MISSION 401: Primary Care Underserved Model

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Veterans Health Administration
Office of Research & Development

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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

- We discuss model improvements – adjusted capacity + All Enrollee Survey
- We explore OPC's questions on efficiency + correlation

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 underservedness in primary care, mental health, specialty care

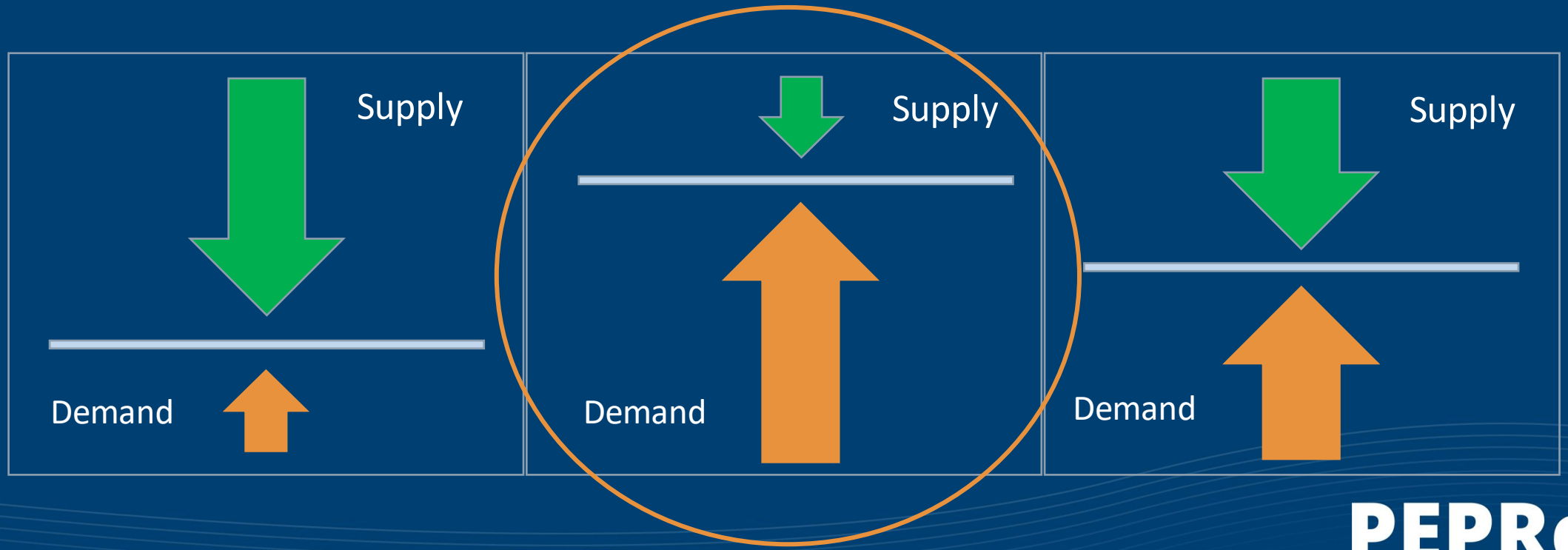
- Must consider certain variables –
  - Veteran to provider ratio, range of specialties provided, wait times, local community underservedness

Policy Implications of Underserved Models

- Underserved models allow us to do so much more than respond to a congressional mandate (MISSION 401). They allow us to –
  - Allocate CRH/MDT resources in an evidence-based way (MISSION 402)
  - Assist OMHSP and CIDMO in mental health clinic operations modeling
  - Assist Dr. Stone and CSO with budget forecasting
  - Provide local leadership with tools to improve access at their facilities (specialty care clinic efficiency pilot)

Supply and Demand

- **Supply** – the amount of care a VA facility can provide
- **Demand** – the amount of care requested from the Veteran population



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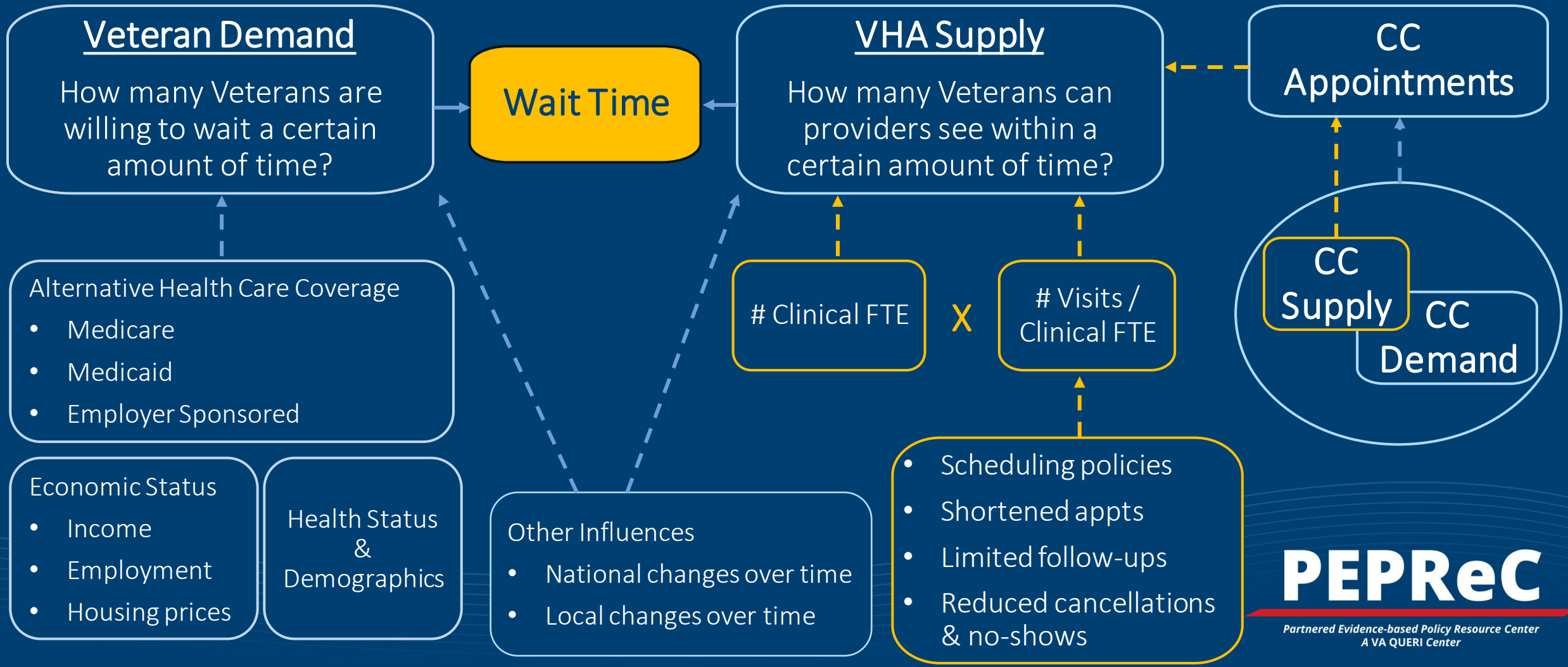
Conceptual Model of Wait Times



