Operator: Welcome to the VA HSR&D Investigator Insights Podcast Series. In this episode, Rob Auffrey of the Center for Information Decimation and Education Resources, talks with Sam Edwards, a Core Investigator at the HSR&D Center to improve Veteran involvement in care. Dr. Edwards is also a Primary Care Physician at the Portland VA Healthcare system, and an Assistant Professor at the Oregon Health Sciences University. His research focuses on the goal of primary care and health systems.

Rob Auffrey: Thank you Dr. Edwards for agreeing to meet with me today to discuss your research into care fragmentation in VA home based primary care. So that we can get to know you a little better, please tell me what are your overall research interests?

Sam Edwards: Well I think I’m broadly interested in sort of how primary care functions as parts of health systems. So I’ve done work on a team-based care in VA primary care. But I think I’m most interested in how the primary care complex older adults. So that kind of led me to research at home based primary care, which is a disciplinary home care model for mostly home bound older people. And how does it make that care work best for them. That’s my focus.

Rob Auffrey: Have you been at the VA for most of your career?

Sam Edwards: Yeah. And I guess it started with, like so many physicians like in medical school, I rotated with the Cleveland VA in geriatric service, and then I trained in medicine in Boston and worked at the West Roxbury VA in the general medical service. And then a research fellowship at Harvard through the Boston VA. So continued to work there clinically. So I’ve always sort of appreciated the VA’s serve a sense of mission as a real commitment to Veterans and sort of – not just in the medical care but in their overall well-being. So yeah, when I finished fellowship I took a position at the Portland VA Medical Center as a Clinician Investigator and that’s where I’ve been since, so – yeah, I’ve been in Portland for about eight years now.

Rob Auffrey: And that brings us to what you’re presenting on today.

Sam Edwards: Yeah, so I gave a presentation today about Home Based Primary Care. And a fragmentation for older medically complex adults typically require care from a lot of different physicians in order to keep them healthy. But care from a lot of physicians can be good if it’s really well coordinated. You know you’re taking advantage of the expertise of all the specialties. But it can also be fragmented you know, where you’re seeing multiple specialists for the same reason. Like we drop off and information, it can be poly pharmacy where patients are taking medicines they shouldn’t, potential conflicts. And that’s just a huge burden on patients to see like multiple specialists if they don’t need to, and it’s costly and inefficient.

So, we’re interested the sort of concept of fragmentation, whether you could measure it in home-based primary care, and then what – how it relates to outcome specifically emergency department visits and hospitalizations. So care fragmentation’s been studied for a long time, and there are a lot of different measures of it, mainly looking at sort of how concentrated care is in a particular provider or group. So we examined how fragmentation care is within HPPC compared to other high-risk patients, found that home based primary care patients tend to get less fragmented care than similarly sick other Veterans. Which is not really surprising since it’s a team-based model. But that home-based primary care patients within the program, the more fragmented the care they get, the more likely they are of having an emergency department visit or hospitalization. Even a program that provides very consolidated, coordinated care, there’s still a spectrum of fragmentation that’s associated with more health care use. So we think that could mean consolidating care more among patients in HPPC could lead to fewer ED visits and hospitalizations.

Rob Auffrey: So this is comparing Veterans who receive home-based primary care with Veterans who don’t receive home-based primary care?

Sam Edwards: Well there are kind of a couple of pieces to the study. One we just sort of did a very simple comparison of patients who are in the program, and patients who weren’t. And looked at who could have had more fragmented care. And then for the similar level of sickness, HPPC patients have less fragmented care. But then we just looked within HPPC patients, how much fragmentation they had, and the more fragmentation they had, the more likely they were of having a hospitalization or ED visit. So, the one level we’re comparing and then we took it sort of a deeper dive in the patients in the program to see if fragmentation might be a target for improving outcomes.

Rob Auffrey: What I was driving at was, did you find any differences between Veterans who received VA home-based primary care and Veterans who received primary care through Medicare or a community-based primary care?

Sam Edwards: Yeah well we didn’t investigate that specifically, but one of our strengths of our study is we do include Medicare data. So we’re getting data on all their cares. So whether the fragmentation goes across systems, so whether they’re getting care at both from non-VA providers and VA providers. And then whether they’re getting hospitalized or emergency department visits in VA or non-VA settings. So an interesting extension would be to see how much of that fragmentation that we’re measuring is sort of cross system fragmentation versus just seeing a lot of specialists within the VA. But yeah, super important issue for fragmentation across systems.

