INTRODUCTION

Improving Access to VA Care

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The United States Secretary for Veterans Affairs (VA), Eric Shinseki, has made improving access to care one of his three main priorities. To support the Secretary's access initiatives, the VA Health Services Research and Development Service (HSR&D) convened a State-of-the-Art conference (SOTA) in September 2010 on "Improving Access to VA Care". The objective of the SOTA conference was to identify what we know and what we need to know about the determinants of access and the impact of access on utilization, quality and outcomes. Conference attendees comprised an interdisciplinary group of VA and non-VA investigators and policy makers with expertise in telemedicine, informatics, economics, rural health, women's health, race/ethnic disparities, clinical leadership, and VA operations. This panel of 75 national experts explored five topics related to access: 1. Defining access and constructs; 2. Identifying access issues for special populations; 3. Impact of access on utilization, quality, outcomes, and satisfaction; 4. Impact of policy and organization of care on access; and 5. Adoption and implementation of IT. Each workgroup presented their policy and research recommendations in a plenary session and their recommendations were discussed by a panel of VA leaders. The manuscripts in this supplement include both the white papers commissioned as background for the SOTA conference and manuscripts submitted in response to a post SOTA open solicitation for original research and reviews pertaining to improving access to VA care.

The first three articles focus on how eHealth technologies can improve access to services for veterans. VA's capitated reimbursement environment has facilitated the widespread adoption of many eHealth technologies and VA has become a national leader in this area. The article by Jackson et al. describes eHealth technologies that are currently being used in VA. Hogan et al. make specific recommendations about how two eHealth technologies (e.g., Care Coordination Home Telehealth program and My HealtheVet personal health record) could be used more synergistically to optimize outcomes. The article by Kvedar et al. describes the potential use of emerging eHealth technologies that could be used to further improve access and the challenges to their implementation and adoption. With future payment reform, there may be financial incentives for providers to embrace eHealth technologies even more quickly. However, a

concern raised in several of the articles is the potential growing digital divide in which some segments of the population may not gain access to eHealth technologies. Several of the articles raise concerns about the unintended consequences of eHealth technology adoption, such as overloading providers with digital communications from their patients.

As the US healthcare system continues to evolve and undergo what is perhaps the largest change in how care is provided since the creation of Medicare, the concept of "access" needs to evolve beyond the seminal framework put forth by Aday and Anderson in 1974. Since that time, considerable changes have occurred in how healthcare is delivered, thus requiring a "re-conceptualization" of access. The article by Fortney et al. presents a re-conceptualization of access that specifically accounts for the digital connectivity that enables synchronous and asynchronous communications between patients and providers. Another key issue raised in this article is the need to measure access both objectively and subjectively, as is done in the next article by Buzza et al. Interestingly, they find that while the rural veterans in their sample face very long travel distances, when measured objectively, there was wide variation in how Veterans perceived this barrier, which depended on their personal and clinical context. Importantly, Buzza et al. also stated that travel was the most commonly reported barrier for rural veterans. The article by Washington et al. reports on measures of access among a national probability sample of female veterans. For female veterans, they found that financial access (i.e., lack of health insurance, lack of perceived affordability) is the most important barrier to attaining needed care in a timely manner.

Another important issue raised in the re-conceptualization of access article by Fortney et al. was the importance of measuring the impact of access on utilization, quality, and outcomes. The articles by Kramer et al. and Mayank et al. examine the issue of dual system use among veterans eligible for both VA and the Indian Health Service and those eligible for both VA and Medicare, respectively. Pizer et al. examined the effect of appointment wait times on downstream outcomes. With universal healthcare coverage, wait times are likely to increase substantially in the future, and the VA healthcare system has comprehensive wait time performance data with which to examine the potential consequences. Pizer's review of the literature suggests that veterans receiving care in facilities with longer wait times have moderately worse clinical outcomes including higher hemoglobin A1C levels, acute myocardial infarction, hospitalizations for an ambulatory care sensitive

condition, and all cause mortality. These findings indicate that wait times should be closely monitored during the transition to universal healthcare coverage. The article by O'Toole et al. examines the impact of using the Patient Centered Medical Home (PCMH) model to improve access and outcomes among vulnerable populations. VA has been an early adopter of the PCMH model (known as Patient Aligned Care Teams or PACT in VA) and this is the first published study to examine how this model of care increases access to care (e.g., open access clinics, telephone based encounters, co-location of mental health and primary care services), and the impact of increased access on downstream outcomes. Results indicated that veterans receiving care in the PACT model experienced a substantial increase in the number of primary care encounters and substantial decreases in elevated blood pressure and hemoglobin A1C readings. These early results support the continued implementation of the PCMH model.

Finally, Kehle et al. performed a systematic review of interventions to improve Veteran's access to care. Of 16 studies identified, only four reported clinical outcomes and only one demonstrated an improvement in health-related quality of life. Both perceived and actual access were improved by opening additional clinics, co-location of primary care and mental health, and adoption of telehealth. The conclusion was that organizational and structural interventions can improve access, yet the impact on clinical outcomes is limited.

The VA healthcare system employs an assortment of e-health technologies that promote patient-provider digital communications outside the context of a traditional face-to-face clinical encounter. These 21st century innovations to improving access have tremendous potential, yet may also have possible unintended consequences. VA is also embracing the PCMH model with its emphasis on enhanced patient access through digital and other channels of communication. As a national fully integrated healthcare system, VA has the potential to transform into an exemplar for how to deliver continuous and coordinated health care in the digital age. Common barriers to care such as travel distance, cost, and wait time could potentially be addressed through the proactive use of non-encounter-based digital communications between veterans and their care teams. The articles in this supplement provide a solid foundation upon which to build policies and research programs to support this vision.

Disclaimer: The views expressed in this paper are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs.

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