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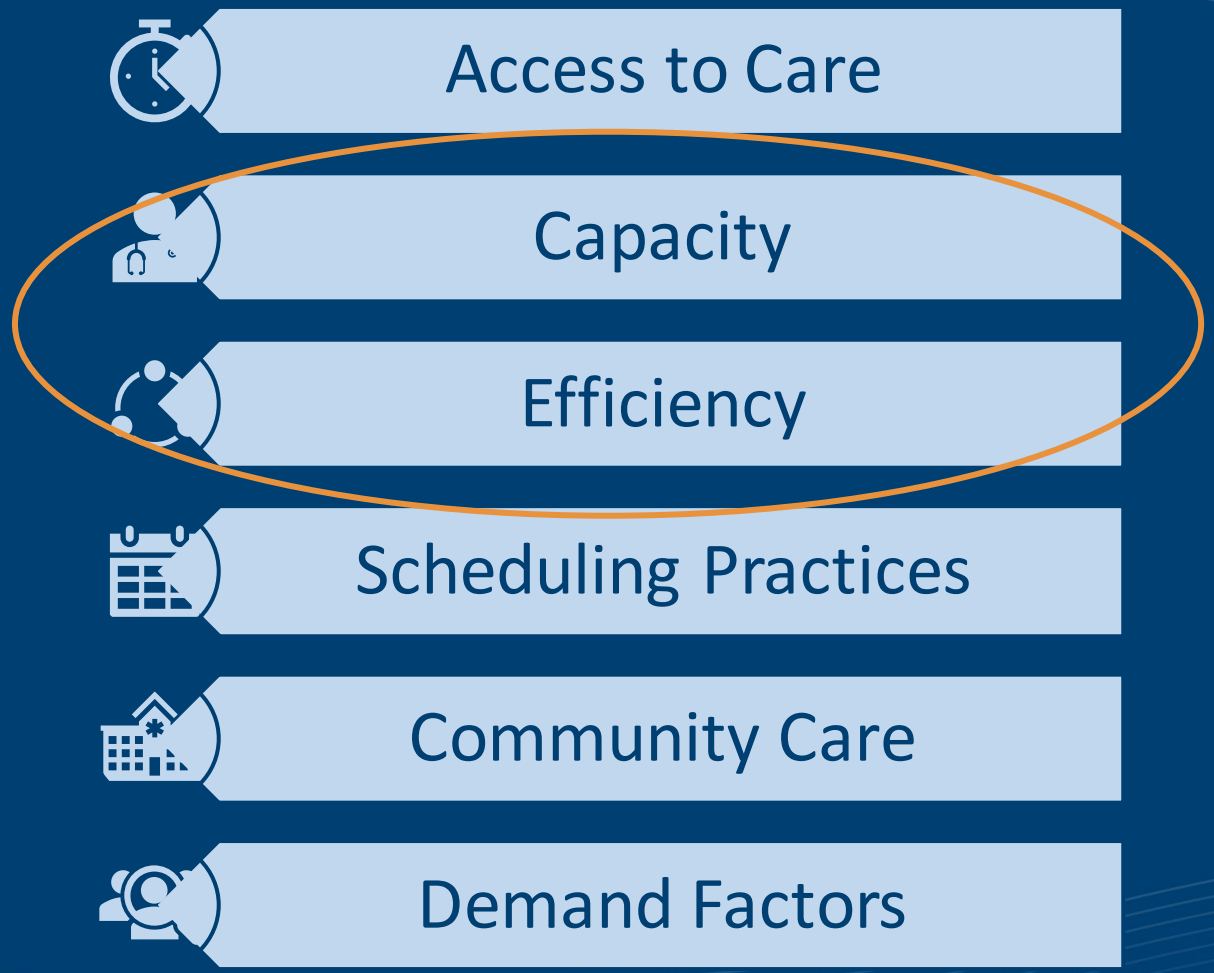
Important Model Concepts



