The Bauhaus of Measuring Access: Form Should Follow Function in Deciding What to Measure

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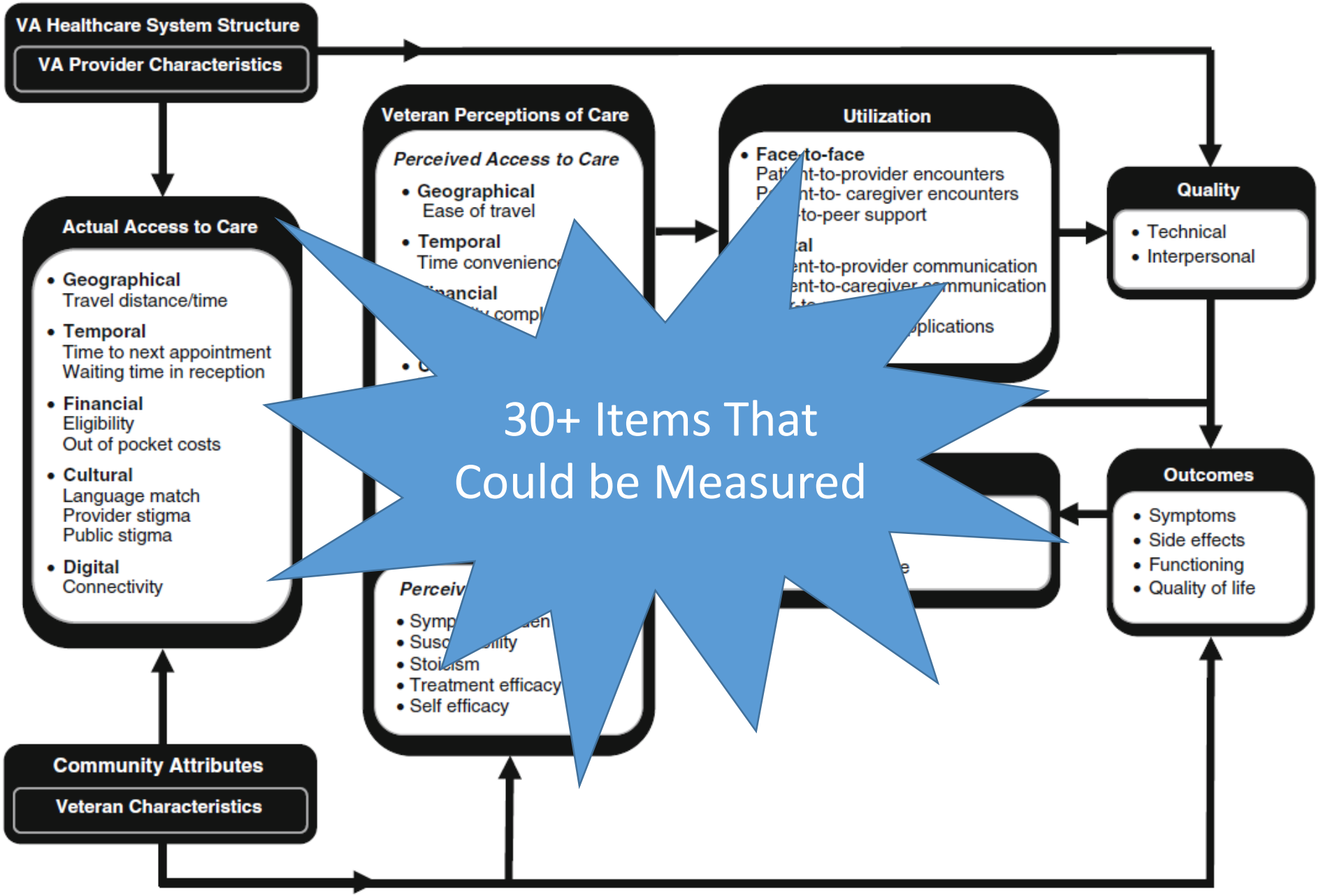
Conceptualizing Access

- From previous session, we know that access is multidimensional and complicated
- Which raises challenges for measurement



