

# FORUM

translating research into quality healthcare for Veterans

VA



U.S. Department of Veterans Affairs

Veterans Health Administration

Health Services Research & Development Service

## Commentary

### Improving Access to High-Quality VA Care: MISSION Act Ready

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The Office of Veterans Access to Care (OVAC) is committed to the oversight and support of access in VA. A range of factors affects access to care in VA, from MISSION Act eligibility for community care to meeting the urgent needs of Veterans to the implementation of a more comprehensive electronic health record (EHR). Future opportunities for research are needed to understand how best to improve upon access efforts over the coming years.

#### MISSION Act

VA has been buying and providing community care for Veterans since 1945. The passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in June 2018 consolidates community care into one permanent program. VA is not privatizing but continuing to put Veterans at the center of their healthcare by giving them a choice. The MISSION Act's access standards for eligibility that went into place in June 2019 offer Veterans a choice for community care if wait times for an appointment in VA primary care and mental health are greater than 20 days and greater than 28 days for specialty care. In addition, the standards include eligibility if a Veteran drives more than 30 minutes for a primary care or mental health appointment—or 60 minutes for a specialty care appointment. Moreover, if a provider and Veteran agree that it is in the best interest of the Veteran to receive community care even if the VA facility is meeting all standards, the Veteran is eligible to do so.

The MISSION Act also calls for development of a program in facilities with medically underserved populations. Thus far, we have worked in primary care and mental health to identify underserved sites using a robust module.

#### ICEP

The OVAC is collaborating with the Office of Clinical Operations, Community Care, and others to lead improvement efforts in access with the Increasing Capacity, Efficiency, and Productivity (ICEP) initiative. This initiative is aimed at improving access in primary care, mental health, and specialty care to get facilities "MISSION Act Ready" for access standards implementation in June 2019 and continuing to improve over time. Because evidence supports VA as the best choice for Veteran healthcare, this initiative enables increased care in VA.

When considering wait times and quality measures, VA compares favorably to the community. Wait times over the past few years in the community have shown little improvement. In fact, a recent *JAMA Network Open* study found that the mean overall wait time in VA was 12 days shorter compared to wait times in the community in 2017.<sup>1</sup> Average wait times in VA have improved by 4.92 days from 2014 to 2017, while the private sector showed no improvement. The *JAMA* study points to VA's efforts to improve access through reducing wait times in recent years. A recent RAND study found

that VA demonstrated a higher quality of care compared to the private sector.<sup>2</sup> Also, mental healthcare in VA proves to be better for Veterans' needs than the private sector.<sup>3</sup> Overall, VA healthcare exceeds private-sector care in quality and timeliness and is the best choice for Veterans in many circumstances.

The ICEP initiative is building on the momentum of these achievements, preparing facilities to become MISSION Ready. The first phase of the initiative began in January 2019 with a focus on ensuring accurate expected time in clinical activities to actual time in clinical activities for providers. With support from other VA program offices, OVAC has provided training to all VA medical centers that includes strategies proven to improve capacity, efficiency, and productivity, and to increase the time VA providers are conducting direct patient care. We continue to identify sites that do not meet the access wait times standards and support review of core processes, whether it be additional staff, space, or a way to align clinic grids. As of March 2019, 68.5 percent of primary care sites have average wait times for new patients of less than or equal to 20 days, with 98.6 percent in mental health. It is expected that the number of sites meeting the standards will continue to rise. Specialty care also is trending toward improvements in waiting times for new patients of less than 28 days. For example, 86 percent of sites are meeting MISSION standards for average new patient wait times of less than 28 days in cardiology

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## DIRECTOR'S LETTER



It has now been five years since the scandal of long waiting times and manipulated data broke at the Phoenix VAMC. Since then, VA has undertaken a variety of sweeping changes to try to improve access, including expanding community care options, instituting same-day access at all VAMCs, and expanding video telehealth into Veterans' homes. These changes create

a fertile environment for researchers to answer a series of critical questions: 1) has access actually improved and by how much? 2) what factors underlie the remaining access problems in VA and how can we address them? and 3) what role should community care play when Veterans can't get timely or convenient access within VA?

Wait times in VA have improved—91 percent of appointments are scheduled within 30 days of the requested date. On the VA website created to help Veterans, average wait time for a new patient was under three weeks at the vast majority of VA facilities in Pennsylvania and although comparable wait time data are hard to get outside VA, one would be hard pressed to get in to see a new primary care provider in under three months in most cities. Despite these gains, VA still has plenty of work to do from the perspective of our Veterans. Based on the CAHPS Survey questions that ask whether they were able to receive needed care, only half of all Veterans say they could “always” get care as soon as they needed.

HSR&D needs to play a bigger role in helping VA with one of its most challenging problems. To date, much of our access portfolio has been focused on the important but narrow solution of telehealth. At a meeting last summer with leaders from the Office of Veterans Access to Care, three priority areas seemed the most promising for policy-relevant research: 1) improving metrics to track access, including wait times; 2) understanding relationships between wait times and patients' satisfaction with access; and 3) improving productivity and reducing no-shows as a way to expand clinical capacity and access.

To improve our ability to inform VHA stakeholders concerned with access, which includes Rural Health, Primary Care, and Connected Care, HSR&D is establishing a Consortium of Research (CORE) on Access to build more effective partnerships, refine our research agenda, expand the pool of collaborating researchers, and communicate policy-relevant findings. We hope that this will address research's own access challenge—providing our partners with access to the information they need when they need it so that they can apply effective solutions to better ensure that all Veterans can get the care they need when they need it.

David Atkins, MD, MPH, Director, HSR&D

as of March 2019. Many sites have received virtual one-on-one site visits to review capacity data, offer suggestions, and develop strategies for improvement, with action plans to increase the number of appointments for Veterans to be seen.