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Capacity

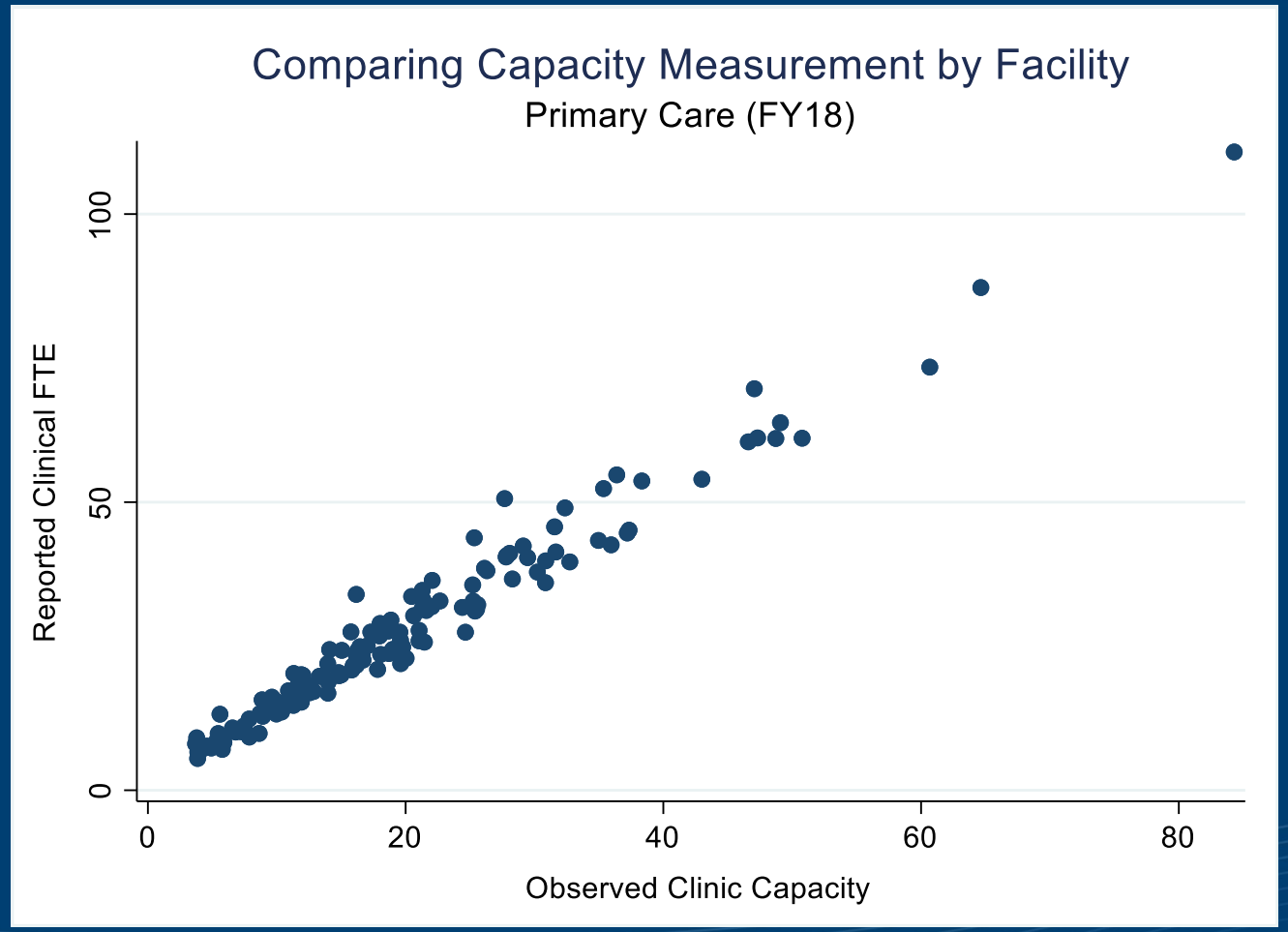
Concept

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

Metrics

- Full Time Equivalents (FTEs)
- Observed clinical time based on workload capture
  - Granular and specific measurement
  - Sensitive to changes over time
- Clinical staff members
  - Physicians/APPs/primary providers
  - Other clinic staff

FTEs v. Observed Clinic Time



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Efficiency

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

$$\textbf{\textit{Clinic efficiency}} = \frac{clinic\ production}{clinic\ capacity}$$

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

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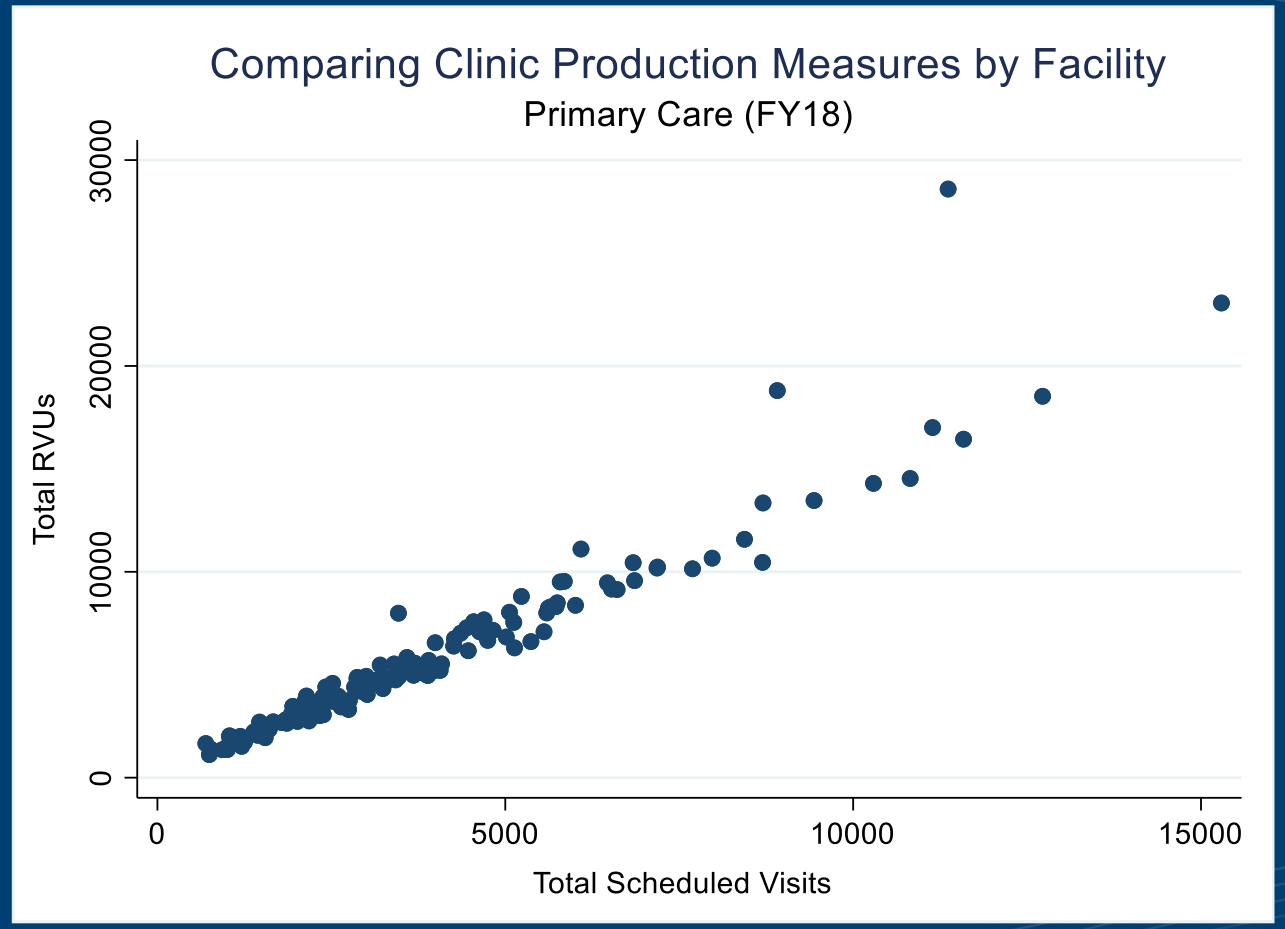
RVUs v. Total Encounters



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Variable List (June 2022 CMR)

Supply Variables

- Clinic capacity per enrollee (physicians/APPs)
- Clinic capacity per enrollee (other staff)
- Clinic efficiency (physicians/APPs)
- Established patient scheduling
- Community care visit volume
- PACT panel size
- Return visit rate
- MH, ICU/surg, complex clinical program complexity

Demand Variables

- Alternative health care coverage and availability
- MA community penetration rate
- Medicare Advantage penetration rate
- Enrollee age/demographics
- Enrollee income & employment
- Enrollee priority status
- HCC Medicare Severity
- HPSA score
- Housing price index
- Rurality (drive time & population density)

