MISSION 401: Specialty Care Underserved Models

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QUERI VA Quality Enhancement Research Initiative
EVIDENCE INTO PRACTICE

Bottom Line Up Front

- Section 401 of the MISSION Act requires VA to identify and mitigate underservedness nationwide

- Underservedness – an imbalance between Veteran demand for care and VA supply of care
- Underserved score – *adjusted, predicted* new patient wait time

- Developed and implemented a *primary care* underserved model in FY18
- Expanding a similar methodology to *specialty care*

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MISSION 401

- "Development of criteria for designation of certain medical facilities of the Department of Veterans Affairs as underserved facilities and plan to address problem of underserved facilities."

- Must measure and report underservedness at least once a year
- Must measure and report underservedness in primary care, specialty care, mental health care

- Consideration of certain variables are required by law
  - Veteran to provider ratio, range of specialties provided, wait times, local community underservedness

Policy Implications

- Models updated each year based on lessons learned, feedback from stakeholders
- Underserved rankings finalized once a year (Oct/Nov)
- Facilities at top of lists required to submit action plans to OVAC (Dec/Jan)
- Facilities at top of lists reported to Congress (June)
- OVAC works with facilities to implement action plans and mitigate underservedness with mixture of national and local resources

Primary Care Example (FY21)

VARIABLE	NON-NUMERICAL WEIGHT
Time-varying characteristics	
1. *Efficiency (Physicians/APPs)	- HIGH
2. Clinic Capacity (Physicians/APPs)	- HIGH
3. Medicare Advantage Penetration	- HIGH
4. Percent of Est Patient Appts Scheduled > 90 Days	+ HIGH
5. Number of CC Visits	- MED
6. Household Median Income	- MED
7. Percent Private Insurance (Males 18-64)	+ MED
8. Percent of Enrollees Priority 7/8	- MED
9. Clinic Capacity (non-Physicians/non-APPs)	- MED
10. Number of Enrollees	- MED
11. Percent of Enrollees 65 or Older	- MED
12. Unemployment Rate	- MED
13. Nosos Risk Score	- MED
14. PC Healthcare Primary Shortage Area	- LOW
15. PACT Panel Size	+ LOW
16. Zillow House Price Index	- LOW
17. Average Drive Time to PC	- LOW
18. PACT Return Visit Rate	+ LOW
Fixed facility characteristics	
19. Mental health program complexity	- LOW
20. ICU/surgical program complexity	- LOW
21. Complex clinical program complexity	- LOW

STATION NAME
(1V06) (590) Hampton, VA HCS
(1V01) (608) Manchester, NH HCS
(1V01) (405) White River Junction, VT HCS
(4V19) (666) Sheridan, WY HCS
(3V15) (657A4) Poplar Bluff, MO HCS

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Primary Care Example (FY21)

Underserved List

STATION NAME
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Action Planning