Rob Auffrey: Okay, so to reel back from my tangent.

Sam Edwards: Okay.

Rob Auffrey: What did you find?

Sam Edwards: Oh, I mean the main findings of this is a fragmentation this is associated with worse outcomes. And I think the challenge with these fragmentation measures is they’re so highly associated with measures of how sick and complex people are. So disentangling those is really challenging, but I think it’s a good news for HPPC as it seems like they’re providing pretty consolidated care. Like we found about 55% of outpatient visits that home-based primary care patients get, are from the home-based primary care team. Which is a pretty good ratio.

Rob Auffrey: Did you come up with any recommendations for clinicians or teams?

Sam Edwards: Well I think it’s – for the teams in HPPC, I think that you know, trying to think about fragmentation is an important issue and how to reduce it is probably valuable and could lead to less acute care use. So if you learn that your patients are seeing a different cardiologist or a different cancer doctor in the community, trying to resolve those conflicts is probably going to reduce their chance of acute care use in the future. But I think that’s fairly intuitive, and I think most clinicians are trying to do that anyway. Anytime there’s confusion around who’s driving the bus for care? Like we want to figure that out, cause that fragmentation can frankly be dangerous.

Rob Auffrey: What did I leave out? Is there anything that I forgot to ask or anything that you’d like to add?

Sam Edwards: Um, well I guess that one interesting thing to say, I didn’t have a chance to present today cause there’s just not enough time is there is a subset of patients in home-based primary care where their fragmentation measure is perfect, meaning that they only receive care from the home-based primary care team in a year. So they don’t see anyone else. And I think that’s a group that we should investigate further, like on a quick pass, we see that they tend to be very old. So the mean age in our sample is about 80, but these patients are more like 88. They almost all have dementia. And then they don’t see any other specialists. So I think what we’re seeing is a little bit of sort of simplification of care and end of life, where people are like maybe end stage dementia, they don’t have a lot of functional needs that can’t be provided by the home-based primary care team. And they don’t really need a lot more specialist input, so things are almost like sort of simplifying as they head towards palliative care. So I think sort of the more longitudinal look at how their care patterns change over time, and how they might simplify towards the end would be good. Cause I think that hope is the program is providing people a sort of patient centered end of life. You know, like us, they get sicker and older instead of having a really messy complex series of interactions with the health-care system, like repeat hospitalization, nursing home stays, that they’re kind of getting their goals met, and they can stay at home as long as possible with fewer transitions. So there’s some signal there that would for a subset of people, they have a very, very consolidated care towards the end.

Rob Auffrey: This is probably going to be another tangent, but do you see reducing fragmented care as a way to help drive universal health care, single payer health care – single payer health care model?

Sam Edwards: That’s a good question. I mean I think – with VA right now where we’re still dealing with the community care versus VA, we’re very much in the like tangling with the value and problems with using two systems. I think having a single system from a clinician perspective is easier. You know, like knowing who your specialists are, who people go to, making sure those lines of communication are open is really valuable. And when people are getting care outside of our system, when those communication channels are not there, it can be harder. So, in the sense that the VA is kind of like a single payer system, I think those communication channels are really valuable, and the fragmentation can be hard. But you know I think the tradeoff is sort of access, you know if people can get better access to care through other systems that might have value too. I don’t know if that’s a good answer but yes, generally.

Rob Auffrey: Thanks, I know that’s not the focus of your research. If you’re comfortable, would you mind taking a few moments in talking about what it’s like for you doing research with and caring for Veterans?

Sam Edwards: Yeah, well I mean, as I said you know, sort of being part of the VA has been part of my whole clinical training, so and it’s humbling. Cause as I started my VA training, we still were caring for a lot of World War II Veterans, and we’re kind of watching as time goes by, the demographics of our Veterans change and the circumstances of which they served. It’s just very humbling you know, to care for people who have volunteered part of their lives to serve their country in the way the Veterans have. And I’m really appreciative of the VA as a system that really is trying to look out for them across all stages of life certainly in the health setting. So yeah, very appreciative of that opportunity to care for Veterans.

Rob Auffrey: Well thank you Dr. Edwards. I really appreciate you taking the time.

Sam Edwards: Thank you.

Operator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research, and do not necessarily reflect current or to be implemented VA policy. To learn more about this research, visit the VA HSR&D website at www.hsrd.research.va.gov.