Phase 2 of ICEP will focus on strategies to improve access including, but not limited to, increasing the use of non-traditional care (i.e., electronic consults from primary care to specialty care, VA Video Connect-virtual appointments on a phone or tablet), utilizing nursing staff effectively, and discharging patients from specialty care back to primary care. The ICEP initiative will provide networks and medical centers with a menu of strategies to support improvement. The third phase of ICEP will focus on recapturing appointments being sent to the community by implementing longer-term national and regional strategies. In partnership with the Office of Community Care, OVAC will identify medical centers with

the highest volume of community care to prioritize resources.

Additional strategies to increase access are currently under review. Leading healthcare systems provide clinical contact centers that offer urgent healthcare needs via video and telephone calls. In addition, all 18 VA networks have Clinical Resource Hubs that provide primary care and/or mental healthcare via virtual appointments. The addition of specialty care and clinical pharmacy specialists is planned. MISSION will put decision-making about where to receive care squarely in the providers' hands. Providers will use a new application called the Decision Support Tool (DST), developed by the Office of Community Care, to inform providers and patients about eligibility for Community Care at the time they are discussing care plans with patients. The DST will guide informed decisions about the use of VA and/or Community Care resources.

### Same Day Services

VA has taken many steps to modernize our approach to scheduling appointments and consults that have resulted in shorter wait times and improved access to high-quality care. As of December 2017, OVAC achieved same-day services in primary care and mental health at all VA medical centers and community-based outpatient clinics nationwide, enhancing access for all Veterans by providing them with timely care. Same-day service means VA will respond to Veterans' requests right away. This includes things like authorizing a medication refill, answering a health-related question via phone or email, providing a nurse visit, administering walk-in vaccinations, or resolving issues with a medical device/equipment. Ongoing trainings and further education are under development to support frontline teams in providing same day services.

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# Improving Veterans' Access to Care through Research-Operations Partnerships

Melissa M. Garrido, PhD, and Steven D. Pizer, PhD, both with the VA Partnered Evidence-based Policy Resource Center, Boston, Massachusetts

The MISSION Act has placed renewed focus on ensuring access to care among Veterans. In her article, Dr. Kirsh highlights four priority initiatives to improve access that are underway at the Office of Veterans Access to Care (OVAC): improving access in response to MISSION Act mandates; the Increasing Capacity, Efficiency, and Productivity (ICEP) Initiative; increasing provision of same day services; and electronic health record modernization. Partnerships among researchers and OVAC facilitate the generation of robust evidence to support and inform these and other access to care related activities. In this article, we highlight past successful partnerships among researchers and OVAC, ongoing evaluations, and upcoming opportunities to use these partnerships to improve access to care.

HSR&D and Quality Enhancement Research Initiative (QUERI) researchers have a long history of collaboration with OVAC on key evaluations and quality improvement efforts. These include validating administrative waiting time measures for new patients in primary care and established patients referred to specialty care,<sup>1</sup> a pilot study and retrospective evaluation of recall reminder policy changes,<sup>2</sup> linking variations in access to health outcomes for Veterans,<sup>3</sup> and an evaluation of a major resource-based scheduling software investment.

In the context of the MISSION Act, there are many current and upcoming opportunities for enhanced partnerships. Current collaborations involve OVAC and research teams from across the country, and are focused on MISSION Act initiatives, including the medical scribes pilot (MISSION Section 507) and identification and response to underserved facilities (MISSION Sections 401 and 402). These efforts build on past research by using established conceptual models relating supply and demand to waiting times combined with wait time measures validated by HSR&D and QUERI researchers.<sup>1</sup>

The future holds many opportunities for research to evaluate and inform strategies to improve access to care. In August 2018, OVAC, the Partnered Evidence-based Policy Resource Center (PEPRc), and HSR&D organized a meeting to inform development of a VA HSR&D access to care research portfolio. The priorities and opportunities identified during the meeting will guide generation of rigorous evidence about the impact of policies and programs in which OVAC is invested, including the ones highlighted by Dr. Kirsh. They also will be useful for informing development of alternative policies and programs to improve access to care.

The meeting began with a list of broad OVAC focus areas, in order to help meeting attendees develop access to care research priorities. To identify opportunities with the greatest potential impact, we solicited feedback from other operations stakeholders on the extent to which OVAC focus areas overlapped with other offices' priorities. To evaluate HSR&D capacity to address opportunities, investigators engaged in access to care research identified the extent to which these focus areas overlapped with their own research portfolios. All meeting attendees brainstormed opportunities for new areas of investigation that could improve access to care.

To increase the chance that research in OVAC's focus areas will lead to meaningful real-world impact, we used feedback from the meeting to refine broad foci into a list of research priorities. We identified areas in which research:

- Is likely to directly inform policy or impact outcomes;
- Improves the experience of Veterans interacting with VHA;
- Is not already being funded under a different portfolio;
- Focuses on innovations most likely to be feasible, sustainable, and generalizable throughout VHA; and
- Aligns with researcher interest and expertise.

Access to care research priorities can be categorized by interventions and outcomes of interest. Interventions that should be prioritized for evaluation include those focused on identifying and developing best primary care and specialty care practices, as well as those improving clinic flow within a clinic or between primary and specialty care settings. Innovations may relate to care provided in-person or virtually. To measure improvements, a key near-term objective is to develop administrative measures of access to care that reflect patient experiences with virtual care. Research on all of these topics will enhance OVAC's ability to respond to the MISSION Act, complete the ICEP initiative, and provide same day services.

Discussions with meeting attendees highlighted the importance of ensuring that access to care studies include a standardized set of high-priority outcomes to facilitate comparisons of the impact of different interventions on access and productivity. Consistent use of access measures will be especially critical for identifying practice innovations that help VHA be maximally responsive to MISSION access standards. The highest priority outcomes include no-show rates, productivity, wait times, and patient satisfaction. Provider turnover also should be evaluated consistently where applicable.