Fortney JC et al. J Gen Intern Med 2011; 26(Suppl 2):639–47

The Risk: Data Overload and Unintended Consequences

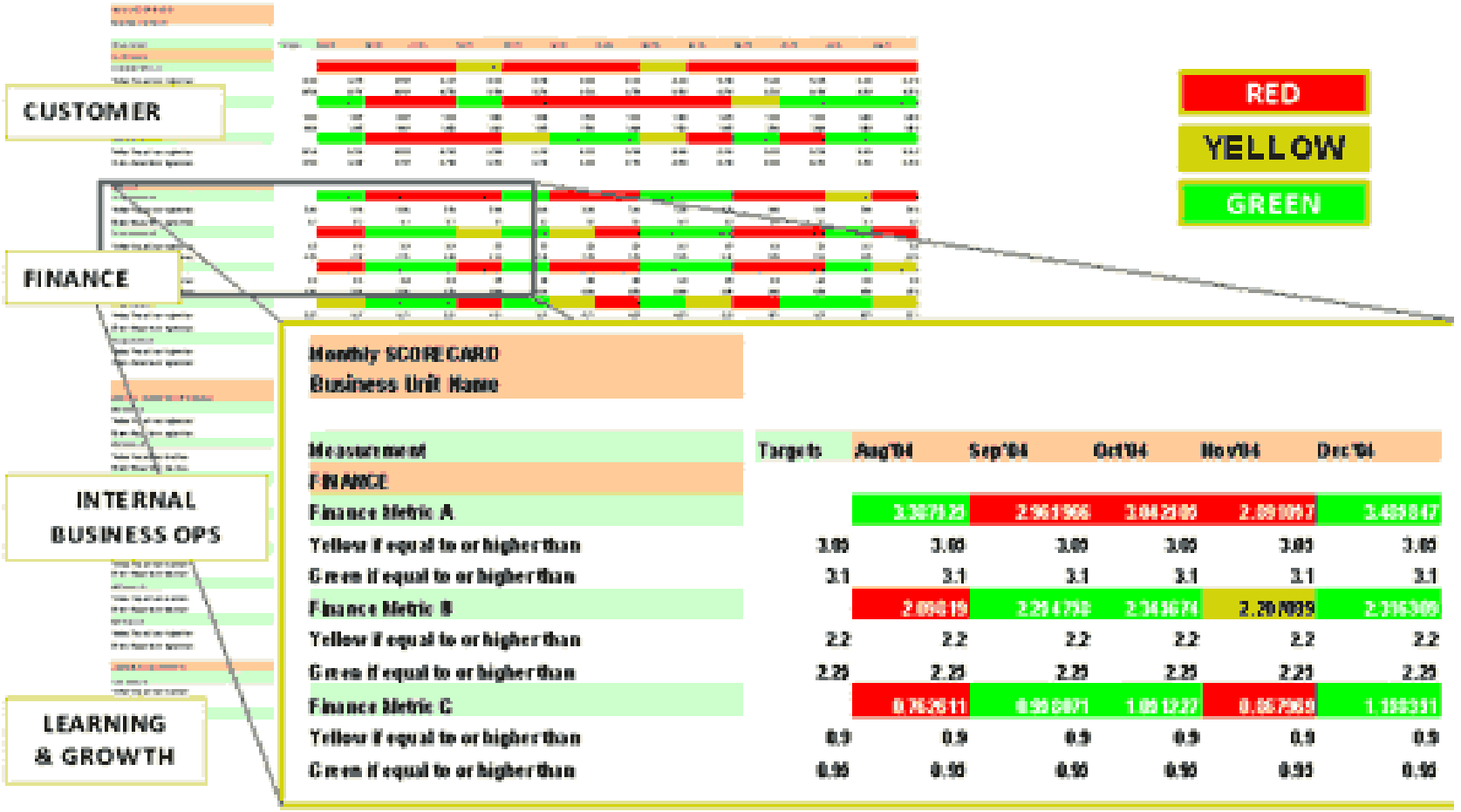
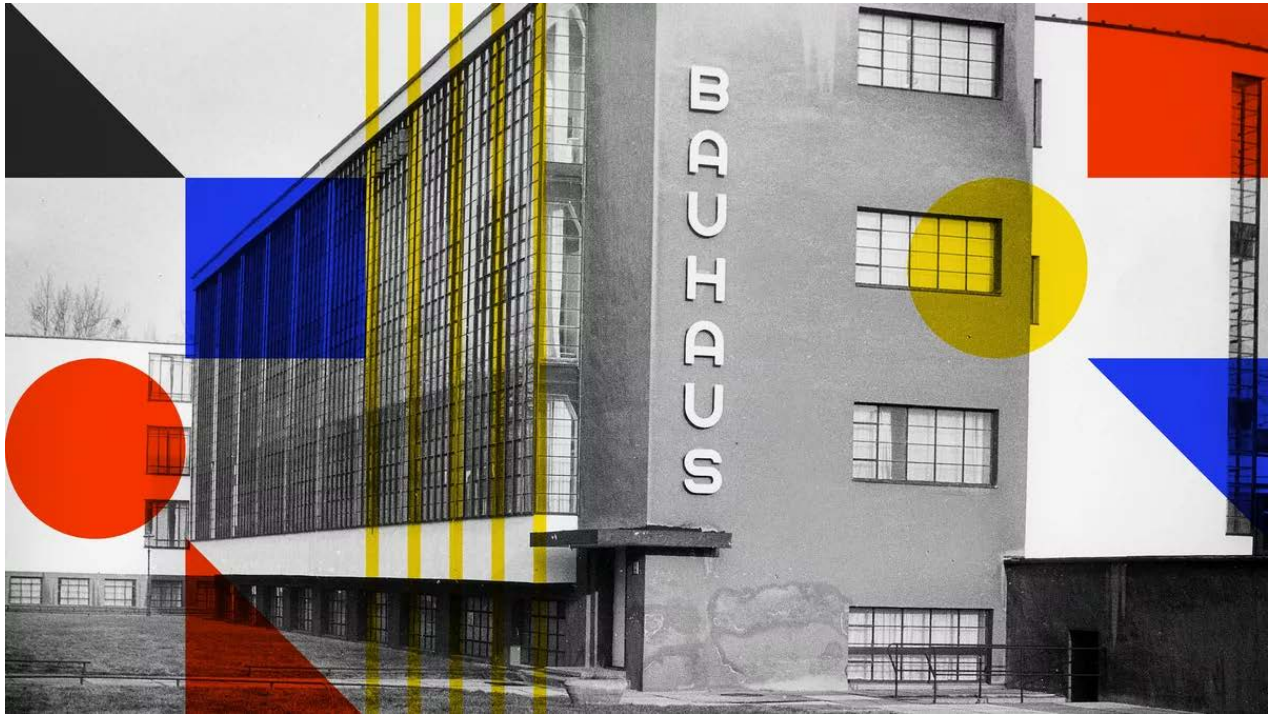