Improvements (June 2022 CMR)

- **Adjusted capacity – capacity per enrollee**
  - Combined capacity and # of enrollees as one variable
  - Structural change, both ways are statistically sound
  - Ensures smaller facilities aren't penalized unfairly

- **All Enrollee Survey – demand variables**
  - More granular look at enrolled Veteran demographics and socioeconomic status
  - More recent data

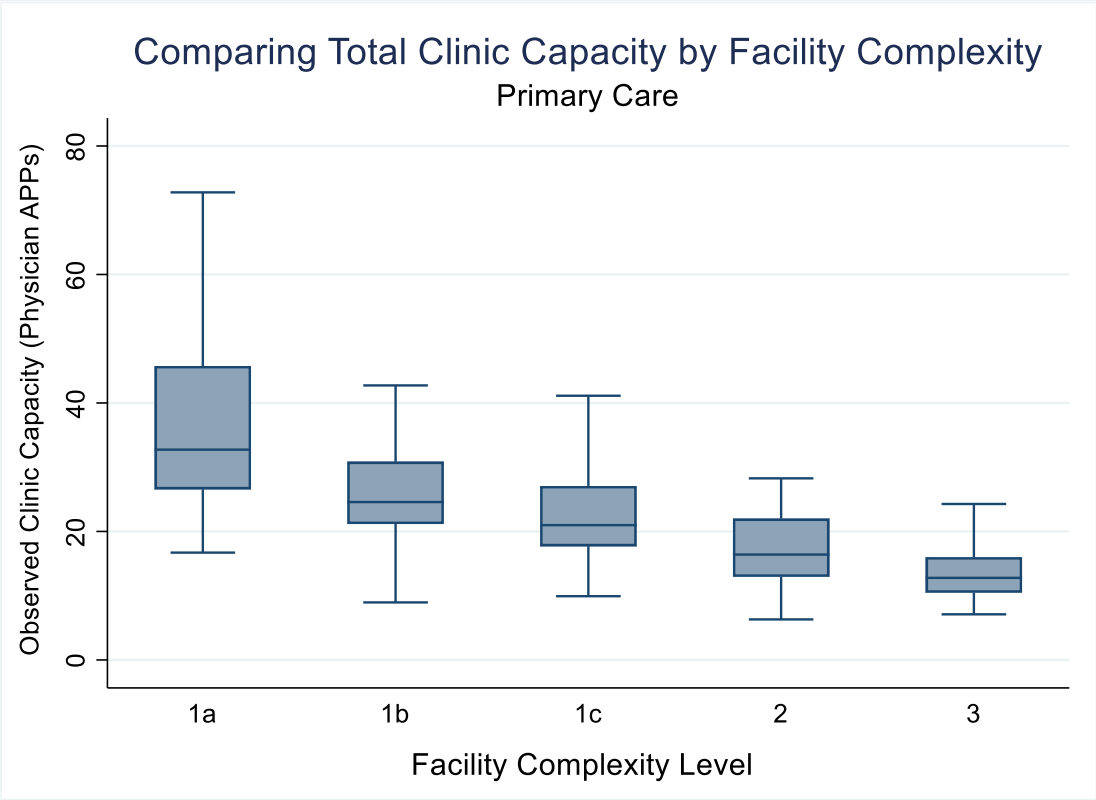
OPC Questions

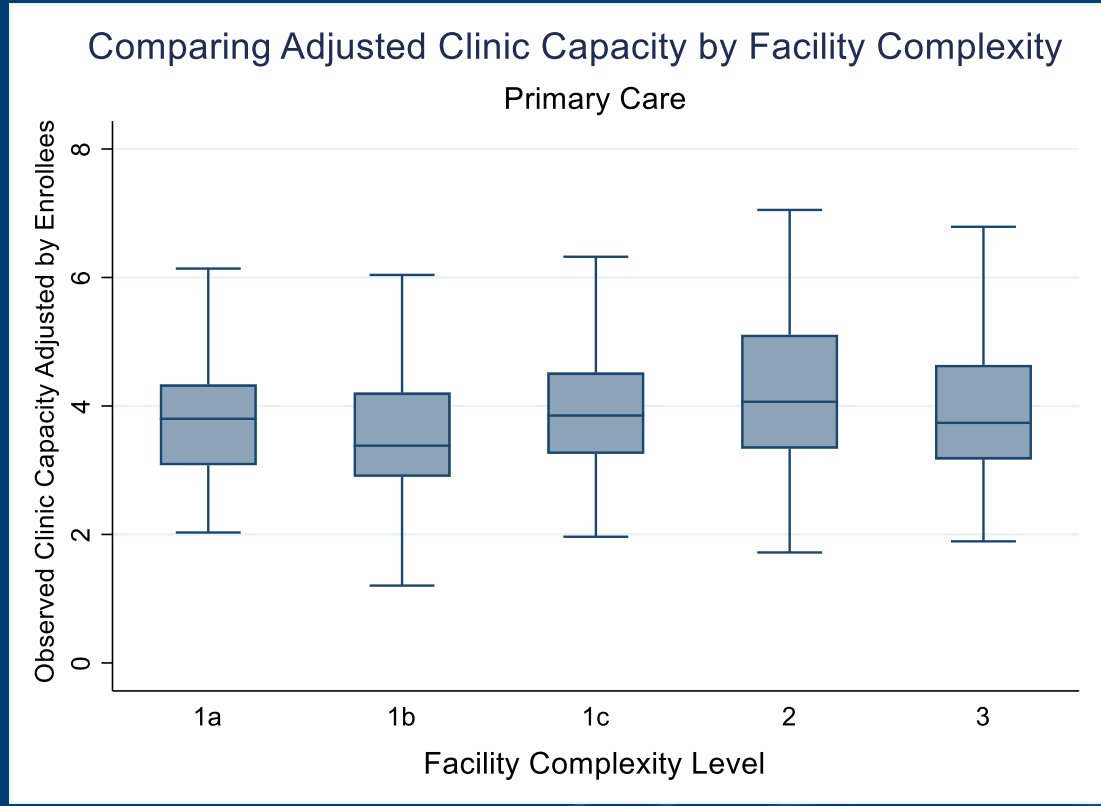
1. **Compare PEPReC's capacity & efficiency metrics at various types of facilities**