Priorities identified during the meeting informed the request for applications for an Access to Care Consortium of Research (CORE), which provides a more formal structure for OVAC-research partnerships. Among other activities, CORE leaders will facilitate collaborations among access to care researchers and develop specific plans to address identified access to care priorities, as well as conduct research that leads to a demonstrable improvement in access to care outcome measures. In addition, PEPRc will provide technical assistance on best practices in access to care metric use and will help connect research activities to OVAC needs and priorities.

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# Perceived Access Inventory Reflects Experience of Access to Mental Healthcare

Jeffrey M. Pyne, MD, HSR&D Center for Mental Healthcare and Outcomes Research (CeMHOR), North Little Rock, Arkansas, and the PAI Development Team\*

Over the last few decades, VA has identified improving access to healthcare as a priority area. VA focus on access intensified substantially with the waitlist crisis and the subsequent Veterans Access, Choice, and Accountability Act (VACAA) of 2014. The VACAA authorized the Veterans Choice Program (VCP) as a temporary program to enable eligible Veterans to receive inpatient, outpatient, pharmacy, and ancillary medical services in the community. More recently, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 continues to emphasize access to care by consolidating community care programs, improving the coordination of VA and non-VA care, and increasing the use of telemedicine technologies.

During this time, VA HSR&D and other VA offices have also focused on improving access to VA healthcare. For example, in 2010, VA HSR&D convened the State of the Art (SOTA) Access conference. One of the results of this SOTA conference was a re-conceptualized access model that added a fifth domain (digital access) to the four commonly recognized domains of access: geographical, temporal, financial, and cultural. In keeping with this model, the 2010 SOTA conference defined access as "...the potential ease of having virtual or face-to-face encounters with a broad array of health care providers and resources including clinicians, caregivers, peers, and computer applications."<sup>1</sup> In 2012, VA Office of Inspector General (OIG) recommended that VA "reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments."

In 2014, HSR&D funded the Center for Mental Healthcare and Outcomes Research (CeMHOR) to develop a patient-centered Perceived Access Inventory (PAI) that would reflect the patient experience of access to mental healthcare and include access to digital (e.g., telemedicine)

technologies. The PAI project was part of a VA HSR&D CREATE (Collaborative Research to Enhance and Advance Transformation and Excellence) suite of projects with the overall title of Improving Rural Veterans' Access/Engagement in Evidence-Based Mental Healthcare.

We used a multiphase, mixed-methods approach to develop the PAI. In Phase 1, we conducted individual, semi-structured, qualitative interviews with 80 Veterans to explore their experiences and elicit the barriers and facilitators they faced in seeking VA mental healthcare. We recruited Phase 1 Veterans from VA community-based outpatient clinics in Northern California, Arkansas, and Maine. In Phase 2, we generated a preliminary set of survey items based on Phase 1 qualitative data. In Phase 3, an external expert panel rated preliminary PAI items in terms of relevance and importance, and provided feedback on format and response options. In Phase 4, Veterans gave feedback on the readability and understandability of the PAI item-set generated through Phase 3. The resulting PAI included 43 items addressing five domains: Logistics (5 items), Culture (3 items), Digital (9 items), Systems of Care (13 items), and Experiences of Care (13 items).<sup>2</sup> The PAI is structured so that most items consist of two parts. Part One is a Yes/No question assessing the presence/prevalence of a potential barrier. Respondents who answer "Yes" to Part One are then asked to rate the impact of that barrier using a 5-point Likert scale ranging from no interference with getting needed mental health services to complete interference.

In response to the Veterans Choice Program, we conducted mixed qualitative and quantitative interviews with 25 Veterans who had experience using community mental health services through the Veterans Choice Program in 2017. This study was funded by the South Central Mental Illness Research, Education and Clinical Center (MIRECC) and used the same research

## Key Points

- With significant input from Veterans, CeMHOR developed a patient-centered Perceived Access Inventory (PAI) that reflects the Veteran experience of access to mental healthcare, and that includes access to digital technologies.
- PAI contains 43 items across five domains: Logistics, Culture, Digital, Systems of Care, and Experiences of Care. Two versions of PAI are available: for VA and for community-based mental healthcare.
- PAI can be used to assess access to care and to identify actionable barriers to care.

infrastructure that was used to develop the PAI. Analysis of qualitative interview data identified four topics that were not raised by the initial sample of Veterans receiving VA mental healthcare: Veterans being billed directly by a VCP mental healthcare provider, lack of care coordination and communication between VCP and VA mental healthcare providers, Veterans needing to travel to a VA facility to have VCP provider prescriptions filled, and delays in VCP re-authorization.<sup>3</sup> These additional barriers were largely administrative (rather than arising from the clinical encounter itself) and were included in a version of the PAI designed for use with Veterans receiving mental healthcare in the community.

Current VA access measures include: wait times, Veteran satisfaction with mental health appointment access, Veterans' perspectives as reflected in the Survey of Healthcare Experiences of Patients (SHEP), and Strategic Analytics for Improvement and Learning (SAIL) measures. The PAI differs from each of these access measures. For example, wait times are averages calculated from administrative data

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and may not reflect Veterans' experiences trying to get an appointment. The Veteran Satisfaction Survey asks Veterans about the timeliness of mental health appointments but does not ask about specific access barriers. The SHEP asks Veterans about the timeliness of mental health appointments and about a limited number of barriers (e.g., inconvenient appointment times, transportation problems, cost). SAIL measures include items from the Veteran Satisfaction Survey and SHEP questionnaires plus composite measures of continuity of care and experiences of care. In contrast, the PAI includes a comprehensive list of specific perceived access items across five domains derived from Veterans' experiences accessing VA mental health services.

