**STATEMENT OF**

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**BEFORE THE**

**COMMITTEE ON VETERANS' AFFAIRS,**

**U.S. HOUSE OF REPRESENTATIVES**

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Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity to appear before you today to comment about assessing and tracking wait times and timely access to care and the evolving nature of what access to care means in a world that is increasingly connected by advanced communications and information technology. Thank you also for asking me to offer some thoughts about steps that the Department of Veterans Affairs (VA) might take to improve the transparency and availability of its wait time data to assist veterans make informed choices about where to receive care.

My comments to you today are informed by my prior experience in multiple different professional capacities in which assessing access to care was an important part of my duties. Among others, these roles have included serving as:

- A physician in military, private practice and academic health care settings;
- California's top health official where my responsibilities included managing the nation's largest Medicaid program (Medi-Cal), as well as numerous public health programs serving disadvantaged populations;
- VA's Under Secretary for Health for five years in the late 1990s, where I oversaw an internationally acclaimed transformation of VA health care, which included materially improving access to care and decreasing wait times;
- Founding President and CEO of the National Quality Forum, a public-private partnership organization which endorses performance measures that are widely used today by health plans and insurers, health systems and individual health care providers throughout the nation;
- Chief Medical Officer for the California Department of Managed Health Care, where my duties included assessing health plan network adequacy to ensure timely access to care;

- Director of the Institute for Population Health Improvement at the University of California, Davis, where, among other things, I oversaw programs and research studies aimed at improving access to care; and
- A health care consultant to various private and publicly funded health systems seeking to improve access to care, including the Los Angeles County Department of Health Services which manages the second largest publicly funded metropolitan health system in the nation.

## BACKGROUND AND CONTEXT

Assuring timely access to care is widely recognized as an important dimension of high-quality health care and has been a priority throughout American health care for many years. However, consistently achieving timely access to care continues to be a challenge for most health plans, health care providers, patients and families throughout the U.S., as it is in other countries. Wait times for health care vary greatly across the nation, ranging from same day service to waits of many months, depending on the health care provider, the type of service sought, and individual patient factors such as type of health insurance and place of residence.

Except for certain well-defined emergent situations in which time to treatment is definitively linked to care outcomes there are no industrywide standards for timely access to care. Situations in which widely accepted timeliness of care standards exist include time between onset of symptoms and administration of thrombolytic medication in cases myocardial infarction (heart attack) or stroke, the time to surgical treatment in cases of severe trauma, and the time to administration of systemic antibiotics in cases of sepsis. In contrast to these emergency care situations, however, many different sets of timeliness standards are variously used by health plans and health care providers when assessing timeliness of care for primary, specialty, hospital or post-acute care. As a result, numerous different methods are used to assess wait times and access to care, making it difficult to understand and compare the timeliness of care across health systems and among individual providers. Further compounding this, information about wait times for private health care providers are not routinely made publicly available.

A good review of the many different methods used for measuring and tracking the timeliness of care is provided in the Institute of Medicine's 2015 report on patient scheduling and access.[1] Of note, this study was commissioned by the VA.

The problems related to long wait times (e.g., poorer health outcomes; patient inconvenience, frustration and dissatisfaction; and increased utilization and costs due to delayed care, among other things) are well known. As Drs. Jaewon Ryu and Thomas Lee succinctly summarized this in an article in the *New England Journal of Medicine* in 2017 when they said, "When patients wait weeks or months for physician's

[1] Institute of Medicine. *Transforming Health Care Scheduling and Access: Getting to Now*. Washington, DC. National Academies Press. 2015.

appointments, bad things happen."[2] Clearly, the goal of all health plans and health systems should be to ensure the timely delivery of care for each patient every time in every setting.

In 2001, in its landmark report *Crossing the Quality Chasm*,[3] the Institute of Medicine identified six defining properties of high-quality health care – that it be safe, effective, patient-centered, efficient, equitable, and timely. Given all that we know about the adverse consequences of untimely or delayed care, it is ironic that of the defining attributes of high-quality health care, timeliness of care is the least-well studied and least-well tracked as a health care performance metric. Forums such as today's hearing are important in focusing greater attention on better understanding and assuring the timeliness of care.

There are multiple reasons for the widespread problems in timely access to care in this country, and much has been written on this subject. Delving into these reasons is beyond the scope of this statement. Suffice it to say that among the patient-related reasons for delayed care, lack of health insurance or the type of a one's health insurance (e.g., Medicaid) continue to be the most common reasons for lack of timely access to care.

From a health system perspective, however, problems in timely access to care are primarily the result of the extreme complexity of American health care and the generally non-systematic approach to the design, implementation and assessment of patient scheduling protocols and scheduling systems and the absence of national performance standards for timeliness of care. The lack of reliable performance standards that can be used to assess and improve health care scheduling is due in significant part to the technical difficulties in reliably capturing all the data variables that go into accurately measuring wait times and the resultant paucity of good data on which to provide care setting-specific guidance on reasonable timeliness for care.

Measuring wait times seems on one level like it should be very straightforward, if not simple; however, in practice it turns out to be extremely complicated. For example, it is very difficult for scheduling systems to capture all the variables that go into patient preference and how one's preference for when he or she would like to be seen may change quickly and repeatedly due to real life circumstances. Likewise, it is very difficult for scheduling systems to capture clinical issues related to the appropriate urgency of being seen by a clinician. The same presenting complaint or reason for seeking care in different people with different histories and circumstances may translate into very different timeliness of care needs.

Notwithstanding what is said above, and despite the many technical challenges, health systems are developing systems-based approaches to improving access, and

[2] Ryu J, Lee TH. The Waiting game – Why Providers May Fail to reduce Wait Times. *N Engl J Med* 2017; 376 (24):2309-2311.