2. Compare PEPReC's efficiency metric to more traditional metrics

3. Compare underserved scores to established access metrics

Question 1





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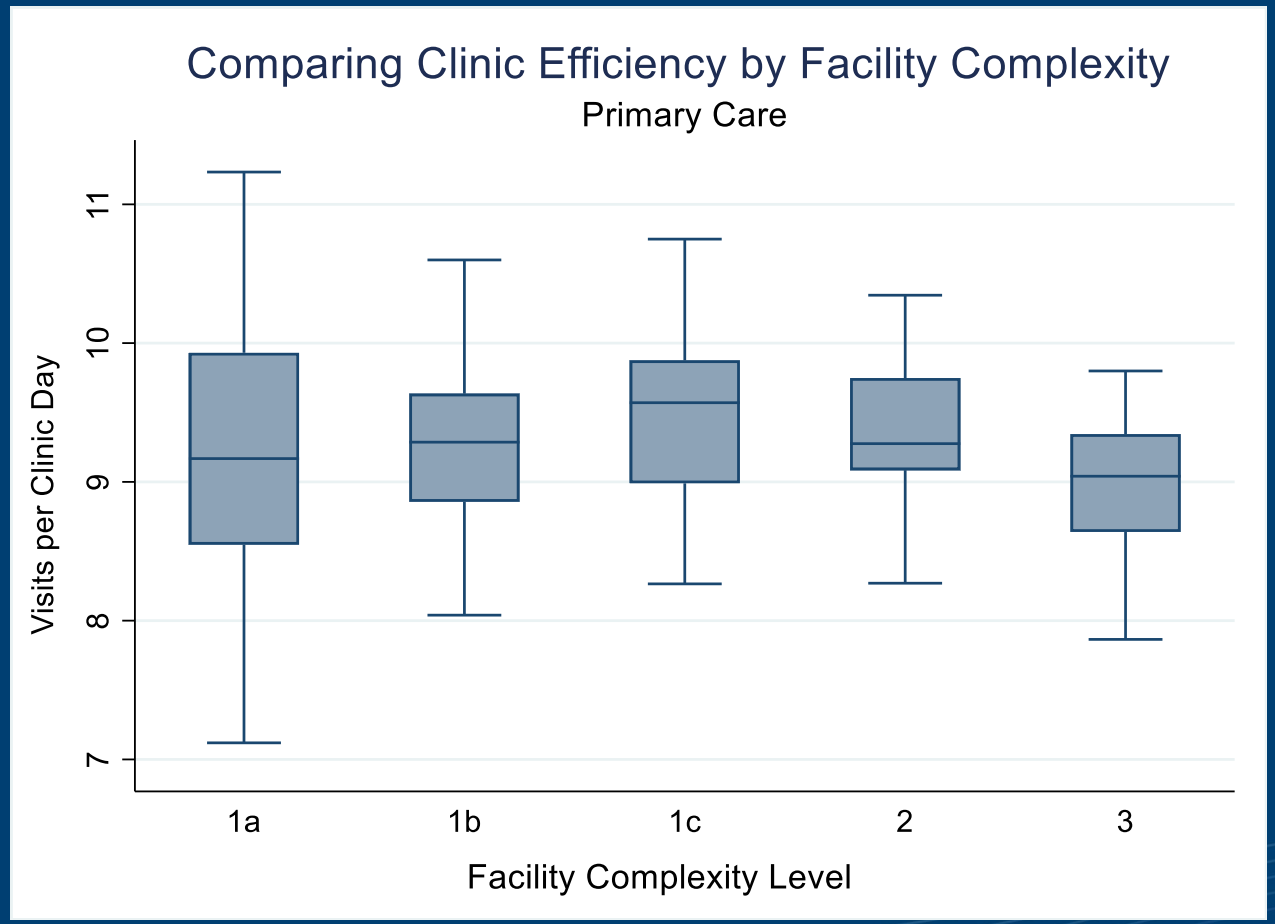
Question 1