In general, the PAI fulfills the OIG recommendation for measures that accurately reflect the patient perspective and experience of accessing mental healthcare. Going forward, the PAI may be useful for VA in several ways. First, as VA expands its coverage of community-based mental healthcare through the 2018 MISSION Act, the PAI for community care could be used to assess access to mental healthcare in

the community. More specifically, as the Veterans Choice Program transitions to the Veterans Community Care Program, the PAI could be used alongside other access measures to provide the Veteran perspective on access during the transition period. Most of the items in the community care and VA versions of the PAI are identical, which allows for comparison of access to VA and community mental health services at the same point in time. Second, the specific barriers included in the PAI could be used to develop interventions to improve access to care. One such project will use the PAI to identify barriers for an individual Veteran that are specific to the treatment that is preferred by the Veteran. This information will be used by a peer specialist to improve initiation and engagement in mental healthcare. Third, customer service is the first priority for VA and is an important determinant of where Veterans choose to receive care, even if they qualify for care in the community. According to the SOTA access model, perceived access to care is associated with treatment satisfaction, care quality, and clinical outcomes. As mentioned above, the SHEP asks about a

limited number of access barriers, but the PAI includes a more comprehensive list of specific and actionable perceived access items that were developed from patient interviews and experience. As such, the PAI can be used to identify actionable access barriers that can be addressed to improve customer service and satisfaction. Future work with the PAI includes concurrent and predictive validation and use of the PAI for intervention development and implementation.

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- \* PAI Development Team: P. Adam Kelly, PhD, Ellen P. Fischer, PhD, Christopher J. Miller, PhD, Patricia Wright, PhD, Kara Zamora, MA, Christopher J. Koenig, PhD, Regina Stanley, BA, Karen Seal, MD, and John C. Fortney, PhD.

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## Electronic Health Record Modernization

The Electronic Health Record Modernization (EHRM) project entails implementation of Cerner commercial off-the-shelf solutions, which will provide an accurate and comprehensive health record at the point of care, resulting in improved patient care and safety. The integrated scheduling solutions will allow VA to better manage supply and demand, thus improving access for Veterans. To date, the EHRM Councils and Workgroups, consisting of field experts within VA who can act as Solution Subject Matter Experts, have completed five of eight workshops. The plan is to go-live at the Initial Operating Capability (IOC) sites, Puget Sound, American Lake, and Spokane, in March 2020.

### MISSION Act

Consolidates community care into one permanent program/addresses Veterans in designated medically underserved facilities

### OVAC Priorities



### EHRM/Cerner

Implementation of new EHR, including standalone scheduling

### ICEP Initiative

Prepare facilities to be "MISSION Act Ready" for access standards implementation by June 2019 and sustainment of these access standards

### Same Day Services

VA provides an array of services to enhance timely care including clinical resource hub

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# VA Physician Burnout and Its Implications: What We Know and Why We Care

Katerine Osatuke, PhD, Tyler Barnes, PhD, and Dee Ramsel, PhD, MBA, VA National Center for Organizational Development, Cincinnati, Ohio

Experts agree that physician burnout is more than just being exhausted or stressed out. Burnout includes people’s whole relationship with their work and their experience of the usual stresses involved in carrying out their tasks. For this reason, the same factors that define core job requirements also define job-specific stress zones. When meeting those core job requirements becomes challenging, they become stressors and—with repeated stress—can create burnout. In other words, burnout has a social focus. It reflects more than people’s personality or coping skills; it is a person-job interface that is closely connected to organizational settings, workplace culture, work systems, and job processes.

## While Burnout has a Social Focus, It has Business Implications

Previous research on provider burnout has stated its impact on both the mission and bottom line of healthcare organizations. For example, Swenson and Shanafelt (2017) reported a direct relationship of physician burnout to clinical and organizational performance metrics. They explained that burnout impedes access to care in two ways: it causes negative impact on the care provided, and it makes providers less willing to stay with their organization. Research also connected burnout with actual reductions in full-time employment positions over the following 24 months (Shanafelt et al., 2016), and reported correlations between burnout and ratings of quality and safety culture, as well as quality and safety standards (Lee et al., 2013).

Across the VA healthcare system, ensuring access to care is a strategic priority, as reflected by the MISSION Act. Safety and quality culture also is among the key lines of effort. Given these priorities, it is important to proactively assess and address provider burnout, and to prevent it from causing provider shortages and ultimately hurting Veterans’ access to care.

Burnout in the VA workforce is a serious concern, and at the forefront of VA’s effort to address this is VA’s focus on reducing physician burnout. Why physicians? They are a mission-critical occupation, the most expensive to replace, with the highest burnout rates among clinical providers, and they often lead other staff involved in patient care. These factors create unique demands and stressors for these providers, as well as unique opportunities for them to impact clinical care and patient outcomes in VA.