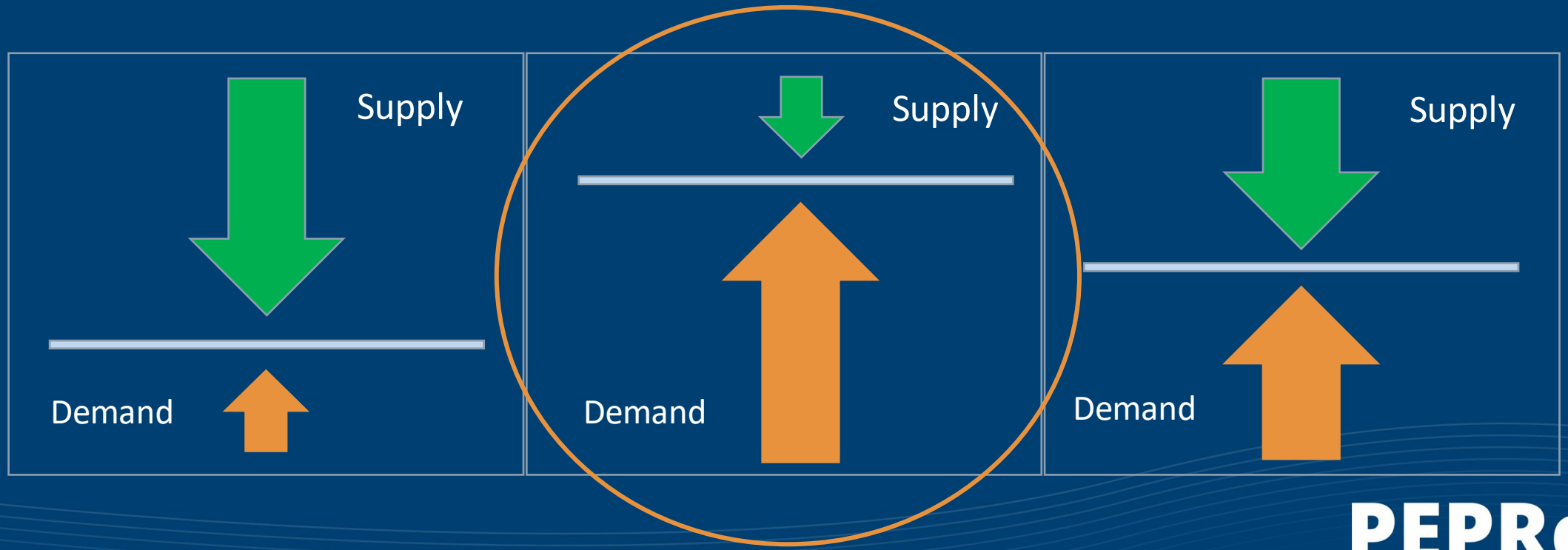
- Top underserved facilities write action plans
- OVAC submits annual report to Congress

Evaluation

- Feedback from the stakeholders
- Changes in underservedness due to action plans
- Dissemination of findings

Supply and Demand

- We use the economic principles of supply and demand to measure underservedness.
  - **Supply** – the amount of care a VA facility can provide
  - **Demand** – the amount of care requested from the Veteran population



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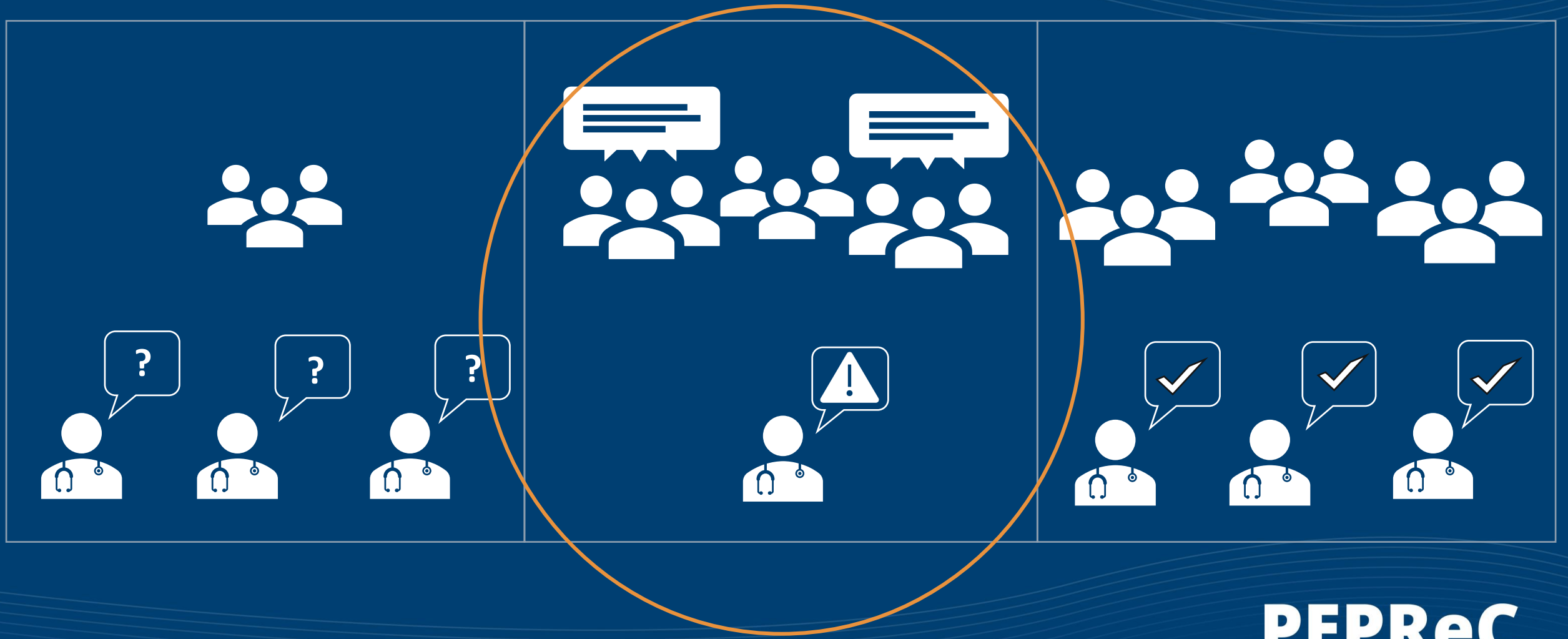
Supply and Demand