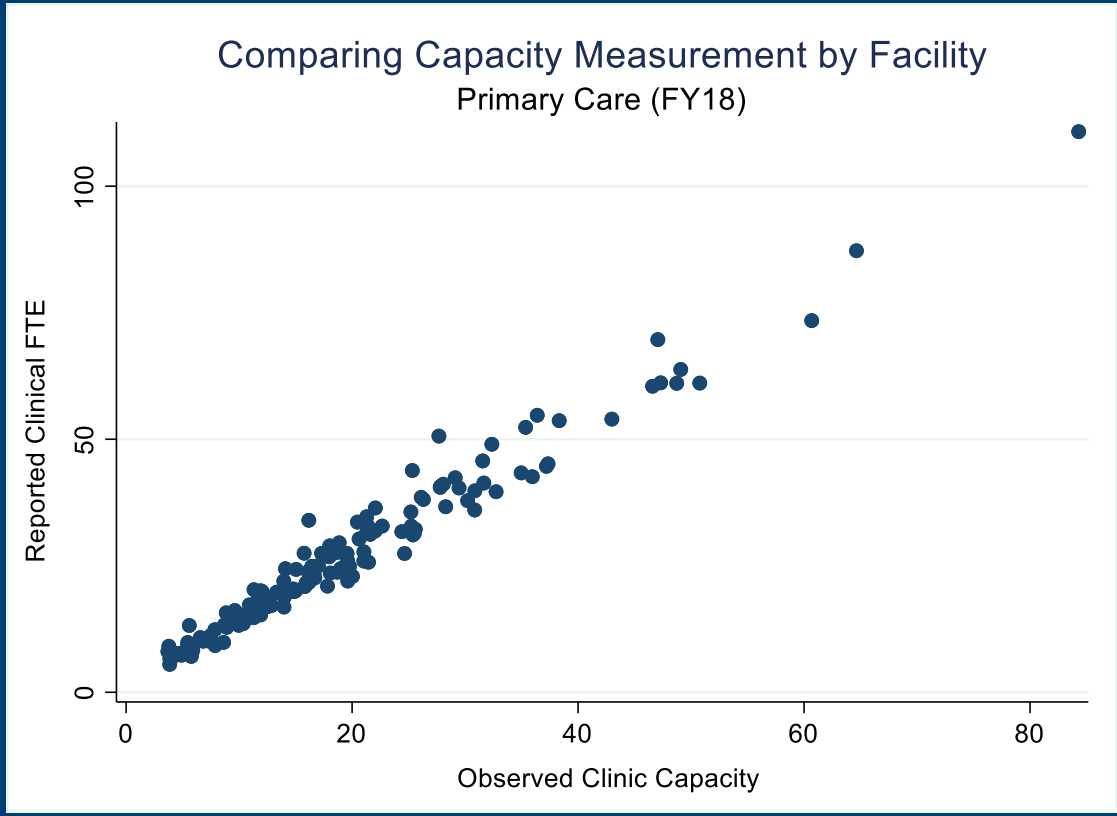
Question 1 – Summary

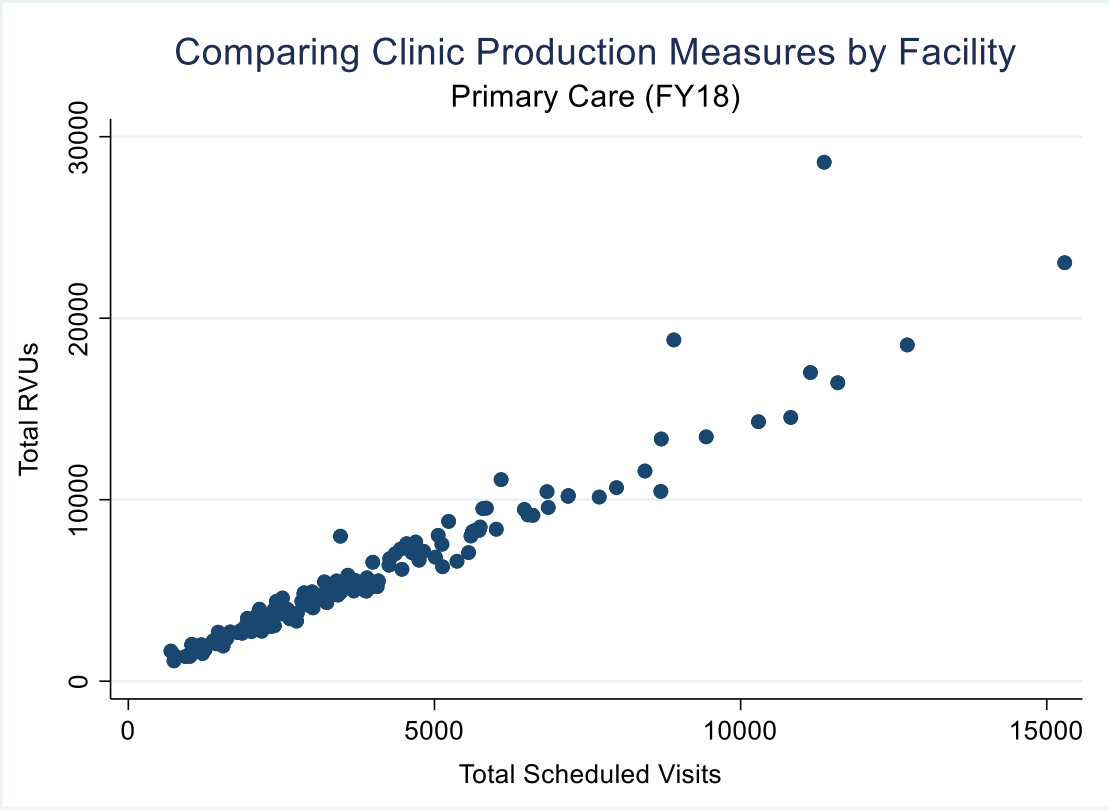
- When adjusted for enrollees, PEPReC's capacity and efficiency metrics are fair and respond similarly in the model at all types of VHA facilities

OPC Questions

1. Compare PEPReC's efficiency metric at various types of facilities
2. **Compare PEPReC's efficiency metric to more traditional metrics**
3. Compare underserved scores to established access metrics

Question 2





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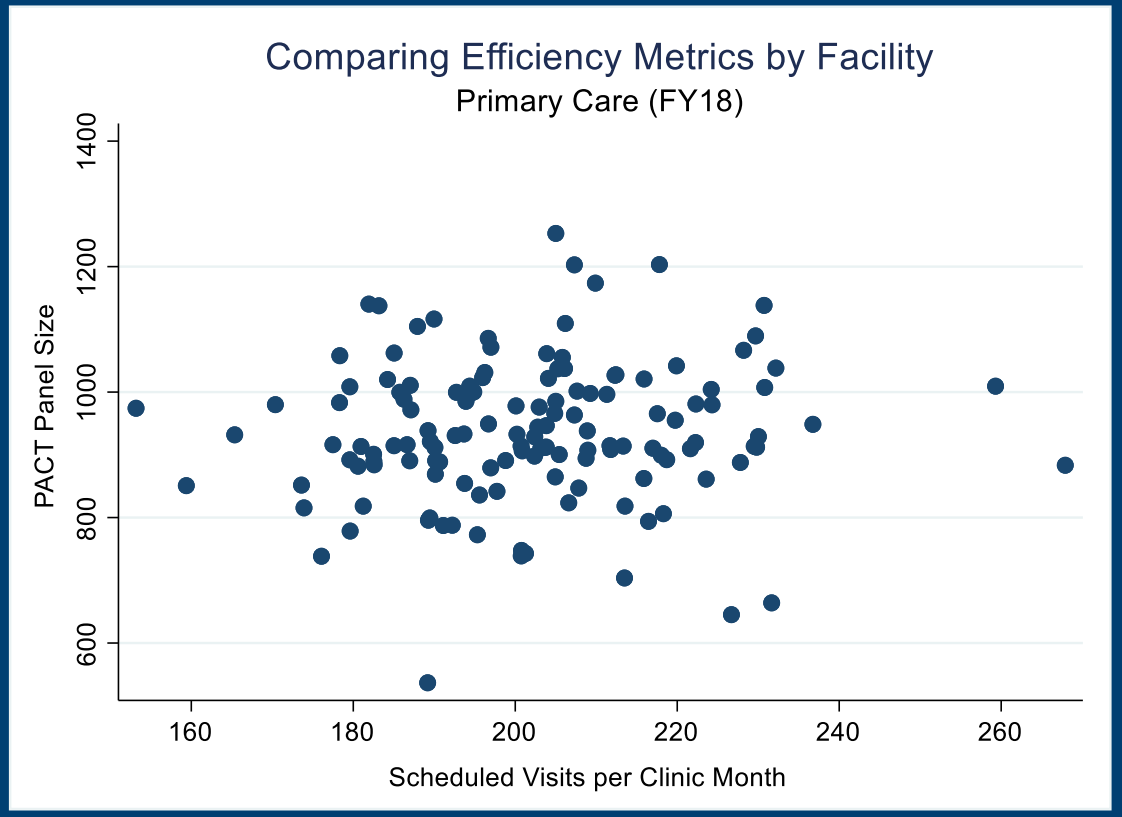
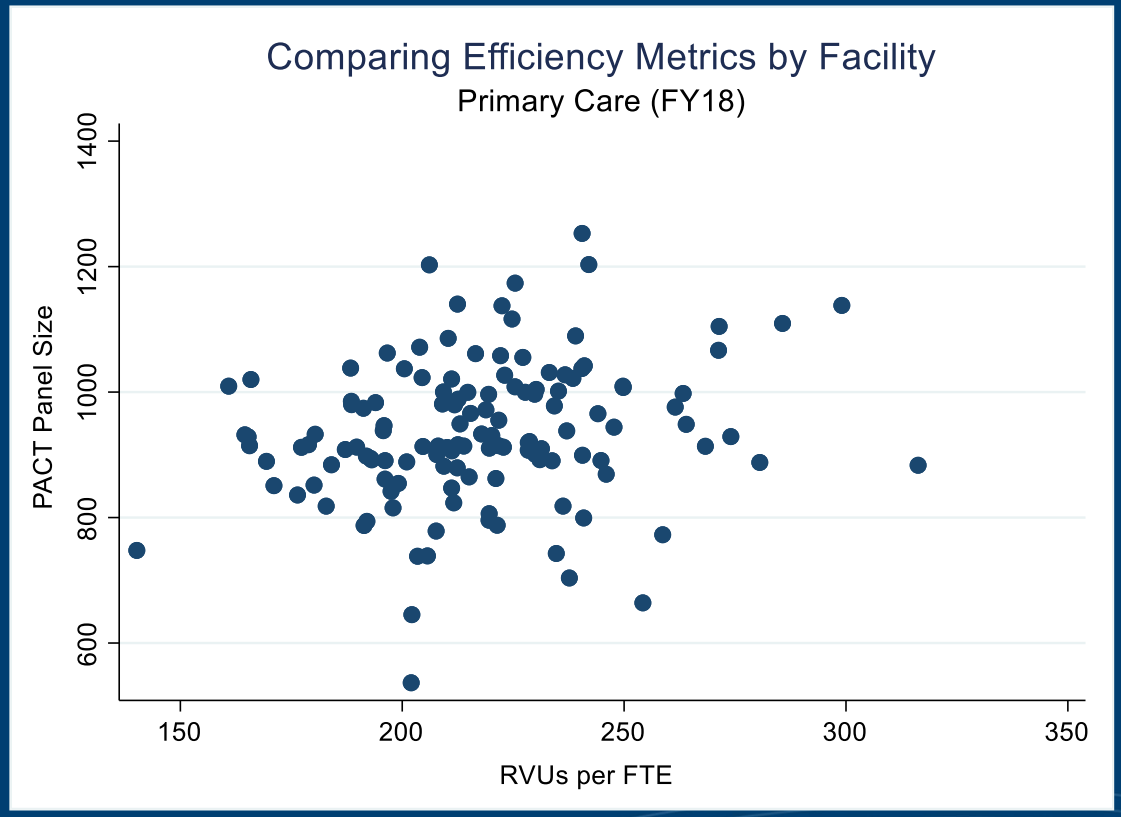
Question 2