Figure 1: Red-yellow-green tabular scorecard example.

Think Bau Haus: Form Follows Function



- Why do we want to measure this?
- How will a measure be used?
- What is its functional purpose?
- Then we can decide what and how to measure

Function: Broad Assessment of System Performance on Access

- Overall, how are we doing?
- High level “scorecard” on key metrics
  - Actual performance vs benchmark or target
- Audience: key stakeholders; e.g.:
  - Congress, VA national and regional leadership, veterans
- Measures should be simple to understand, few in number, meaningful, represent important domains; e.g:
  - New patients with a primary care visit
  - Days from referral to specialty visit
  - Patient reported global measure of access
  - Ideally with an equity lens (eg, stratified by race-ethnicity, geography)
- Pros and cons of rolling up multiple measures into cumulative “balanced scorecards” across domains

Function: Inform Operations to Improve Access

- Why isn't access as good as we'd like, and what can we do to improve it?
- Audience: operations stakeholders at the local practice unit level
- Measures can be more detailed and focused on a particular access domain with actionable implications, often drilling down to individual team or clinician level
- E.g., if there is an access problem for patient visits, could measure
  - Panel sizes and demand-capacity mismatch
  - Unused appointment slots (including drill down on cancellations, no-shows, bumped appts)
  - Return visit intervals for routine chronic care follow up
  - "Repatriation" rates from specialty to primary care

A Case Study: VA Survey of Healthcare Experiences of Patients (SHEP)

- Several items measuring different elements of patient-reported access
  - Appointments: same-day, urgent, routine, after hours
  - Telephone: regular hours, after hours
  - Online secure messaging
- Should 1 or 2 of these measures be used for the function of high level tracking of access?
- Do all of these measures have functional value for local operational efforts to improve access?

SHEP Measures (cont'd)

- Study by Augustine et al. found that of SHEP measures, only access to after hours visits was predictive of lower rates of ambulatory care sensitive hospitalizations
  - Does this imply that this specific access measure is the most important one for both high level tracking and local operational improvement? Or maybe not?

- Bindman, Grumbach, et al. found that in a general population, a single, simple self-reported access measure was a powerful predictor of lower rates of ACS hospitalizations
  - "Overall, how difficult is it for you to get medical care when you need it?"
  - Single item explained 50% of variation in ACS hospitalization rates at neighborhood level
  - Should we focus more on global self-reported measures?

Augustine et al. J Gen Intern Med 2019;34(8):1546–53; Bindman AB, Grumbach K, et al. JAMA 1995;274:305-11

Conclusion

- Form should follow function
- What is the functional goal of different access measures:
  - For what purpose?
  - For what audience?
  - To what end?