Hydroelectric Model of VHA Care

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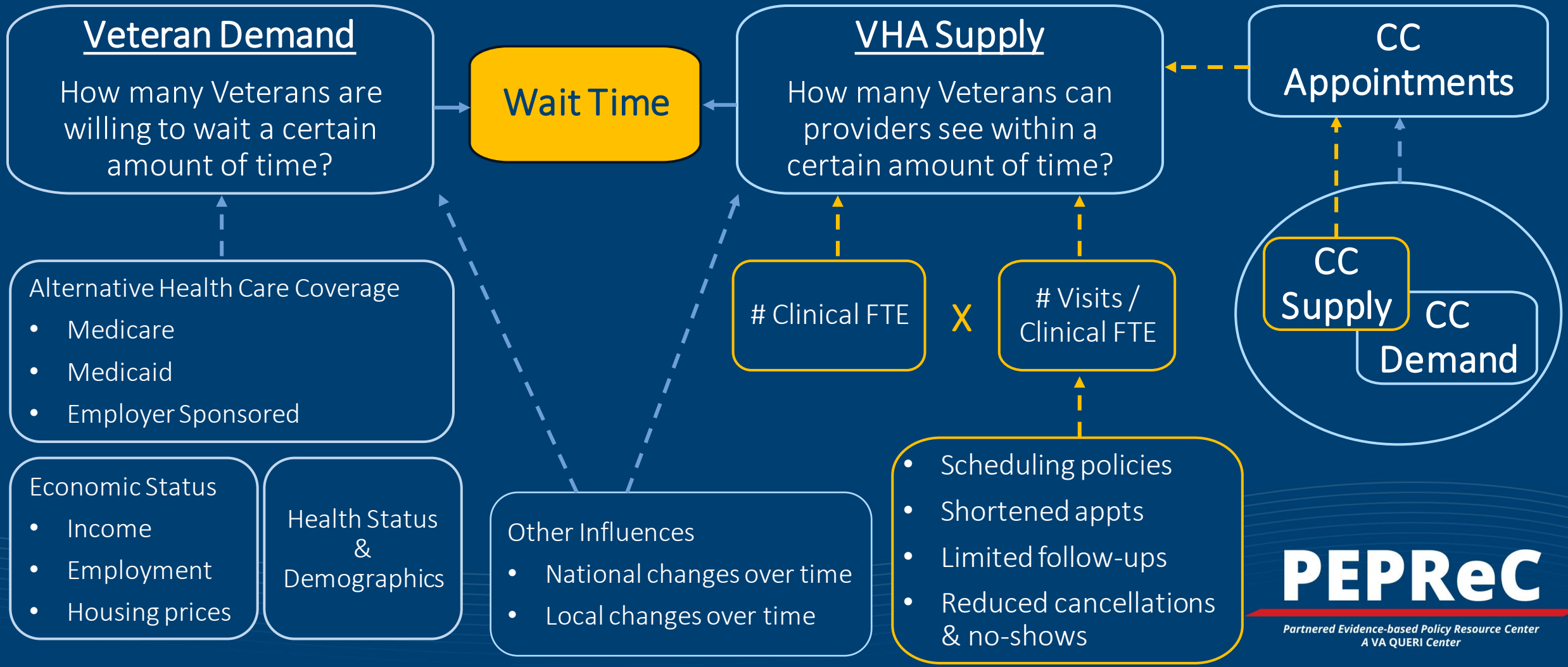
Conceptual Model of Wait Times



