, raise questions about what the right frequency of follow up is on average for our patient population. Patient satisfaction seems to be maximized with follow up time of three to four months.

**Rob:** Thank you. Next question. I’m wondering if the patients are viewing access to care as strictly within the PC, with the PCP, sorry, or with the PACT team?

**Megan Ellis Price:** Could you repeat that question? You’re wondering if the patients, if this relates to strictly with the PCP or with the PACT team?

**Rob:** Yeah. Exactly.

**Megan Ellis Price:** Okay. Well for this analysis we did not break down individual providers. We looked at how often patients come back to a primary care clinic but we didn’t, we specifically did it at the facility level rather than the individual provider level in large part because it’s difficult to entangle supply and demand if a particular provider is booked up, they might be booked with somebody else in the PACT team. So particularly for that reason, but because we did it on facility level that essentially means that it kind of averages within the whole clinic at a given facility rather than focusing on any given provider.

**Dr. Steve Pizer:** And I think I would only add to that, you know, the data are what they are so SHEP asks the patients what their feeling is about their access to care. There’s no distinction in the question, that I recall, focusing on a physician or another group of the team. It’s just what the patient’s subjective experience of access is.

**Megan Ellis Price:** The SHEP question specifically says like there is a, I can go back a few slides and pull it up or just read it to you. It is specifically access to care with the provider but I think that we’ve known from various other research that patient’s answer SHEP questions in a way that reflects broader feelings about the VA than specifically what the question asks. So it’s quite hard to tease that out.

**Dr. Steve Pizer:** Thanks Megan.

**Rob:** Thank you. This next person states that this is more a comment than a question and it also says that this is very timely research and thank you for presenting. But the comment goes like this; our group has interviewed Veterans about their thoughts on access to care at the VA and they largely talk about being satisfied with access to routine care but not urgent care. I’m curious to go back to our sample and look at some of the predictors you discussed. Again, this person said it was more of a comment than a question but, perhaps, it will prompt you to comment on it.

**Megan Ellis Price:** I think that’s very interesting and I’d be curious if the, I’d be interested in that and if you could send me an email I’m Megan.Price3@va.gov . I’d be interested in learning some more about your survey. I pulled up the slide here, which is slide 11, which has access satisfaction to baseline. So the questions we looked at specifically here were, Could the patient could urgent care in one day or less? Or could the patient easily get routine care usually or always? And these questions came from the SHEP survey and I think satisfaction, I mean the answers may differ depending on the specific exact question that’s asked, but I would be interested in learning more about that. Thank you for [unintelligible 42:58].

**Rob:** Thank you. Megan could you forward to your last slide that has your email address on it?

**Megan Ellis Price:** Yes. It’s Megan.Price3@ va.gov.

**Rob:** So there you go questioner. That person did say they will definitely email you.

**Megan Ellis Price:** Okay. Great.

**Rob:** That was the last question or comment that we have queued up. At this time I’d like to give either one of you an opportunity, or both of you to more of the point, an opportunity to make closing comments.

**Megan Ellis Price:** Ah sure. I’d like to first thank all of you and thank the Cyberseminar group and Rob, in particular, for putting this together. I think this project draws a lot of question to a lot of differences in how often primary care visits are scheduled at VA facilities. And as Steve mentioned, there may be some relationship with facilities managing their appointment demands by, partially through varying how often patients come back but we don’t really know, and we’d like to learn some more about that. We did find that there is a definite relationship between how often patients come in and how satisfied with their access to care. And that is something that facilities can start to think about and we’d like to do more work on this as well. Steve would you like to add anything?

**Dr. Steve Pizer:** Only that I think that you did a terrific job and thanks to Rob and Molly and everybody for helping to organize and thanks to the participants. We got useful comments and feedback which we very much appreciate.

**Rob:** Wonderful. Thank you. Attendees when I close the Cyberserminar momentarily you’ll be presented with a short survey. Please do provide answers to that survey. We count on those answers to continue to provide high quality Cyberseminars such as this one. And Megan Price, Steve Pizer of PEPReC thank you for your work and thank you for presenting today. And with that, I’ll just wish everyone a good day.

[END OF AUDIO]