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Commentary

Access Issues Within VA Offer Challenges, Research Opportunities

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Access is one of the key "domains of value" for VHA. As access is largely determined by the structure and functioning of the health care system, health services research is uniquely positioned to investigate this aspect of health care.

The Merriam-Webster dictionary defines access as: "permission, liberty, or ability to approach or communicate with a person or thing," or "freedom or ability to obtain or make use of something." Reflecting on this definition, it is apparent that access has several dimensions.

Dimensions of Access

Geographical. The first aspect is geographical access. Is a particular health care service available within a given geographical area? Traveling long distances for care can represent a significant barrier to obtaining needed services. VHA began as a hospital benefit but has gradually expanded to include the full spectrum of care. Veterans live in every community in the country, often far from the nearest VA Medical Center. The development of Community Based Outpatient Clinics (CBOCs) was an effort on the part of VHA to improve the geographical availability of its services.

CBOCs have been successful in improving access to primary care, but providing VHA primary care far from VHA specialty and hospital services creates significant difficulties for VHA primary care providers. The geographic distance between primary and specialty care services delivery also has contributed to the growth of dual care, with patients receiving care in multiple (VA and non-VA) systems. The recent creation of an Office of Rural Health in the Office of Policy and Planning reflects the continued concern over providing VA care to patients in sparsely populated areas far from urban centers.

Financial. The necessary financial resources are a prerequisite to obtaining health care. In the United States, the lack of health insurance represents the greatest barrier to accessing health care for millions of citizens and has been the focus of much policy and political debate. One of the strengths of VHA has been the relative freedom from financial barriers to care once a patient is enrolled in the system, and it is often considered an "equal access system." Nevertheless, the presence of copayments, the size of copayments, and decisions about inclusion or exclusion of priority groups are all issues that reflect financial influences on access even within the VA. These issues are ripe for investigation.

Cultural. Ethnic or socioeconomic factors can contribute to financial and geographical barriers, but cultural differences may also play a role in access. Differences in cultural expectations and communication styles between patients and health care providers can result in significant difficulties in patients obtaining the care they need or desire. These cultural differences can arise on the basis of ethnicity, socioeconomic status, gender, religion, age, and other factors. The difficulties that vulnerable populations, such

Director's Letter

Efforts to improve health care for our veterans are at the heart of VA HSR&D research. Conducting veteran-focused HSR&D research and implementing findings to improve care and clinical practice requires dedication, communication, and in many cases, collaboration with our public- and private-sector colleagues.

Over the past decade, efforts to work in closer collaboration with our partners in the Department of Defense (DoD) have been numerous. But simply maintaining those established endeavors is not sufficient—strengthening our connection with DoD is critical for enhanced research efforts, and ultimately, improved care. That's why we are pleased to announce the creation of a Collaborative Research Listserv (CRL) to foster the connections among VA and DoD researchers. This exciting endeavor will provide a real-time forum for HRS&D researchers to discuss ideas with their VA and DoD colleagues, obtain collaborative research partners, identify researchers interested in a specific area of study, and share expertise.

I encourage HSR&D researchers to participate in the CRL, to establish new collaborations, and continue building on existing efforts. This valuable tool will offer a convenient method to further integration and synergy across research areas and among peers. For information on how you can join, please email vadodcri@va.gov.

In other news, HSR&D recently held an Office of Research and Development (ORD) State of the Art Conference (SOTA) on traumatic brain injury (TBI)— a critical area of concern for our OIF/OEF veterans. Important products from the SOTA thus far include the inclusion of SOTA-identified research questions in an upcoming ORD-wide RFA on neurotrauma and the planned publication of commissioned SOTA papers in the *Journal of Rehabilitation Research and Development* in early spring 2009.

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nals. These publications fall into the following general subject areas (with some articles covering more than one area): cultural factors such as race and vulnerable populations (23 citations); access to health care in general or specific health care services such as rehabilitation, or automated external defibrillator (18); access to mental health services (11); geographical factors (11); communication technologies such as the Internet (6); insurance (3); and timeliness (1).

". . .the need for VA HSR&D to maintain its rigorous focus on improving our understanding of the key access challenges experienced by veterans, especially those related to geographic, financial, cultural, and timeliness barriers."