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Question 2 – Summary

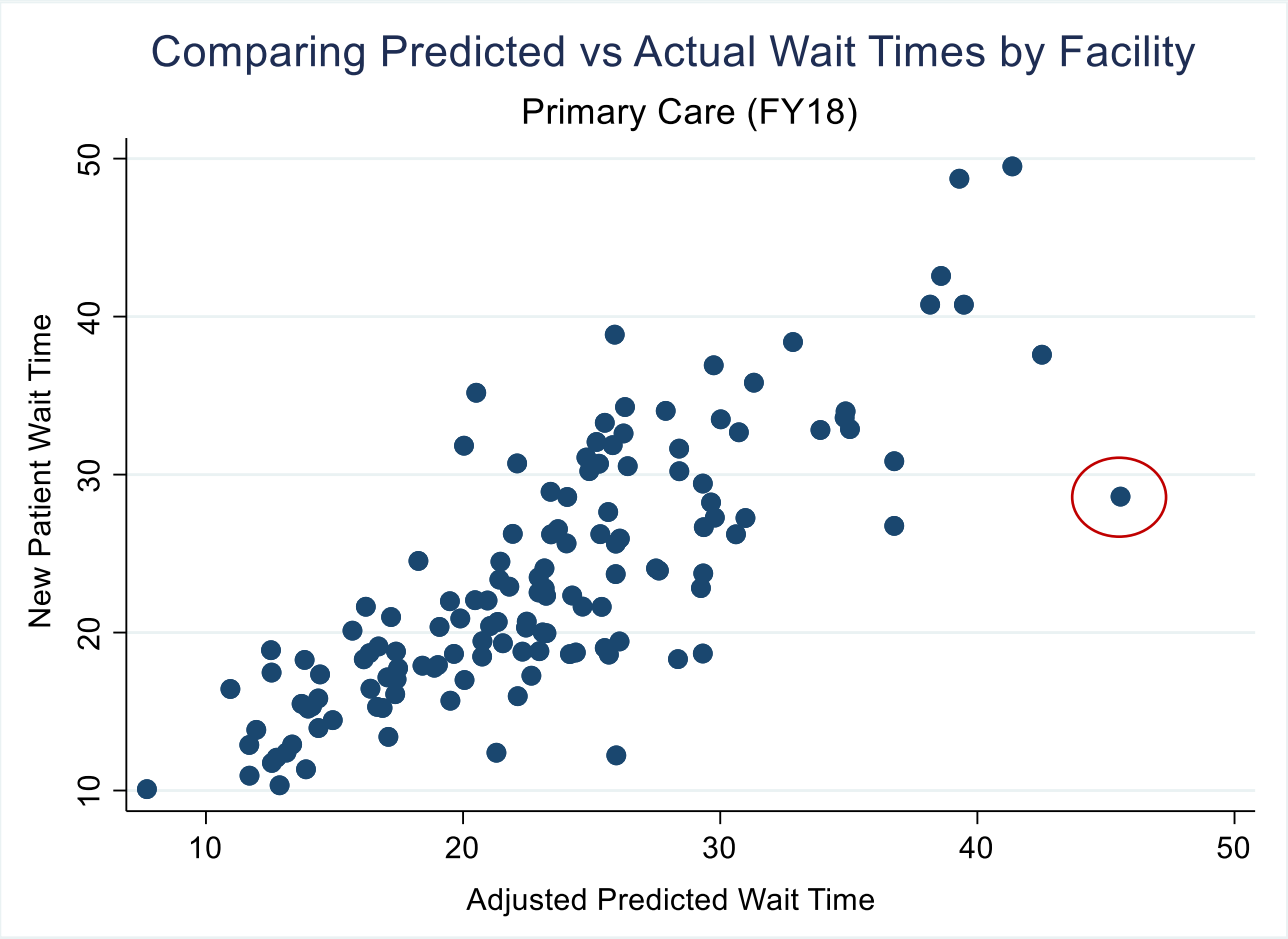
- PEPReC's efficiency metric incorporates clinic capacity and clinic workload
  - PEPReC's clinic capacity metric correlates well with FTEs
  - PEPReC's clinic workload metric correlates well with RVUs

