David Pryor, M.D.
July 10, 2020

Developing a Patient-Centered Approach to Optimizing Veterans' Access to Health Care Services: A Workshop

Summary Statement

Thank you for allowing me to participate and to make some observations.

I have no financial conflicts. I have worked with the National Academies, the National Quality Forum, and the VA in a number of different roles both currently and in the past. Ascension is a community care provider for the VA in a number of markets and strongly committed and supportive of the VA system. My comments are my own and not meant to represent those of any organization.

It has been a pleasure to listen to the outstanding presentations that were made and the obvious skill that the planning committee and National Academies staff brought to organizing the workshop. I am particularly pleased because of the importance of the topic and recognizing the responsibility and the desire of everyone to improve patient-centered approaches to optimizing veterans' access to health care services.

My comments today are not directed at summarizing each session—those of you familiar with National Academies workshops know that this will be done in the consistently excellent fashion that the staff at the Academies always brings to a workshop summary. Rather, I've been invited to contribute my observations around consistent and common themes I've heard as well as to provide my own commentary and thoughts.

The first key theme we consistently heard is that the issue is complex with multiple dimensions and that there is no single measure like wait times, or a single approach that will deliver on the goal to our veterans. One size will not fit all. We are also not starting from ground zero. There has been extensive work within the VA and other systems, previous workshops and roundtables, and outstanding outcomes that have been achieved in specific examples within the VA as well as in other systems. There is much that we have learned from those examples and that should inform our approach.

The complexity and multimodality of the issue suggests that the overall goal should include the establishment of continuously improving system for patient-centered approaches to optimizing access. This might seem obvious, but I would consider making it explicit and a necessary requirement of the design. This is important because it impacts the improvement system design and what you measure. It is also important because with such a complex issue it is unlikely that there will be universal agreement across all stakeholders—with veteran's advocacy groups, congressional oversight committees and VA leadership—and yet some agreement on how to proceed is essential to engaging the support that is required for moving forward. By recognizing that this will be a journey, the dialogue becomes not about which of the issues

should be addressed but rather shifts to the order in which the issues are addressed and makes the required compromise easier because it's not about if, but rather only when.

We've heard from multiple speakers about the importance of both actual and perceived assessments. It cannot be an either or, but rather must include both. They are intimately related to each other and true improvement cannot occur without measuring both and understanding the influence each has on the other. Actual and perceived assessments are further complicated by multiple other issues. There are condition specific (e.g. mental health) and population specific issues (e.g. homelessness) in the services provided and the measurement of access to those services. There are issues around continuity of care, integration of care across providers and systems, affordability of care, social determinants of health and equity, trust in the provider, and implications for structure, process, and outcome assessments. Improving access is important but, as we just heard from the advocacy panel and from a number of the other speakers, it is probably more important that the improved access is to the right resource (e.g. the right person, at the right time, in the right way) rather than measuring access to any resource.

Access has many aspects—for example, availability, accessibility, accommodation, affordability, and acceptability—as we heard this morning. Other frameworks like the aims in *Crossing the Quality Chasm* incorporate quality, effectiveness, efficiency, equity, timeliness, and person-centeredness (i.e., recognizing the need to provide care that responds to emotional needs and builds trust.) Within any specific variable measurement there are the issues around each measure—validity, reliability, reproducibility, and so on, measuring what is available vs. measuring what matters, and the balance between measuring enough but the parsimony required to make the veteran and care provider response burden reasonable. The conclusion seems inescapable that there are far too many areas and issues to address at once. The approach should incorporate a framework and process to prioritize.

Another theme we heard relates to how we might think about prioritization. There is a need to address overall performance of the system. There is also a need to improve specific programmatic access. There is some consistency we heard that the overall performance should really be assessed by veteran perceptions of access to care, perhaps with a very limited set of actual care measures as well, although there is a risk of worsening appropriate access in using actual measures, particularly if these are used for incentives or overall performance grades.