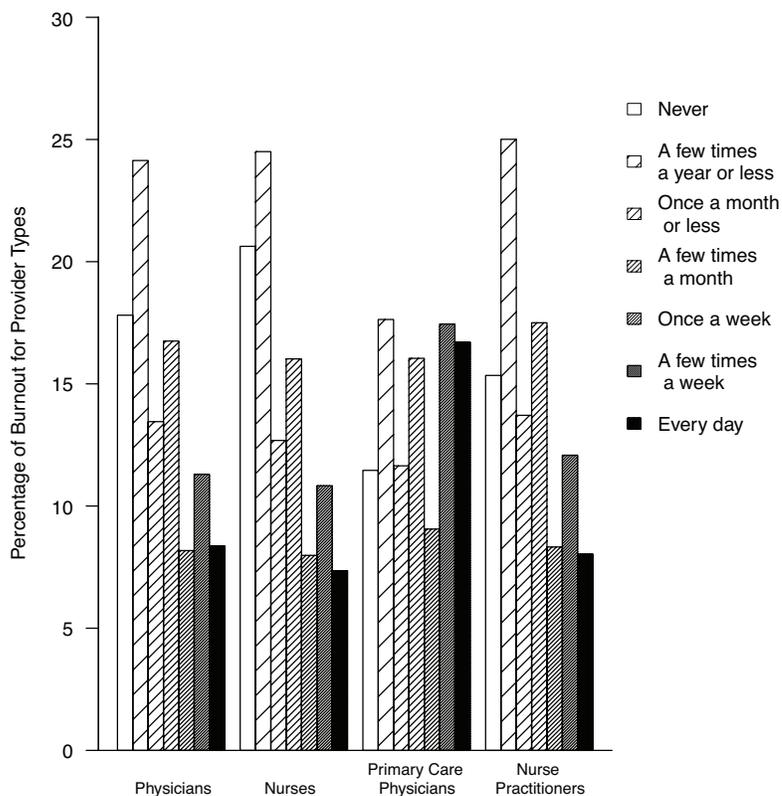
## VA Provider Burnout is Widespread

As the graph below depicts, the highest burnout rates among all VA clinical providers are among primary care physicians—a mission-critical occupation. Among nurses, the highest burnout rates are among nurse practitioners.

### Key Points

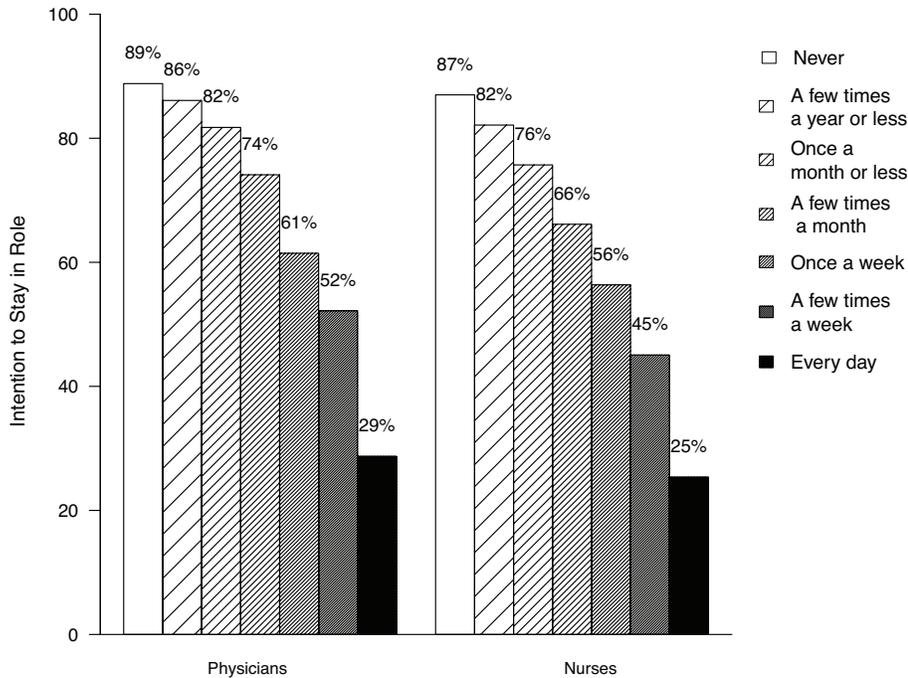
- Physician burnout is more than just exhaustion or stress. Burnout has a social focus that is connected to workplace culture and job processes.
- VA providers who are burned out from their work have higher turnover intentions and see lower satisfaction in the Veterans they serve.
- Addressing organizational factors that underlie VA provider burnout will help attract clinical providers, many of whom have mission-critical occupations.

How Often do you Experience Burnout?



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## Provider Burnout and Intention to Stay in Role



### VA Providers' Experience of Burnout Shows Human Side of Problem

The comments below, from the Patient Aligned Care Teams (PACT) 2016 survey (shared at the VA Physician Burnout summit in 2016), offer a glimpse of how it feels to be a VA physician who is experiencing burnout.

*VA physician on sleep deprivation and family neglect:*

"I am very burned out... I work 16 hours many days and get little sleep during the week and am neglecting my young daughter due to work."

*VA physician speaks to overwhelming demands and new requirements:*

"I feel like I'm spinning here—being exhausted at the end of the day. All physicians stay way after hours to complete alerts, answer multiple calls which come all day from Call Center, answer secure messages etc., etc. It is crazy to work like this—and still come new demands and new requirements. I see too many initiatives and regulations which keep coming..."

*VA physician warns about effects of "bad" data:*

"Our team is demoralized by a consistent barrage of "Bad" data and demands to fix problems that are only problems on paper,

not in practice. It's this blind allegiance to the "Numbers" that will ultimately result in my resignation from the VA."

As the graph above depicts, VA providers burned out from their work have higher turnover intentions. They also perceive lower satisfaction from Veterans receiving care at their workplaces. This latter perception consistently and highly correlates with Veterans' own ratings of quality of care in VA.

### Four Drivers of Provider Burnout

Research outside of VA points to four drivers of physician burnout:

- Inability to deliver quality care,
- Work process inefficiencies,
- Limited opportunity for work input/feedback, and
- Lack of recognition.

In VA, preliminary work shows much similarity. This research suggests the importance of systems-based interventions to reduce provider burnout.

In 2016, VA hosted a virtual summit to discuss the scope, drivers, and outcomes of VA physician burnout and to outline strategic directions for improvements. Guest speakers included the Acting Under Secretary for Health

and Acting Principal Deputy Under Secretary for Health. An expert group of researchers from VA and beyond, senior leaders of VA clinical programs, and VA decision-makers collaborated through working groups. They identified areas of highest leverage for VA (i.e., evaluating physicians' workflow to allow greater delegation of administrative tasks) and generated several proposals. All summit materials are available online through the VA Workforce Surveys Portal. Start at <http://aes.vssc.med.va.gov/research>, go to the bottom Data Library, and select the Topic: Burnout Summit.