While this simple search no doubt identified only a portion of relevant articles, the results are of interest. The extensive effort by VA HSR&D to evaluate cultural factors on access is impressive. This includes numerous studies on vulnerable populations, including those with mental illness and HIV, and their access to care. Access to mental health services has been a particular focus of activity, and a variety of these publications explore geographical factors. Given the relatively small influence economic factors have on access within VA, the number of publications in this area is not surprising. The paucity of research on timeliness represents an important opportunity for HSR&D.

When discussing access, Dr. Jonathan Perlin, former Under Secretary for Health, would frequently say "Without access there is no quality." His message is a salient reminder of the need for VA HSR&D to maintain its rigorous focus on improving our understanding of the key access challenges experienced by veterans, especially those related to geographic, financial, cultural, and timeliness barriers.

as those with severe mental illness and the homeless, experience in accessing care can be considered in this category as well.

Timeliness. Another barrier to access is delay in receiving needed services. While services may be geographically available, affordable, and culturally accessible, long appointment wait times and treatment delays can lead to disruptions in patient care. This barrier has been a particular concern for the VA.

Important research questions arise for all these areas. How can researchers define and measure these dimensions? To what degree does health care utilization vary across these dimensions? What effect does this variation have on actual health care outcomes? What effect do changes in health services delivery have? For example, VA needs to better understand the impact on access of the presence of CBOCs, variation in copayments, creation of women's clinics, and Advanced Clinic Access initiatives.

A search of the HSR&D publication database found 170 citations where the word 'access' appeared. Of these citations, 62 were for publications in peer reviewed jour-

Response to Commentary

Access to Care: A VA Research Agenda

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In his commentary, Dr. Mayo-Smith describes how geographic, financial, cultural, and chronological aspects of health services delivery might influence access to care. He rightly notes that organization of the health care system influences access. Three questions should drive a VA research agenda regarding access to care.

What is the goal of providing access to care?
It is important that a health care system articulate the overarching goal for improving access to care. A health care system may have many such goals—to make shareholders money, to train new health care providers, to meet political needs, or to sustain a bureaucracy. However, for the VA, the goal of access should be to improve the health and well-being of its service population. Competing reasons should be subjugated to this one.

What kind of health care should VA provide access to in order to improve the health of its service population?
Not all health care is created equal. Researchers at The Dartmouth Institute for Health Policy and Clinical Practice have defined three categories of health care.[1] *Effective care* refers to the relatively small set of clinical services where all patients with a specific clinical indication should receive the treatment. The U.S. health care system is able to deliver such services less than 55 percent of the time, although VA performance is somewhat better.[2] To improve the health and well-being of its service population, VA should enhance access to effective care.

Preference-sensitive care refers to services for which there are multiple reasonable courses of action that present significant health trade-offs—such as between a poten-

tial gain in life expectancy and a greater likelihood of serious side-effects. The volume of preference-sensitive care that VA provides should depend on the values and desires of the patient population being served. Decision aids can help ensure that care is consistent with those desires. Implementation of decision aids can help patients' stated needs drive the delivery of services, while minimizing the costs of providing care that patients do not want.

Finally, Drs. Jack Wennberg and Elliott Fisher estimate that 50 percent of all medical spending in the United States is consumed in providing *supply-sensitive care*—where the supply of resources strongly influences the frequency of their use. Examples of supply-sensitive services include the use of the hospital as a site of care, the frequency of physician and specialist visits, and the use of imaging services. Greater use of supply-sensitive care is associated with lower quality and with equal or slightly worse health outcomes—most likely due to greater difficulty with care coordination and with unnecessary, but not risk-free, hospital stays. Provision of more supply-sensitive care is therefore the ultimate inefficiency.

How should VA enhance access to effective, patient-centered care while limiting access to supply-sensitive care for its service population?
Much of VA's service population, by choice, obtains care outside of the VA. Therefore, improving the health and well-being of the service population requires that both VA and non-VA health services provision be considered when addressing access issues. For instance, if additional VA access points provide redundant, as opposed to complementary or coordinated, care, increasing access might inadvertently increase supply-

sensitive care and impair population outcomes.