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Important Concepts

Access to Care

Clinic Time

Clinical Work Rate

Scheduling Practices

Community Care

Demand Factors

Access to Care

Concept

- How long do Veterans have to wait to access specialty care services?
- Which wait time measures best represent access to care?

Metrics

- New patient wait times
- Consult wait times
- First/Third next available appointment

Clinic Time

Concept

- What resources does a clinic have to meet Veteran demand for care?

Metrics

- Full Time Equivalents (FTEs)
- Observed clinic time
  - Include virtual care
- Clinical staff members
  - Physicians/APP/primary providers
  - Other clinic staff

Clinical Work Rate

Concept

- How well does a clinic use its existing (and limited) resources to meet Veteran demand for care?
- How do the trade-offs in provider workload responsibilities impact access to care?

Metrics

$$\textbf{\textit{Clinical Work Rate}} = \frac{clinic\ production}{clinic\ time}$$

- RVUs per FTE
- Total encounters per clinic day
  - Focus on scheduled workload
- Unique patients per clinic day
  - Incorporate unscheduled work

Scheduling Practices

Concept

- How are scheduling practices associated with new patient access?
- What are current VA scheduling policy priorities?

Metrics

- Return visit rate
- New/established patient ratio
- Rate of advanced scheduling
  - Established patients scheduled greater than 90 days in advance

Community Care

Concept

- What factors influence whether an eligible Veteran utilizes a community care provider?
- How many community care appts are purchased for Veterans at a facility?
- What portion of community care utilization may feasibly be recovered?

Metrics

- Total number of CC visits
- Unique number of Veterans who use CC
- Amount paid on CC claims
- Identify subset of CC utilization that impacts access to care

Demand Factors

Concept

- What factors influence Veteran reliance on VA care?
- What influences how much VA care Veterans request?

Metrics

- Size and health status of Veteran enrollee population
- Veteran enrollee demographics and socioeconomic status
- Alternative health care coverage
  - Medicare, Medicaid, employer-sponsored
- Community factors
  - Rurality, availability of alternative health care providers, house prices

Model Overview

Supply variables

Management levers:

- Clinic time
- Clinical work rate
- Established patient appts scheduled > 90 days out
- Community care visits
- Return visit rate

Demand variables

- Alternative health care coverage and availability
- Medicare Advantage penetration rate
- Enrollee priority status
- HCC Medicare Severity
- Size of enrollee population
- Population density
- Enrollee age/demographics
- Enrollee income & employment
- Health provider shortage area (HPSA)
- Housing price index
- Average drive time

Control for unobservable factors that influence access to care

Modeling Considerations

- Specialties currently included in empirical models
  - Cardiology
  - Urology
  - Orthopedics
  - Gastroenterology
- Pooled model v. individual specialty models
- Rural v. urban access

Next steps

- Incorporate your feedback/suggestions

- Models finalized – August 2021
- Underserved scores calculated – October 2021
- Underserved lists sent to Congress – June 2022

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