

Clinic Efficiency: Improving Access to Care Within Resource Constraints

Callie MacDonald, MPH, VA Boston Healthcare System

Policy Analyst, Partnered Evidence-based Policy Resource Center

David Biko, MHA, VA Boston Healthcare System

Research Fellow, Partnered Evidence-based Policy Resource Center

Kyle Barr, MS, VA Boston Healthcare System

Sr. Data Strategist, Partnered Evidence-based Policy Resource Center

Elsa Pearson, MPH, VA Boston Healthcare System

Policy Director, Partnered Evidence-based Policy Resource Center

Alex Woodruff, MPH, VA Boston Healthcare System

Senior Policy Analyst, Partnered Evidence-based Policy Resource Center

Steven D. Pizer, PhD, VA Boston Healthcare System

Chief Economist, Partnered Evidence-based Policy Resource Center



U.S. Department of Veterans Affairs

Veterans Health Administration
Health Services Research & Development Service

Bottom Line Up Front

Clinic efficiency is the rate at which providers in a clinic see patients. The Partnered Evidence-based Policy Resource Center (PEPReC) aims to improve clinic efficiency within the Veterans Health Administration (VHA) to promote consistent access to care. By taking advantage of selected opportunities to improve clinic efficiency, VHA can treat more patients without overextending its workforce or budget. PEPReC's pilot program will work directly with VHA facility leadership to optimize clinic efficiency.

Introduction

Approximately 16% of Veterans live in primary care shortage areas and 70% live in mental health care shortage areas.¹ To promote long term health, it is essential to provide Veterans with consistent access to both preventive care and treatment. However, the Veterans Health Administration (VHA) operates within the constraints of a congressionally allocated budget. This limitation means that access to care cannot be easily improved by increasing provider capacity. Therefore, it is in VHA's best interest to improve the efficiency of individual clinics by better allocating existing resources as much as possible.

Balancing Supply and Demand Through Clinic Efficiency

Under Section 401 of the MISSION Act, VHA aims to improve access to care by identifying and mitigating underservedness. In this context, underservedness is defined as an imbalance between Veteran demand and VHA supply of care. Aspects of clinic operations, such as scheduling practices and community care utilization, can be optimized to increase VHA supply and thereby reduce underservedness.² Ultimately, the amount of direct care that VHA is able to provide to Veterans given fixed labor inputs is characterized as the efficiency of the clinic.

Clinic efficiency is the productivity, or work rate, of the providers in a clinic. Clinics that are more efficient provide more care from the same resources as clinics that are less efficient. In analyzing clinic efficiency, there are several clinic efficiency metrics that can be used to assess a clinic's overall functionality, including how it serves specific populations. For example, *total clinic efficiency* is determined by dividing the total number of patient encounters by the clinic's total capacity for patient encounters. *New patient clinic efficiency* measures the clinic's total number of new patient encounters per unit of clinic capacity. Each metric provides local management with greater transparency into a particular dimension of care delivery.

The MISSION Act

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was passed in 2018 with the goal of improving and expanding Veteran access to care.

Section 401 of the MISSION Act created the underserved program, which identifies underserved facilities and helps obtain necessary resources.