Given VA patients' high reliance on the private sector, for effective care, VA might best improve the health and well-being of its service population by taking on a new role: helping those who choose private-sector services find hospitals that best provide effective care.[3] Finally, guided by decision aids, coordinating VA and non-VA care through collaboration across insurers could benefit veterans by improving outcomes and benefits, and by resulting in lower out-of-pocket costs. This coordination could also benefit the VA health care system by more efficiently and effectively meeting the needs of its service population and taxpayers by offering greater value for their investment in veterans' health care.

A Goal of Coordinated Care Delivery
These three questions should serve as the basis for research that explores whether improving the health and well-being of the service population is the primary goal of access, whether VA is allowing patient values to drive resource allocation while minimizing supply-sensitive care, and whether care coordination across systems of care can efficiently provide value. Working with VA leadership, researchers can both create systems that inform and engage patients about health care choices, and help veterans coordinate insurance-mediated access to give them a better benefits package. Researchers can also support models of care delivery that maximize effective care and minimize wasteful supply-sensitive care—regardless of which system of care a veteran uses.

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Research Highlights

Advanced Clinic Access: Enhancing Access by Reducing Clinic Wait Times

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Reducing wait times for clinic appointments is a high and visible priority for VA, and has been for several years. In 2000, in an environment of growing demand for VA health care and long wait times for clinic appointments in many areas, VA launched a national program, the Advanced Clinic Access (ACA) Initiative, to reduce wait times in targeted clinic areas across the system.

ACA, by now widely-recognized across VA, is a well-established set of 10 clinical operational practices called key change principles for organizing and managing clinics so that patients have access to the medical care they need—when and where they want it. To encourage and support the use of these principles, the ACA Initiative, working originally with the Institute for Healthcare Improvement (IHI), built an extensive infrastructure, including: a national steering committee, a full-time national clinical director, a person designated to lead ACA in every VISN and most medical centers, and a network of clinical access coaches to stimulate peer networks of advocacy and support. As intended, the infrastructure has

ACA 10 Key Change Principles

1. Work down the backlog,
2. Reduce demand,
3. Understand supply and demand,
4. Reduce appointment types,
5. Plan for contingencies,
6. Manage the constraint,
7. Optimize the care team,
8. Synchronize patient, provider, and information,
9. Predict and anticipate patient needs at the time of appointment, and
10. Optimize rooms and equipment.

continued to strengthen and expand and is now referred to as VHA Systems Redesign.

An important component of the original ACA Initiative was a comprehensive evaluation of the implementation and effectiveness of ACA. The evaluation, based on the experience of clinics in 78 VAMCs in 2003, was commissioned by the ACA Steering Committee and conducted by the HSR&D Management Decision and Research Center (MDRC), now the Center for Organization, Leadership, and Management Research (COLMR).[1]

The evaluation found that successful ACA implementation, defined as the use of a high proportion of the ACA principles, was significantly associated with shorter wait times, with the relationship stronger in primary care than across specialty clinics. Underlying this overall good news, however, was substantial variation across clinics and medical centers in the extent to which the ACA principles were implemented. In order to implement ACA more consistently, it is important to understand the factors that account for this variation: Why were some clinics more successful in implementing ACA principles than others?

Local Factors Affect Successful Implementation of ACA

While the ACA infrastructure provided important resources and support for ACA, local factors were also important. The ACA efforts at the national and VISN levels interacted with people, processes, and structures within medical centers and their clinics. One source of variation in factors affecting implementation is the six clinic areas targeted by ACA (primary care, orthopedics, eye care, cardiology, audiology, and urology). Each of the six clinic areas is based in its own professional history and practices, and each clinic area approached ACA differently. However, across target clinic areas, five factors were significantly associated with successful ACA implementation:

■ **Strong management support for ACA,** as demonstrated in concrete actions of: appointing an ACA oversight body to elevate the visibility of ACA, incorporating ACA into facility priorities, holding managers accountable for improvement-related performance, explicitly designating champions for each clinic area, reporting on ACA progress and lessons at meetings of senior managers, and targeting resources to remove obstacles to ACA implementation.

■ **Clinic teams having the knowledge and skill needed to do their work well and make changes successfully,** as reflected in: seeking information and effectively using that information; using data regularly to design, test, and track process improvements; regularly assessing team progress; and learning from efforts of others to implement ACA.

■ **Clinic staff review of ACA wait time performance data** that is trustworthy and timely so that clinic teams providing care can assess the current level of the problem and monitor the impact of improvement efforts.

