



State of the Art Conference

VA Emergency Medicine (SAVE)

Community Care Workgroup

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This is a draft and may not represent the final recommendations that will be forthcoming.

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Key Issues identified

- 1. ED Utilization, Access, and Costs**
- 2. Post-ED Visit Care Transitions**
- 3. Comparing Quality, Safety, and Experience between
VA and Community Care**
- 4. Policy/Implementation**

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1: ED utilization, Access, and Costs

What we know:

The ED is an essential care setting

- 20% of Americans makes at least 1 visit to the ED each year
- 23% of Veterans made at least 1 ED visit annually (*FY 19 data*)

Veterans do not have ready access to VA EDs, sometimes having to rely on community EDs.

- 98% of all civilian Americans live within 1 hour of an ED
- 87% of Veterans live within 1 hour of a VA ED
- Veterans have a higher burden of psychosocial needs, social vulnerabilities, and unstable housing and transportation, resulting in greater risk of needing ED services and seeking care in both VA and community EDs



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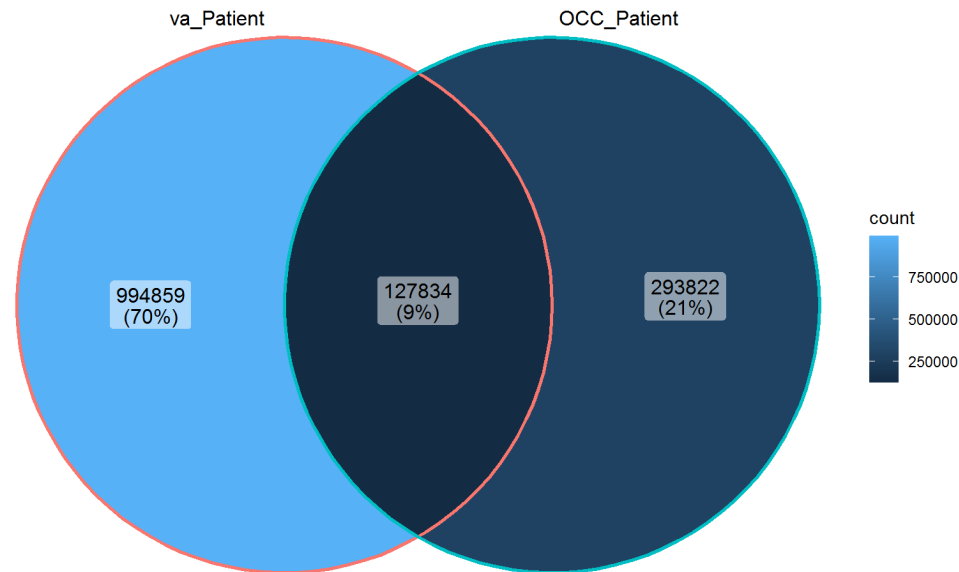


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1: ED utilization, Access, and Costs

- 70% of Veterans with an ED visit in FY 19 used only the VA
- 21% used only community EDs* (paid for by VA/OCC)
- 9% had visits in both settings*

*excludes any ED visits *not* paid for by VA (i.e. Medicare, OHI)



Distribution of ED pts by setting, FY19
N = 1,416,515 veterans

Vashi, Pilot data

1: ED utilization, Access, and Costs

ED visits and related hospitalizations now represent the largest provision of community-based care.

- ED visits and related hospitalizations cost over \$4 billion in FY21
- Emergency care is the single largest contributor to VA community care spending and rising rapidly as ED visit expenditures are up 46% since 2020.
- Claims data from FY21 indicate VA community care costs averaged approximately \$500 million per month

As part of the the MISSION ACT VA began offering a new urgent care (UC) benefit that allows eligible Veterans to receive UC from providers within VA's community network, without prior authorization from VA.

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1: ED utilization, Access, and Costs

- 1. To what extent did expansion of ED (and UC) community care (CC) change patterns of use and costs in VA and CC, for all Veterans and specific subgroups? We are especially interested in causal inference where the methods provide insights into the mechanisms of change, particularly modifiable factors, whether those changes relate to utilization, access, or costs for example:**
 - Was expansion associated with change in use of VA EDs/UCs (regional variation, subgroups)?
 - What factors (particularly modifiable factors) influence Veterans' choice of acute care setting? (i.e., acuity, reason for visit, cost, gender, wait times, distance, availability of same day PCP appointments, network adequacy, VA ED capabilities)
 - Is the increase in CC ED/UC related to a decrease in VA ED/UC (i.e., substitute) or pent-up demand (i.e., complement)? How has the case-mix of patients changed by setting type (ED, UC, Primary care)?
 - How has the expansion of CC impacted total VA expenditures related to acute unscheduled care and how do costs vary for comparable episodes of care (i.e., CHF) in different acute care settings (i.e., ED, UC, Primary care) in VA and CC?
 - How do VA and CC virtual care options impact the use and costs of CC ED/UC care?

1: ED utilization, Access, and Costs

Barriers:

- Impact of other health care insurance on decision to use VA vs. community EDs
- Availability of non-VA data, lag in Medicare data, comparability of cost data
- How do we account for changes in trends given known changes in ED utilization due to COVID?
- Impact of changing veteran population (e.g., demographic shifts)
- Role of choice in ED access (patient, provider, EMS)
- Diagnostic coding in VA is different from community

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2: Post ED Visit Care Transitions

What we know:

- Poor communication and coordination across care transitions leads to medical errors, adverse clinical outcomes, duplicative and/or inefficient care, and less favorable patient experiences
- Not receiving appropriate follow-up care, and having unmet needs after an ED visit, increases the likelihood of having adverse outcomes
 - ED revisits, hospitalizations
- Patients with complex social and/or medical issues, common in the VA population, are at higher risk for experiencing ED discharge process failures
- Transitions between health care systems (e.g., between VA and Community) are especially prone to communication/coordination failures
 - information discontinuity (e.g., no shared medical record); different resources, workflows and cultures

2: Post ED Visit Care Transitions

1. Among Veterans who have received CC emergency care (or urgent care), what are their follow-up care needs, and how well are those needs being coordinated, communicated, and met?