[3] Institute of Medicine. *Crossing the Quality Chasm*. Washington, DC. National Academies Press. 2001.

there are emerging best practices for scheduling and for improving timely access to care. A number of these approaches are highlighted in the previously referenced 2015 report from the IOM. I am hopeful that additional research and validation of some of these promising practices will soon provide the foundation for consensus standards for timely access to care.

Especially important to note in this regard are patient-reported measures of the timeliness of the care. Increasingly, health systems are finding that among the most useful ways to assess whether they are providing timely care is to ask patients to rate their ability to get the appointment they wanted or to report back on how satisfied they were with the length of time it took to schedule an appointment and whether the person scheduling the appointment seemed to care about them as a person and making sure they were seen as quickly as possible. While not as quantitative as wait time measures, patient-reported qualitative measures are very revealing as to how well a health system works.

Given the inherent difficulties is accurately measuring wait times, many health systems are increasingly relying upon patient reported measures for accountability purposes. They are not abandoning measuring wait times but are using wait times data more for quality improvement purposes. That is, they use wait time targets more for quality improvement than accountability.

I think what is clear from the evidence available today is that to measure and track timeliness of care we need to rely on multiple methods of assessment using a balanced mix of quantitative (e.g., wait times) and qualitative (e.g., patient-reported satisfaction) measures and that more attention needs to be focused on specifying setting-specific timeliness of care performance standards.

## THE NEED TO REFRAME OR REDEFINE WHAT ACCESS TO CARE MEANS

In considering the timeliness of care and how accessibility should be measured today, we need to ask a basic question about what access to care means in an era of enhanced connectivity through information and communication technologies. In a time when a large proportion of the population accomplishes many critically important activities (e.g., banking) via the internet, why do we continue to view access to health care only or primarily through a lens of in-person face-to-face visits.

Measuring access to care by only counting face-to-face encounters between the patient and caregiver is anachronistic and does not promote patient-centered care. Indeed, a variety of public opinion surveys indicate that 70 to 80 percent of respondents would welcome the opportunity to accomplish their health care needs through technology-assisted means such as telehealth.

Increasingly, health systems are finding that a large proportion, if not the majority, of patient-caregiver interactions can be accomplished through technology-assisted methods such as telehealth or secure e-mail. For example, Kaiser Permanente

reports that more than half of its more than100 million annual outpatient encounters are now completed through various types of telehealth communications. In the same vein, the Los Angeles County Department of Health Services has dramatically reduced wait times for specialty care through implementation of an e-consult program.

The VA is widely acknowledged as a leader in telehealth and virtual care, but I believe it has only scratched the surface of what could be done to enhance access to care through technology-assisted methods. The VA was the first health system in the country to hire a chief telehealth officer when it did so in 1999, and it has made commendable progress in telehealth in the intervening 20 years. However, VA has not fully capitalized on its potential to enhance access to care by combining technology-assisted care with more traditional face-to-face. This remains an unfulfilled opportunity.

## A PRESCRIPTION FOR ENHANCED VA ACCESS TO CARE

Mr. Chairman let me close these comments by responding to your request that I offer some thoughts about what VA could do to improve the transparency and availability of wait time data to assist veterans make informed choices about where to receive care. I would preface my suggestions by first noting that I believe the VA health care system has an unparalleled opportunity to become the nation's leader in assuring timely access to care. I believe the VA has the potential to define the future of what timely access to care could and should be.

With the right leadership and technical assistance, I believe the VA could quickly become the nation's gold standard for timely access to care for several reasons. These reasons include the VA being the nation's only truly national health care system, having health care facilities and other care delivery assets in every state - indeed in essentially every major metropolitan area of the country; because it is a federal system that is not encumbered by state practitioner licensure laws, among other things; and because it uses a global method of allocating resources (i.e., payment) and functions as both an insurer and provider so the distinction between cost and lost revenue to providers is much less important than in the private sector. Further, the VA has extensive research and training capabilities that could be applied to evaluating and implementing new methods of access to care.

I believe there are several things that the VA could do to facilitate the transparency and availability of data while making sure that veterans have access to care whenever and wherever they need it. Toward that end, let me note six things here.

One, the VA should set a goal of becoming the nation's leader in assuring timely access to care through a coordinated combination of virtual and in-person care utilizing technology-assisted encounters, face-to-face visits, in-home and group visits, mobile delivery assets, and expanded use of non-physician caregivers, among other means.

Two, the VA should engage the National Academies of Sciences, Engineering and Medicine to help it define what 21st century access to care means and to delineate

the key operating characteristics and functionalities required to operationalize the definition.

Three, the VA should enlist the help of the National Quality Forum in identifying and endorsing performance measures to monitor and track access to care in ways that are transparent, reliable and understandable.

Four, the VA should take immediate and aggressive steps to increase access to care through virtual means such as tele-health and M-health. A systemwide initiative should be launched commensurate with implementation of the Mission Act that would increase the number of encounters by virtual means by an order of magnitude within two years. I suggest that an initial high priority target for such an initiative would be virtual or telehealth urgent care visits.

Five, while the above efforts are in progress, the VA should increase the use of veteran-satisfaction measures of access to care, being informed in this regard by its work with the National Quality Forum. In doing this, VA should use this information, along with the wait times data, within the construct of a health care learning system that uses continuous quality improvement methods to feed information back to the system that leads to continuous improvement.

Six, the VA should call upon its Health Services Research & Development Service to evaluate the most effective strategies and methods to ensure timely access to care that meet the diverse needs of veterans in the many varied communities and settings where veterans live.

Thank you, Mr. Chairman and members of the Committee for the opportunity to appear before you today. That concludes my comments, and I would be pleased to respond to your questions.