■ **Adequate clinic resources,** reflected in primary care by more exam rooms and in specialty care by greater use of consulting physicians.

■ **High demand for care** in primary care (but not specialty care), as evidenced by a high number of patients on the wait list, suggesting that greater unmet demand provides an impetus for change.

Attention to these factors promises not only to strengthen future implementation of ACA, but also to offer lessons in implementing other complex clinical innovations.

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Research Highlights

Telehealth Technologies: Improving Veterans' Access to Care

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While older adults may be less technologically savvy relative to younger individuals, they are nonetheless interested in and willing to use technology to improve their quality of life and ability to "age-in-place." Three areas of particular importance and interest to older adults include: 1) health and well-being, including remote sensing and monitoring; 2) personal safety, including personal emergency alarms and motion sensors; and 3) social connectivity.[1]

Telehealth technologies are being used to provide convenient access to these services in patients' homes. While much attention has been paid to technology and development of innovative equipment, less effort has focused on systematically evaluating the efficiency and effectiveness of these applications. A notable exception is the use of the telephone for follow-up care and patient reminders. Telephone care can improve outcomes through more frequent contact between patients and health professionals, but it requires real-time interaction. With the increasing introduction of low-cost remote monitoring devices that allow asynchronous contact, studies are increasingly being implemented to address the value of home monitoring.

VA's Care Coordination/Home Telehealth Program

The Department of Veterans Affairs has been a leader in the use of home monitoring. Since 2003, more than 43,000 veterans have enrolled in the Care Coordination/ Home Telehealth Program (CCHT). Technology is assigned based on patient needs and includes a range of devices such as videophones, messaging devices, biometric devices, digital cameras, and telemonitoring devices. Each enrolled veteran has an assigned care coordinator to help them manage their condition and coordinate care.

Since 1997, we have been evaluating how telehealth technologies improve veterans' access to services in their home setting. Our earliest studies evaluated the provision of specialty services between a state veterans home and VA Medical Center. We evaluated the feasibility of providing nursing-based wound consultation services and the provision of specialist physician consultation via real-time interactive video. In both studies, clinicians were able to diagnose and treat the health problem using the technology while the patient was able to remain at the nursing home (their home). This eliminated a four hour round-trip for the patient and saved transportation costs. Furthermore, both clinicians and patients expressed satisfaction with the use of telehealth; in fact, most patients felt it was easier to get medical care.

In a second study, we compared the effectiveness of two home telehealth communication modes (telephone or videophone) to traditional care provided for recently discharged outpatients with heart failure. Patients discharged from the hospital following treatment for heart failure exacerbation were randomized to a 90-day, nurse-managed, telephone- or interactive video-facilitated heart failure disease management program or control condition. The intervention resulted in significantly longer time to readmission but had no effect on mortality, hospital days, or urgent care clinic visits. Intervention patients reported higher disease-specific quality of life scores at one year. We found no substantive differences in communication patterns between the telephone and videophone group, thus both approaches worked equally well.

In a third study, we evaluated varying doses of remote monitoring in veterans with co-morbid hypertension and diabetes. To date, most projects have focused on single disease populations, e.g., heart failure or mental illnesses. Furthermore, few controlled clinical trials have investigated varying the intervention dose. Subjects were randomized to three groups: low-intensity monitoring plus nurse care management intervention, high-intensity monitoring plus nurse care management intervention, and usual care. In both intervention groups, patients transmitted vital signs daily.

In addition, the low-intensity group answered two general health questions, while the high-intensity group responded to a complete range of questions focused on diabetes and hypertension, and received educational tips. The intervention groups participated in the protocol for six months following enrollment. Preliminary results indicate that the intervention was effective in improving HbA1c and this effect was more pronounced in the high-intensity group. Only the high-intensity group showed an improvement in systolic blood pressure.

Because family members frequently assist with disease management in the home, a study currently under way is evaluating how informal caregivers support veterans enrolled in the VA CCHT program.

Rigorous Evaluation Needed

Through optimal use, telehealth technologies can be used to leverage limited health care resources to better meet the needs of older adults. The wide array of telehealth technologies has created many new and promising ways to increase access, availability, and quality while reducing costs. Rigorous evaluation is needed to determine which patients may benefit most from telehealth and which technologies are most cost-effective.