There was also some consistency that access measurement for improvement should be more locally driven in specific populations or settings. This recognition that access assessment has these two different goals—global assessment and specific programmatic improvement—is fundamental to how priorities are set, who is setting priorities, and where priorities are set. Developing this prioritization framework in how access is conceptualized and measured may ultimately be more important than the development of the measures themselves. Some balance of impact, speed, and difficulty of implementation will be important to understand. It may be worth

considering whether the characteristics of the framework might be further specified to identify how much can be done at any one time and then back into what's done at any point in time.

The VA has often used programmatic improvement approaches based on pilot approaches and then spreading those pilots if successful. This not only makes sense but underscores the need to separate global assessments from specific programmatic improvement efforts. It is important to integrate all stakeholders in this construct, the two purposes–overall assessment and programmatic improvement, and particularly to secure the voice of veterans themselves or their advocates in this process. The veteran voice will be key in engaging all stakeholders in the framework, the overall program assessment approach, as well as in specific program improvement goals. The veteran voice will help in the design of specific program interventions and to align care providers. (A key characteristic we heard to capitalize on the provider passion and minimize unintended complex system consequences from specific interventions). One could envision an overall process where multiple specific programmatic initiatives are developed, spread, and ultimately impact on improving the overall assessments essentially achieved one veteran at a time with personalized patient-centered care.

There was discussion about specific programmatic capabilities where the VA excels and is the recognized leader in this country, if not across the world. The spinal cord injury programs and post-traumatic stress disorder (PTSD) programs are examples. Why not focus on improving the best programs still further and using that experience to improve access everywhere? A rising tide raises all boats is a clear winning strategy in quality improvement generally, and probably applies here as well. The most rapid improvements across systems occur by focusing on and improving the best, not by raising the worst performers to the next level.

We heard a number of examples of novel specific interventions. What struck me was how powerful these improvement stories were, and how they were always in specific programmatic interventions. This would be another approach to going with the winning strategy—specific interventions in specific populations as opposed to focusing on specific VA programs. In other examples, we heard about special VA populations. Access issues could also be considered for those populations with established or developing programs, e.g., complex patients, blinded veterans, women, or populations with specific equity concerns.

We heard great examples around expanding access capacity. These are best understood within the specific programmatic improvement although many lessons learned will be extendable to other areas. Understanding how to incorporate preferences in one area will likely apply to others as well. I particularly liked the supply/demand constructs because they naturally lead towards mathematically prioritized objective improvement interventions.

In summary, the voice of the veteran is key and has to be the foundation around improving access to the right resource, getting buy-in to separating overall VA access assessment

versus a specific programmatic improvement framework, and in identifying a prioritization framework and strategies.

Key components of improving access are recognizing and improving access to the right resource at the right time provided in the right way. I could imagine a system analogous to help desk technologies—with initial call triage and subsequent different level escalation and hand-offs depending on issues. I can imagine virtual or real assistants that culturally match the desired need of the veteran initiating the contact. I can imagine an artificial intelligence (AI) driven continuously improving system that engages the veteran directly into the scheduling process through a web site or visually-impaired-friendly kiosk, where the veteran answers a few questions and either goes immediately to schedule a visit or the request is escalated—just like sophisticated call centers—ultimately perhaps to a primary care or specialty care provider or both to determine the right resource, how it should be provided, the timing and even might itself end up being a telehealth visit if urgent. This kind of system combines access with urgent improvement strategies. The performance of the system against these recommendations determines actual performance and overall perceived appropriateness and timing is also assessed. I could then imagine how the disposition after the physician visit includes the traditional diagnosis evaluations and prescription but also the next visit follow up time, explicitly identified continuity and integration requirements, and veteran and clinician assessment of the experience so that the access performance assessment is directly integrated into the care delivery process. Integration of other data about the system or context and the individual patient could provide the data inputs to enable AI analytics to continuously improve the system around scheduling, key question identification and responses, and also integration and continuity issues to better anticipate and improve needs and the planning and matching of resource supply with demand needs.

Ultimately, access is an integral feature of the care delivery system, and the separation of access from other important system elements is arbitrary, although perhaps required for improvement design. There is no current system like this anywhere in the world and the lessons learned in the VA system would be broadly applicable. In the final analysis, such a system is what our veterans have earned, and what we all want for ourselves and families.

Thank you.