- PACT panel size is a population health metric; PEPReC's efficiency metric assesses clinic function and is an important mediator of access to care
  - Both are important and should be considered by national and local leadership

OPC Questions

1. Compare PEPReC's efficiency metric at various types of facilities
2. Compare PEPReC's efficiency metric to more traditional metrics
3. **Compare underserved scores to established access metrics**

Question 3



- The primary care underserved scored is an **adjusted predicted wait time** measure
  - **Adjusted** based on the observed relationship between each factor and new patient wait times
  - **Predicted** using most recent data available
- Correlation is strong between predicted and actual wait times, with some exceptions

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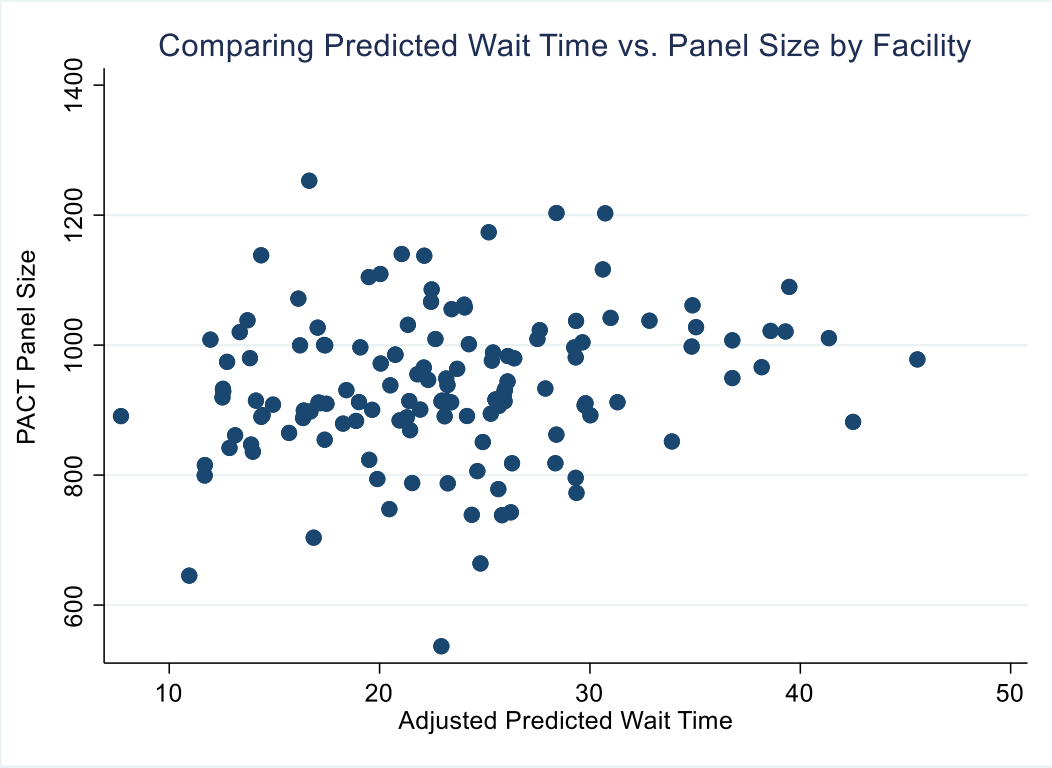
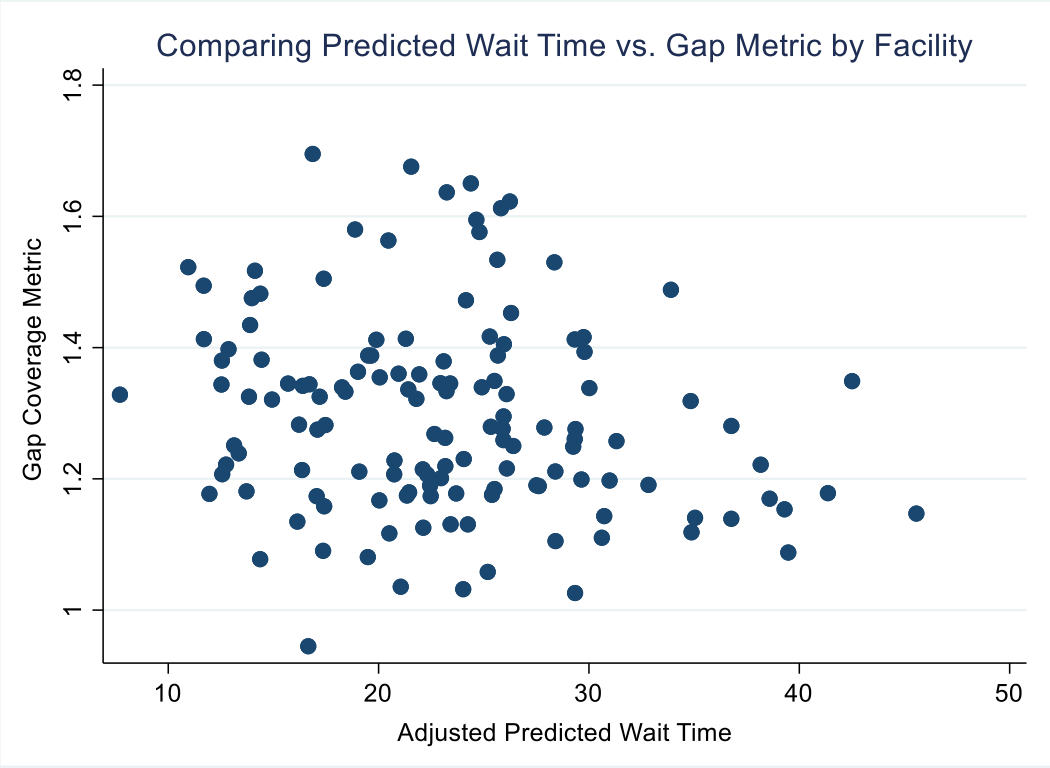
Question 3





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Question 3 – Summary

- Adjusted, predicted wait times correlate well with actual NPCD wait times
- PACT panel size and the gap coverage metric are population health metrics; do not correlate well with wait times or underserved score
- Underserved scores are multifaceted and provide an evidence-based assessment of access to care within a supply & demand conceptual framework

Next Steps

- Incorporate new OPC feedback
- Schedule follow up discussion to finalize this year's model

- Next run – **November 2021** for June 2022 CMR

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