### Reducing Burnout Requires Organizational Interventions

Burnout is a system issue and, thus, responds to organizational interventions. Most institutions incorrectly believe that managing burnout is the responsibility of individual providers. The field is dominated by tertiary interventions: addressing burnout after it occurs. More effective and less costly is pre-empting burnout from happening in the first place.

Reducing burnout is more successful and better sustained when the main focus is on organizational causes (e.g., culture, work structure). Yet, organizationally focused interventions are among the least-tried and least-researched—not surprisingly, as they are the most difficult to implement. Fighting provider burnout requires coordinated efforts within organizations and strong support from organizational leaders. Transitioning to this strategy could become an aspirational target for VA. Addressing organizational factors that underlie provider burnout will help attract clinical providers, many of whom are mission-critical occupations. This designation recognizes the key importance of these employees to Veteran care outcomes.

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# Systematic Review Describes Strategies for Primary Care Access Management & Most Common Interventions

Timely access to care is expected by patients and also is a fundamental characteristic of a quality health system.<sup>1</sup> The primary care practice setting is the most frequent point-of-care for patients, and also serves as an access gateway for mental health, specialty care, and other services. Unfortunately, little is known about the strategies employed to optimize patients' access to quality primary care.

In a recently released VA-commissioned report *Transforming Health Care Scheduling and Access: Getting to Now*,<sup>2</sup> the Institute of Medicine (IOM) noted that while timely access was likely a nationwide problem, there is a lack of evidence to provide setting-specific guidance on what constitutes timely care. Nevertheless, the report described six basic principles to improve access to care in all healthcare settings.

Managing primary care access requires considering many interacting system parts and goals, including continuity, team roles, and management structures. VA requested that HSR&D's Evidence Synthesis Program (ESP) conduct a systematic review of the evidence related to primary care access management strategies so that VA might learn which interventions have been studied for which populations, and what measures are used to define success.<sup>3</sup> ESP organized this review around five key questions and their relevant findings.

For this systematic review, we searched PubMed & CINAHL for titles from 2005 through September 2016 that relate to group practice management and access, and that included studies from articles published before 2005. Included studies required the following elements: assessed primary care patients, involved an intervention to manage access, and reported an access outcome.

Our literature search identified 979 titles, of which 53 publications were ultimately included. Of these, 29 assessed 19 implementations of interventions to manage

primary care access—all but three were published between 2001 and 2010.

## Key Question #1. What definitions and measures of intervention success are used, and what evidence supports use of these definitions and measures?

In the studies of management interventions to improve primary care access, the third next available (TNA) appointment was the most commonly used access metric (14/19 studies). TNA is defined as the average length of time in days between when a patient makes a request for an appointment and the third available appointment for a new patient or return visit, and it is believed to be a more stable measure of access than the first or second available appointment. However, we found no empiric data linking TNA to any health outcome. The next most commonly used access metric was continuity (seven studies), followed by patient satisfaction (three studies). We also found no evidence that these measures were associated with improved clinical outcomes. In addition to few measures of access success, many publications that discussed access management did not include a definition of access.

## Key Question #2. What samples or populations of patients are studied, including eligibility criteria?

Patients included in published studies of primary care access management were not described in detail. In general, though, they are likely patients of primary care clinics that included family medicine as well as VA clinics.

## Key Question #3. What are the salient characteristics of local and organizational contexts studied?

Unfortunately, little is known about the local and organizational contexts of practice sites included in published studies of primary care access management interventions. Many sites were academically-affiliated clinics, part of the British system, or in VA.

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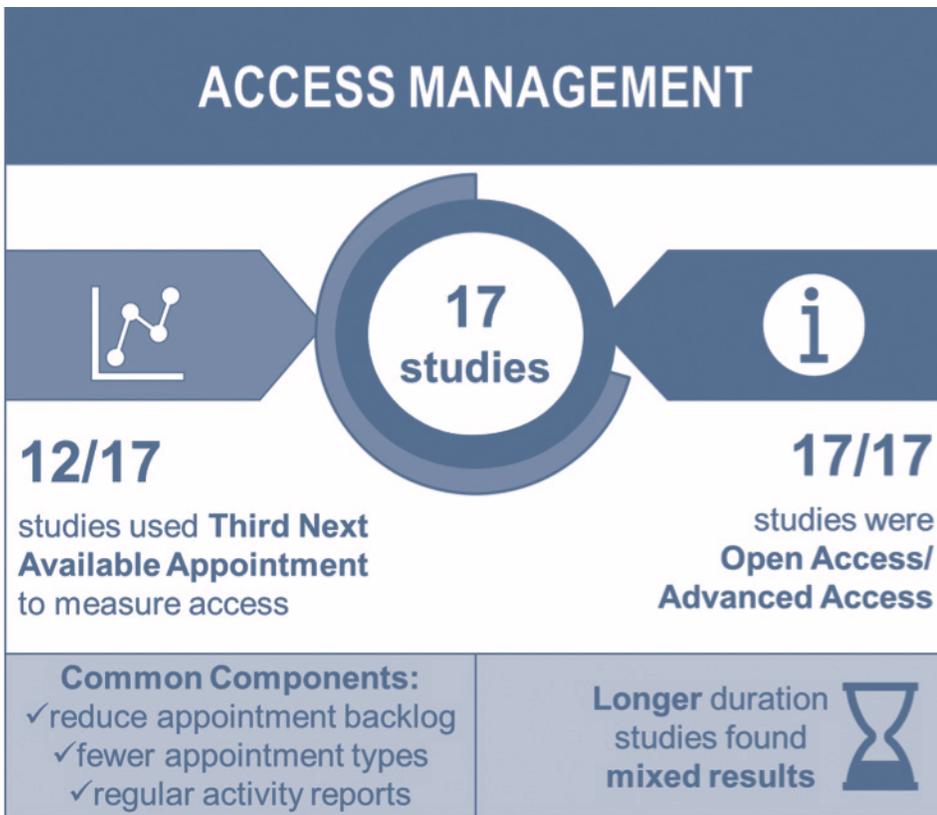
### IOM's Basic Access Principles for All Settings