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Research Highlights

Access to Mental Health Treatment: The Importance of Collaboration

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The FY '08 budget request for VA called for nearly $3 billion in mental health services to continue improvements in access for veterans with mental health problems. Of course, much of this budget request funds mental health specialty care programs. However, there is growing awareness that a key aspect of access to mental health treatment involves the bridge between primary care and mental health specialty programs. In July 2007, then Secretary of Veterans Affairs Jim Nicholson, while announcing plans to bring VA mental health and primary care programs closer together, said, "Given the reluctance of some veterans to talk about emotional problems, increasing our mental health presence in primary care settings will give veterans a familiar venue in which to receive care—without actually going to an identified mental health clinic."

Building a Bridge from Primary to Mental Health Care

Historically, the bridge between primary and mental health care has not been easy to build. Barriers exist at the patient, provider, and system levels. Many veterans are concerned about being stigmatized if they reveal mental health concerns. Many primary care providers report that they are uncomfortable assessing and discussing mental health concerns. Early attempts to educate primary care providers to treat mental health issues themselves and to screen and refer patients with more complicated conditions to mental health specialty clinics proved unsuccessful. At the system level, although VHA is more integrated than many other managed care systems, traditional acute care models do not foster cross-care line cooperation. More than physical co-location is required.

For some years, researchers within and outside the VA have been working to build an evidence base for bringing mental health and primary care closer together to improve access and continuity. Ed Wagner's Chronic Illness Care Model helped researchers understand what changes in the system and processes of care are necessary to improve care of chronic conditions, including depression, unipolar and bipolar disorders, and schizophrenia. Key components of improving care are clinician education and decision support, patient education and self-management support, active collaboration between primary care and mental health specialists, and care management. Current implementation research by VA investigators Rubenstein in depression (TIDES), Bauer in bipolar disorder (CCM), and Young in schizophrenia (EQUIP) illustrate application of these care components.

Collaborative Care Models

TIDES uses a partnership among researchers, clinicians, and administrators to foster a stepped-care model of depression care that builds on the depression screening currently practiced at high levels in VA primary care clinics. The key care system change is the introduction of Nurse Depression Care Managers (DCMs) bridging primary care and mental health specialty care. DCMs are trained to assess depression and comorbid conditions and suggest treatment alternatives to the primary care clinician. DCMs may coordinate depression care in primary care through telephone education and support to the patient or facilitate referral to specialty care in more complex cases. This model achieves high levels of patient satisfaction and efficient use of care resources. One of the primary findings is that depressed patients who were not receiving care are identified, assisted in accessing care, and trained and supported in self-management skills.

Bauer's collaborative care model for bipolar disorder also emphasizes patient self-management skill enhancement, making evidence-based treatment decisions, and using care management to enhance access and continuity. Two initial multi-site studies demonstrated that involving patients with bipolar disorder in a Life Goals group psychoeducation program, assisting their mental health specialty providers with simplified practice guidelines, and introducing a nurse care coordinator significantly reduced symptomatology and duration of manic episodes. A more recent study using the same model found that if care coordination included both mental health and primary care providers, patients' physical well-being also improved. In these studies, improved access to care is reflected in reduced unplanned care episodes.

Young's EQUIP studies use a collaborative care model for schizophrenia to enhance recovery-oriented care by identifying patients in need, providing improved access to evidence-based services, and reorganizing care to support these services. The model incorporates assertive care management, provider education and decision support, and routine standardized patient assessment with feedback of information to treating psychiatrists at the time of the clinical encounter. Providers report that the intervention improves information about their patients, particularly in psychosocial domains, and assists in more effectively monitoring treatment needs.

Together, these three programs of research—each focused on a different mental health problem—demonstrate that collaborative care models can improve access and quality of mental health care. Important questions remain. Current work focuses on the implementation of these models under routine care conditions and identification of what is required to promote long-term model fidelity and sustainability.

Interview

Evolving Access Needs Offer Research Opportunities

Recently, FORUM sat down with Mike Davies, M.D., National Director of VHA Systems Redesign, to ask him his views on the challenges facing VA as it works to ensure timely and appropriate access to care for all veterans.

VA has made significant strides in improving access to health care services for the veterans it serves. Despite these improvements, VA must address three immediate challenges:

1) Ensure ease of access for patients to existing providers and ensure that service gaps are addressed;

2) Improve our understanding and use of support staff roles and team productivity; and

3) Achieve a higher degree of reliability and standardization in the flow of patients from primary to specialty care.