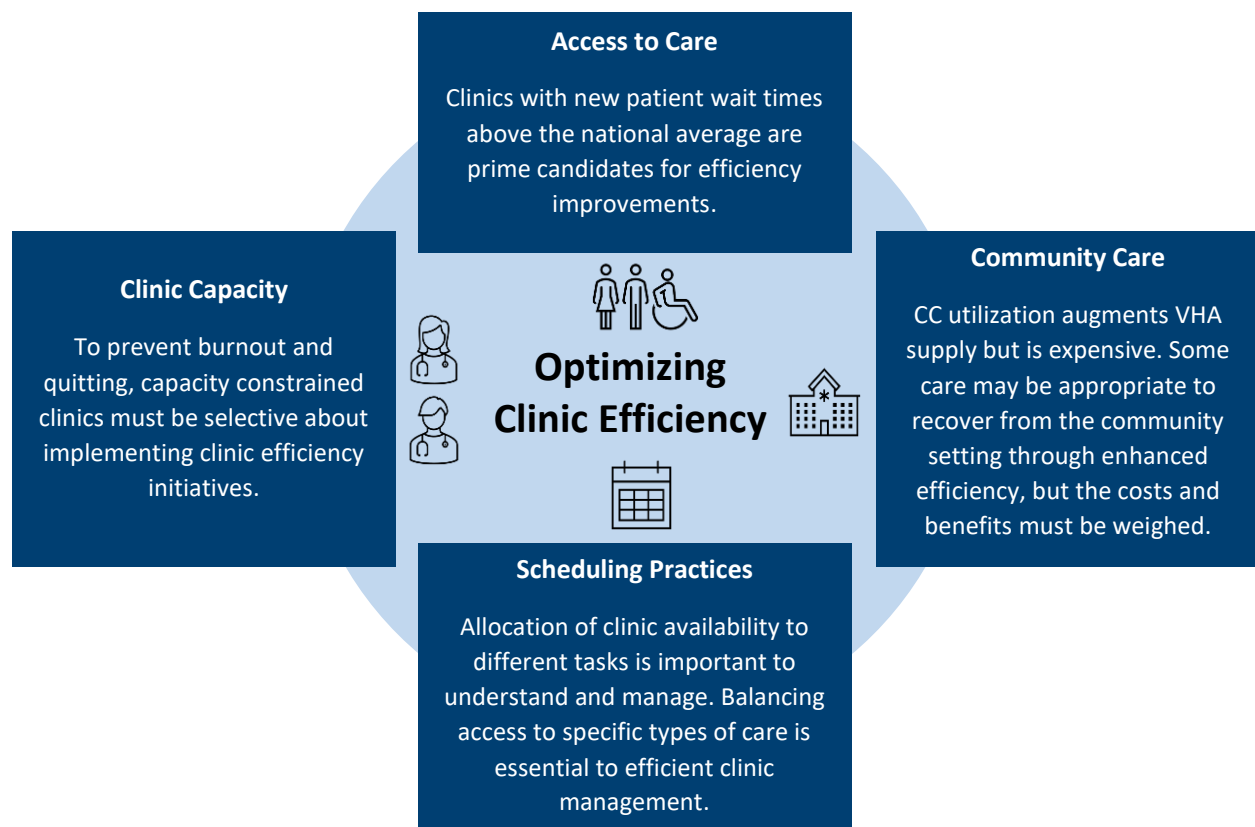
Clinic efficiency is a variable in PEPReC's statistical models implementing Section 401.³

Significance of Clinic Efficiency

PEPReC research demonstrates that clinic efficiency is an important predictor of clinic operations outcomes.⁴ Clinic efficiency exhibits a direct relationship with access to care; primary care and specialty

care modeling has shown that increasing clinic efficiency results in a reduction in new patient wait times.⁵ However, research also shows that improving clinic efficiency can have negative consequences. Consequently, both the costs and benefits must be considered when selecting clinic efficiency targets.⁵

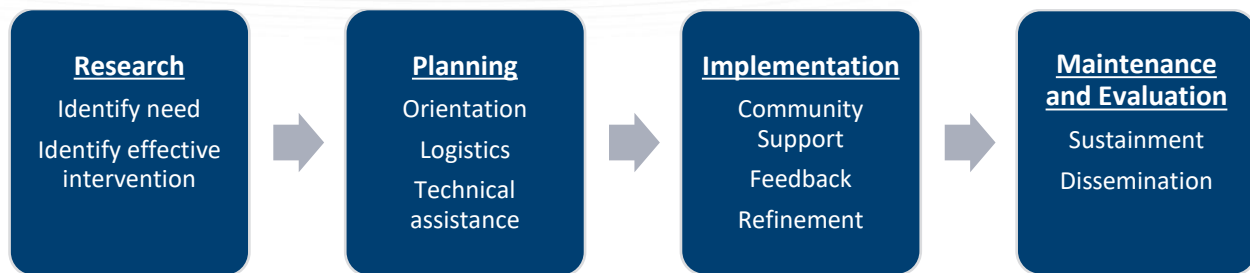
For example, increasing clinic efficiency is associated with intensified provider burnout and turnover.⁶ For this reason, clinics that face staffing shortages may not be ideal targets for an efficiency intervention due to the risk of exacerbating their capacity constraints. Additionally, the availability of community care resources is an important consideration. Facilities that rely extensively on community care providers to care for their enrolled Veterans have a substantial financial incentive to increase clinic efficiency and recover care from the community that might be appropriately provided in-house for a lower cost. The graphic below demonstrates how PEPReC seeks to identify prime candidates for an efficiency intervention.