- Matching supply to demand through formal ongoing evaluation.
- Engaging and exploring patient needs at time of inquiry.
- Inviting patients' preference on the timing and nature of care.
- Providing need-tailored care with reliable and acceptable alternatives to clinician visit.
- Having surge contingencies in place to ensure timely accommodation of needs.
- Continuously assessing changing circumstances in each care setting.

## Key Question #4. What are the key features of successful (and unsuccessful) interventions for organizational management of access?

All the studies identified by this review described the interventions as Advanced Access or Open Access, with 15 of the 19 studies including these phrases in the publication title. The most common intervention components were reducing the backlog of appointments, using fewer appointment types, and producing regular activity reports. In eight studies reporting results of longer than 12 months duration, one study reported initial improvements in access followed by subsequent worsening, one study reported statistically significant decreases in continuity (of uncertain clinical significance), and two studies found a variable effect on access for implementations across many sites.

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**Key Question #5. Are relevant, tested tools, toolkits, or other detailed material available from successful organizational interventions?**

We identified and retrieved six tools or guides for improving primary care access, with four linked to included studies: one from a VA setting, two from the Institute for Healthcare Improvement/Advanced Access group, one from the United Kingdom’s National Health Service, and two additional online tools from Canada.

A key finding of this review is that evidence about primary care access management is essentially limited to the implementation of Advanced/Open Access, with all but three publications falling in a 10-year period from 2001 to 2010. Most studies reported dramatic improvements in access. The most commonly used intervention components were reducing appointment backlog, using fewer appointment types, setting goals, and producing regular activity reports.

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Communication and partnerships among operations stakeholders and researchers are key to the success of any initiatives to improve access to care. Ideally, a robust operations-research partnership should include operations initiatives that can be rapidly implemented and evaluated as well as deeper dives from researchers that investigate mechanisms of

action and identify contextual factors that ensure an initiative’s success. In addition, it should include identification and development of a set of uniform, validated access metrics that can be used to compare results across evaluations. The CORE provides a mechanism to coordinate these elements and generate timely, rigorous evidence to improve Veterans’ access to care.

Unfortunately, whether these are key features of success cannot be determined from the data. Some studies of longer duration reported more mixed results, with rising wait times and the need for modifications to the access management strategy reported in two large, long-term studies.

This evidence-based report represents the first in a series of activities to explore unanswered questions, catalyze novel research and measurement discoveries, and ultimately result in policy changes and innovation. These subsequent activities included an expert panel process, a state-of-the-art conference, and various evaluation efforts occurring in partnership with the Office of Veterans Access to Care, Office of Rural Health, and other program offices. These activities are consistent with the principles of a learning healthcare system and will help inform efforts by VA primary care sites to improve access to care for Veterans consistent with the MISSION Act.

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# As Use of Community Care Services Increases, Researchers Examine Access, Cost, and Quality of Care

With enactment of the Veterans Choice Act in 2014 and the MISSION Act in 2018, VA is dramatically reorganizing how it delivers healthcare services within VA facilities and across community provider networks. As the Veterans Health Administration (VHA) begins to evolve into a payer, the potential implications for Veterans, providers, and healthcare organizational leaders are unprecedented. Three teams have been working in partnership with the Office of Community Care (OCC), and collaboratively, to evaluate the VA Community Care implementation and to address issues related to Veterans' access to care, costs, care coordination and quality, and network adequacy.<sup>1</sup>

## Make versus Buy: Examining Access, Utilization, and Cost

With increased utilization of Community Care (CC) services as a consequence of the Veterans Choice Act, it is critically important for VA to better understand which areas of care it should continue to enhance as a “foundational service,” such as mental healthcare, where it currently excels. It also is important to determine which services VA might better offer through community providers, such as specific surgical specialties with increased demand relative to limited supply. Specifically, we will examine variation in utilization and access to VA versus CC over time, develop and test a methodology to compare VA to CC costs, and examine the use of mental health and surgery services.<sup>2,3</sup> To accomplish these aims, we have published findings on disease burden, as measured by expected costs, between Veterans receiving VA versus those receiving CC care.<sup>2</sup>

We are currently examining access, costs, and quality associated with cataract surgery, which is an excellent example of a surgery that is performed frequently in VA, and, also frequently outsourced. We have used geospatial mapping

to compare distances and time that Veterans drive to obtain cataract surgery in VA and CC; examined 90-day complications of cataract surgery (as an indicator of quality); and have begun work on developing a methodology to compare VA and CC costs of cataract surgery. We also are using episodes of care to examine process measures of mental healthcare. Finally, we are using Survey of Healthcare Experiences of Patients (SHEP) data to compare Veterans' perceptions of specialty care, mental healthcare, and primary care in VA versus CC.