Three Challenges

The first challenge—ensuring a sufficient complement of physicians at VA's medical centers—demands practical solutions. While access for individual patients to their providers is usually good when providers are present, gaps in care occur when providers are absent for any reason, and any length of time. Medical centers and providers need to innovate and be more proactive in developing contingency plans for such absences. Some options include back-up by other team members, specific providers tasked to cover absences, using support staff in new ways, partnering with other departments, contracts with private provider groups, increased patient waiting, or diversion.

The second challenge—improving utilization of staff—involves deepening our understanding of the potential roles of support staff and leveraging staff roles to improve the efficiency of health services delivered. The idea here is that every team member works at the highest level of their licensure and capability while applying that effort to the patient population that benefits the most. A direct relationship exists between the number of support staff and medical team productivity (in terms of population care), and we need to better understand and leverage those dynamics.

Third, VA needs to learn more about how patients move among the wider team of service providers. What care should primary care be responsible to deliver? Are patients shifting from primary to specialty care at the right time? Do they stay in specialty care for the right length of time? Wide variation exists in what is referred to as specialty care. Increased standardization of the definition of primary care versus specialty care services would improve delivery of care to veterans.

Despite these challenges, VA has successfully used Internet technology to advance access for veterans. The availability of medical records through My HealtheVet, videoteleconferencing, and other computer-enabled technologies has improved both efficiency and access to care.

While VA is taking care of a relatively small number of OIF/OEF veterans, we are a nation at war. These returning veterans are a top priority. Access to care for OIF/OEF veterans should be no different than for other veterans. Recently returning veterans have different needs, however, and VA must be nimble in responding to those needs. An increased demand for rehabilitation services is just one example. Furthermore, VA must do better at reaching out to returning veterans and asking, "How can we help?"

To achieve greater efficiencies, VA is opening new ambulatory centers and working more closely with community resources to address gaps in care. VA's recent approach focuses more on partnering with community organizations to provide services when it makes sense, as opposed to building and owning space. This approach is especially important for the delivery of low-volume specialty care.

VA's Bar Code Medication Administration (BCMA) program is just one example of recent efforts to improve efficiency, in this case the efficiency of medications delivered at bedside. While BCMA is a major advance, improvements are still needed to address problems with this new technology. VA delivers thousands of medications daily. Small advances in standardizing and improving the process by which these medications are delivered at bedside would result in huge improvements in the availability of nurses to address other needs.

Research Opportunities

The access challenges facing VA today suggest several compelling research opportunities.

■ **Waiting times.** There is great interest, including by Congress and the Inspector General, in measuring wait times for services, yet not much research has been undertaken in this area.

■ **Elective vs. emergency procedures.** We need to be able to measure and plan for wait times for elective vs. emergency procedures so that we can meet both medical needs and patient expectations.

■ **Variations in patient expectations by generation.** VA needs a better understanding of what our customers want and how those preferences vary by generation.

■ **Disability exams.** The administration of disability exams, necessary for determining pension and disability compensation, is a major new issue and area of dissatisfaction for new veterans.

■ **Appointment failures.** VA needs to explore the reasons why patients fail to "show" for appointments.

Critical to addressing access challenges is the need for VA to improve the efficiency of care provided. VA is keenly interested in process improvement and there is a huge need for knowledge and research in these areas. The academic community has been slow to embrace and value improvement science.

Rural Health, Mental Health

Ensuring ease of access to services for veterans living in rural areas remains a key priority for VA. The Office of Rural Health is focused on ensuring access to VA care for veterans living in sparsely populated areas that lack ease of access to a nearby VA medical center. While veterans living in rural areas may have access to a VA facility, that facility may lack key specialty services. In rural settings, transporting veterans who need specialty care to an appropriate site of care presents a complex logistical challenge.

VA continues to focus on improving access to mental health services. One area of study relates to the supply of providers needed to treat mental health conditions. Key to this focus is improving our understanding of how often and for what duration patients should be seen for mental health conditions. Another challenge is the need to connect patients to the right provider at the right time.

While VA has substantially improved access to health care services over the last decade, additional access improvements remain within reach and must be pursued actively at all levels within VA.