Pilot Program

Building on previous research, PEPReC is developing a pilot program to improve clinic efficiency at select facilities. PEPReC will work with facility and clinic leaders to gain a deeper understanding of the unique challenges these sites face and tailor an evidence-based clinic operations intervention to best suit their needs. A central goal will be to facilitate transparency into clinic operations by reporting and sharing validated data, providing local managers with enhanced insight into various aspects of clinic performance.

The clinic efficiency pilot program will operate in four stages.



In the **first stage** (research), PEPRc will identify target facilities through an analysis of clinic efficiency metrics. However, participation will be solely determined by local management. PEPRc will hold a semi-structured interview with each participating facility's group practice manager (GPM). These interviews will allow the GPM to provide local context to PEPRc's data, including clinic culture and norms. Using this information, PEPRc will propose a specific clinic efficiency intervention, tailored to the facility.

The **second stage** (planning) will consist of collaborating with the GPM to weigh the costs and benefits of implementing the proposed clinic efficiency intervention and providing any technical assistance necessary, including orientating clinic staff to the intervention strategy.

The **third stage** (implementation) will implement the clinic efficiency intervention, providing continued support to the clinic throughout. This will include refining the intervention strategy based on clinic staff feedback.

The **fourth stage** (maintenance and evaluation) will include another GPM interview (one year post implementation) to gauge the clinic's level of satisfaction with the intervention, the outcomes, and the assistance PEPRc provided. The GPM will share what s/he felt was or was not successful and what s/he learned about the relationships between clinic efficiency metrics and clinic operations.

Potential Implications

VHA aims to improve access to care while adhering to congressionally-set budget constraints. Under the right conditions, improving clinic efficiency can be a cost-effective way for VHA to better serve Veterans. Additionally, by incorporating local clinic management's feedback when crafting intervention plans, PEPRc's pilot program may facilitate clinic operations improvements without exacerbating burnout and turnover. Ultimately, the pilot intends to refine an evidence-based clinic operations tool available to local clinic management, who can then decide both how to best utilize the information and PEPRc's technical expertise. Improving access to care is a complex goal that requires a multi-faceted approach. Improving clinic efficiency is one key piece of the puzzle.

References

1. Ohl, M. E., Carrell, M., Thurman, A., Weg, M. V., Pharm, T. H., Mengeling, M., & Vaughan-Sarrazin, M. (2018). Availability of healthcare providers for rural veterans eligible for purchased care under the Veterans Choice Act. *BMC Health Services Research*, 18(1).
https://link.gale.com/apps/doc/A546360600/AONE?u=mmlin_b_bumml&sid=bookmark-AONE&xid=9785f22b
2. Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science*, 2(1).
3. Isakson J. VA MISSION Act of 2018 [Internet]. S.2372, 115-182 (06/06/2018) Jun 6, 2018. Available from: <https://www.congress.gov/bill/115th-congress/senate-bill/2372/text>
4. Pearson, E, Kirsh, S, Pizer, SD. Modeling underservedness: An evidence-based approach to managing access to care. *Health Serv Res*. 2022; 57(Suppl. 1): 77- 82. doi:10.1111/1475-6773.13906
5. Yee, C. A., Barr, K., Minegishi, T., Frakt, A., & Pizer, S. D. (2022). Provider supply and access to primary care. *Health Economics*, 31(7), 1296– 1316. <https://doi.org/10.1002/hec.4482>
6. Kabdiyeva, Aigerim, et al. "Physician productivity and turnover in the Veterans Health Administration." *10th annual conference of the American Society of Health Economists*. ASHECON, 2021.

ABOUT PEPReC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPReC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.