A. CARE-COORDINATION:

- Are care coordination needs different for different Veteran populations (high cost, high need patients, super utilizers, etc.)?

B. COMMUNICATION:

- What information do VA and Community providers, and Veterans, need to ensure safe care transitions (i.e., reason for visit, follow-up, medications prescribed, further testing)? How can that information be efficiently and effectively conveyed/transmitted/accessed?

C. FOLLOW-UP

- How does use of CC acute care affect the subsequent frequency of VA Patient-Aligned Care Team (PACT) encounters? Specialty care encounters? Reliance on VA?
- How does availability of virtual care options impact provider/Veteran decision making and/or facilitate Veterans receiving timely follow-up care?
- What are the barriers and facilitators to Veterans receiving timely follow up care in VA?
 - For example: (1) provider preferences/systems knowledge; (2) VA logistics, capabilities, capacity, (3) Patient preferences/experiences/systems knowledge/self-efficacy; (4) Payment mechanisms or incentives (assuming changes can be made to SEOCs and contracts their implementation)

2: Post ED Visit Care Transitions

Challenges/Barriers:

- Lack timely receipt of cc data, lack of structured data fields for key measures
- Need all payer data to understand the extent to which Veterans are using OHI
- Measurement issues around timely and necessary follow up care
- Difficult to capture community care provider perspective/experience
- Need improved transparency around current acute care SEOCs (where does episode begin and end? What is included (i.e. follow-up care))?

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3: Comparing Quality Safety, Experience between VA and CC acute care episodes

What we know:

- Using an instrumental variable approach, Chan et al examined the effect of VA vs. non-VA emergency care on mortality in dual eligible Veterans (65+).
- They found a VA advantage: a 28-day mortality reduction of 46%.
- Survival gains persist for at least a year after the initial ambulance ride, and they accrue despite lower spending in the VA.

Chan, David: <https://www.bu.edu/econ/files/2021/04/paper.pdf>

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3: Comparing Quality Safety, Experience between VA and CC acute care episodes

Veterans emphasized three major concerns with navigating community emergency care (based on interviews with 50 veterans):

1. They lack information about benefits and eligibility when they need it most
2. They require assistance with medical billing to avoid financial hardship and future delays in care,
3. They desire multimodal communication about VHA policies or updates in emergency coverage.

Nevedal AL, Wong EP, Urech TH, Peppiatt JL, Sorie MR, Vashi AA. Veterans' Experiences With Accessing Community Emergency Care. Military Medicine. 2021 May 24.

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3: Comparing Quality Safety, Experience between VA and CC acute care episodes

- 1. How do VA and CC EDs compare on both established ED quality and safety measures (at both the patient and ED level)?**
 - To what extent does performance on measures vary among historically underserved subpopulations of Veterans (race, age, gender, rurality, and other characteristics or social determinants of health)?
 - Do Veterans who receive community ED care have a greater risk of unnecessary/duplicate care, than Veterans who receive VA ED care?
- 2. How do Veterans' experiences/satisfaction differ across VA and CC acute care settings for different types of care needs (emergency care sensitive conditions [ECSCs], low acuity conditions, mental health conditions)?**

3: Comparing Quality Safety, Experience between VA and CC acute care episodes

Challenges/Barriers:

- Availability of detailed non-VA clinical data
- Lack of standardized ED quality measures
- Need better patient reported outcomes

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4: Policy/Implementation

What we know:

In March 2021, VA Central Office established the Care Optimization in the Emergency Department (CO-ED) initiative.

CO-ED aims to: (1) Optimize VA financial resources to facilitate execution of value-based care that results in the right care, at the right place, at the right time for Veterans; (2) Streamline care navigation processes to make it simple for Veterans to choose VA for their acute care needs; and (3) Repatriate Veterans to VA through enhanced partnerships and communication with local community emergency departments and hospital systems.

All VISNs are currently engaged in pilot projects that address community ED use

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4: Policy/Implementation

- 1. Local and national policies and programs aimed at preventing ED visits in the community (co-pays, transfers/repatriation, intensive case management, follow up in VA) should include rigorous, quasi-experimental evaluations to determine:**
 - Are programs/policies having intended effects?
 - Are there unintended consequences?
 - What are the important implementation factors/strategies to consider?
- 2. What is the best way to use SEOCs/contracts to improve care?**
 - How can CC SEOCs/contracts be a mechanism to better define standardized episodes of acute care?

4: Policy/Implementation

Challenges/Barriers:

- Tier 2 data is not yet available (curates all CC claims data for consults, referrals and claims into one queryable dataset)
- Must consider time/resources/political will required to conduct quasi-experimental evaluation
 - Is it feasible to conduct a phased or randomized implementation?
- Requires early partnerships between operations and research
- Must account for differences in operations and research timelines
- Need to improve exchange of information between research/operations (build communication bridge)



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Cross-cutting critical barriers

1. Need more complete, robust, and timely community care data

1. Need all payer data to understand the extent to which Veterans are using OHI

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Thank You!

- **SOTA planning Committee**
- **Pre-conference workgroup**
- **Conference workgroup**
- **Karen Bossi and Jerry O’Keefe**
- **ESP team**
- **Prometheus team**
- **VA HSR&D**

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