## Evaluating Access, Care Coordination, and Quality

In addition to comparing access, cost, and utilization between VA and CC services, VA is focusing on coordinating care and monitoring the quality of care across VA and community provider sites. The Care Coordination and Outcomes team is focused on assessing approaches used for regional and local VA facility implementation of quality, safety and value, governance and monitoring, and on identifying and evaluating health information exchange needs to support clinical care coordination and quality monitoring under expanded CC.<sup>4</sup> Additionally, the team is developing and applying methods to evaluate and compare process and outcomes-based quality measures—and the extent of duplication of services for Veterans authorized for CC for primary care and specialty care among select high-volume and high-cost procedures (i.e., sleep studies, cardiac studies, colonoscopy, and mammography) with those Veterans receiving care for these services at VA facilities. The team also is working closely with OCC and the Care Coordination and Integrated Case Management initiative to evaluate current practice methods for ascertaining care coordination and case management services in VA and CC—and to make recommendations for additional or alternate measures for future use.

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## Key Points

- The Veterans Choice Act in 2014 and the MISSION Act in 2018 have resulted in increased use of Community Care (CC) services among Veterans.
- Researchers are examining cost, quality, and access to care given this shift.
- Efforts include comparing access, cost, and utilization between VA and CC services, assessing approaches for coordinating care, and monitoring the quality of care across VA and community provider sites, in addition to measuring network adequacy for CC providers.
- Findings from these partnered evaluation projects will be critical in informing future phases of program implementation.

## Network Adequacy

As an increasing amount of VA care shifts to third-party administrators, including Health Net, TriWest, and most recently, Optum, questions remain regarding the adequacy of those networks to provide care to Veterans. Network adequacy refers to a health plan's ability to provide access to a sufficient number of primary care and specialty physicians within the plan's network, as well as all healthcare services included under the terms of the contract.

Measurements of network adequacy can vary, but must include a minimum number of providers and maximum travel time and distance to those providers. These criteria are sensitive to local conditions in that they vary by type of provider and county geographic designation. The network adequacy

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team is focused on evaluating existing measures of network adequacy and making recommendations for additional or alternate measures of network adequacy across VAMCs and VA's 98 markets.<sup>5</sup> Additionally, the network adequacy team will examine how Community Care decisions are made within individual VA facilities and by individual primary and specialty care providers, and identify existing and potential opportunities to expand community partnerships to deliver CC. Finally, the team will examine Veteran preferences for VA versus CC providers and what information Veterans need to make informed decisions.

VA CC is a rapidly evolving program. Research teams are addressing emerging issues, such as working with new CC claims data sources and with dynamic CC authorization procedures.

The researchers leading these projects are working collaboratively to share experiences with new data sources and procedures, and to consider insights gained from their planning efforts. As partnered evaluations, the research teams are working closely with VA leaders in CC to understand the most pressing needs, as well as to identify areas for future research. A panel presentation at the AcademyHealth Annual Research Meeting in June 2019, which included representatives from each of the research teams and the Office of Community Care, exemplifies this partnership and the commitment to disseminating information about the evaluation. With the expected expansion of VA CC, findings from these partnered evaluation projects will be critical in informing future phases of program implementation.

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## Innovation Update

### Can *AboutFace* Really Turn Veterans' Lives Around?

Jessica L. Hamblen, PhD, VA National Center for PTSD and Anouk L. Grubaugh, PhD, Charleston Health Equity and Rural Outreach Innovation Center (HEROIC), Charleston, South Carolina

Despite experiencing significant distress and impairment, treatment-seeking is surprisingly low among Veterans with Post-traumatic Stress Disorder (PTSD) and other psychiatric conditions.<sup>1</sup> Stigma is a major barrier to seeking mental health treatment<sup>2</sup> and this issue is likely to be particularly salient among service members concerned about the impact of disclosing a mental illness on their military career. In 2012, the National Center for PTSD launched *AboutFace*, a website featuring stories from Veterans and their family members who have experienced PTSD, and VA clinicians who treat PTSD. Spanning six decades of military experience, Veterans share their personal stories about PTSD, the treatment process, and how treatment has improved their lives. Partners, children, and friends talk about what it's like to live with someone with PTSD. Mental health providers explain what PTSD is, answer common questions about PTSD, and describe current best treatment options. Using a web-based video gallery of Veterans, *AboutFace* was designed to help Veterans recognize their PTSD, reduce stigma, and motivate treatment-seeking. To date, over a million users have accessed the site, but does it work?

Drs. Anouk Grubaugh and Ken Ruggiero from the Charleston VAMC teamed with Dr. Jessica Hamblen from the National Center for PTSD to find out. An HSR&D-funded pilot study found that Veterans with PTSD would access *AboutFace* when recommended to them at intake and that attitudes towards mental illness and treatment-seeking improved from baseline to follow-up. Now, an HSR&D-funded randomized controlled trial is examining whether Veterans randomized to *AboutFace* will be more likely to initiate and complete treatment relative to those receiving usual care for PTSD. Key stakeholder interviews will also be conducted to optimize future implementation. Outcomes are not yet available, but if effective, *AboutFace* has the potential to increase access to care through the promotion of testimonials consistent with hope and recovery.

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## Future Research Opportunities

A multitude of new VA access initiatives, including the MISSION Act, create the perfect environment for rich partnerships between operations and research. Robust statistical analysis guided the identification of underserved facilities and the development of the new access standards, strengthening OVAC's relationship to researchers in the process. Moreover, researchers are already developing protocols to evaluate upcoming MISSION Act interventions, such as a medical scribes pilot program to improve productivity, and the deployment of mobile clinics to improve access to care in underserved areas. The role of VA research will only grow in the future, expanding beyond the MISSION Act and into other OVAC-led initiatives to improve access to care and productivity.

VA remains committed to ensuring that Veterans receive the highest quality care. VA's long history of working with patients

has set it apart from the private sector with its ability to address the specialized needs of Veterans. The MISSION Act will build on the foundation VA has set for utilizing community care when needed—and is not an effort to privatize. The goal is to keep Veterans within VA and only send them to the community when access standards cannot be met. Through numerous ongoing initiatives at VA, specifically OVAC, we are continuing to improve access at VA and become MISSION Ready.

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