State of the Art Conference
VA Emergency Medicine (SAVE)

Welcome

- Microphones and Cameras are permissible. Please remain muted.
- We will use both “Chat” and “Raise Hand” for questions/discussion. Please unmute ONLY if you are called on.
- We will be recording this meeting.

State of the Art Conference
VA Emergency Medicine (SAVE)

January 12, 2022

David Atkins, MD, MPH
Director, Health Services Research and Development

U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

Welcome to the SOTA on Emergency Medicine

- Background
- Goals and Process
- Perspectives on the Emergency Medicine in VA
- Charge to work groups

Why Emergency Medicine?

- Chad Kessler is very persuasive
- The world of Emergency Medicine is changing rapidly in VA and research is needed to inform those changes.
- Spending on non-VA urgent/emergency services has increased sharpy since the Mission Act
  - Now exceeds $ 4 billion per year.
- ERs are an important source of VA care, through services provided and admission decisions
  - 20% of visits result in admission
- VA has unique challenges in emergency services
  - Older population, prevalent MH conditions

SOTA Process – What We Have Done

- Selected Co-chairs: Chad Kessler and Michael Ward
- Convened planning committee
  - Identified main topic areas
  - Refined key questions
  - Identified subject matter experts
  - Selected pre-conference readings and questions
- Three work groups who developed questions/readings:
  - Geriatric emergency care
  - Emergency mental health care
  - Coordination between community emergency care and VA

Goals of State-Of-The-Art Conferences

- **Where is the evidence sufficient to move to implementation?**
  -- Reach consensus on policy recommendations to emergency care in specific domains

- **What important questions do not have sufficient evidence to guide practice and clinical policy?**
  -- Reach consensus on recommendations for research agenda

- **What issues or new developments are on the horizon that may need to be considered in research, planning, and policy?**
  -- Prioritize issues for future consideration

SOTA Agenda

Jan 12

- Plenary presentations
- Charges to Work groups

Jan 20 - 31

- Each work group holds two 3-hour discussion sessions
- WG leads facilitate discussion to address key questions
- Work group comes to consensus on priority research agenda, policy recommendations and implementation strategies
- Develop summary of work group deliberations

February 17

- Work group summaries presented to all SOTA participants
- Opportunity for clarifying questions and discussion of summaries
- Panel Reaction to Work Group Presentations
- Facilitated full group discussion of next steps

SOTA Products

- Emergency Medicine Policy recommendations
  - Developed from work group consensus items
  - Should be linked to strong evidence, clear rationales
  - Brief to leadership
- Emergency Medicine Research Agenda
  - Refined with input from HSRD
  - Incorporated into call for proposals in Fall 2022
- Journal supplement
  - Agreement with Academic Emergency Medicine
- Cyberseminars

General Recommendations for SOTA

- Use the evidence reviews and the shared articles as primary basis for discussion.
- Use your individual clinical experience and expertise to provide context.
- Distinguish recommendations based on available evidence from those that may be based on expert consensus in absence of evidence
- Focus research recommendations on most important gaps
  - Likely to change practice
  - Important to VA patients
  - Unique opportunity for VA to study

Thanks

- Clinical Partners: Chad Kessler and Neil Patel
- Research co-chairs: Michael Ward, Dawn Bravata and Erica Abel
- Work Group Chairs:
  - Anita Vashi and Kristin Mattocks (Community Care)
  - Jason Chen and Christine Timko (Mental Health)
  - Nicki Hastings and Ula Hwang (Geriatrics)
- Planning Committee Members: Steve Asch, Christian Helfrich, Gayle Iwamasa, Pamela Owens (AHRQ)
- CIDER Team
  - Jerry O'Keefe, Karen Bossi, Rob Auffrey
- Evidence Synthesis Team: Nicholas Parr

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January 12, 2022

State of the Art Conference on Veterans Emergency Care: Welcome & VHA Emergency Medicine Overview & History

Chad Kessler, MD, MBA, MHPE
National Program Director, Emergency Medicine
Veterans Health Administration
Professor of Medicine
Duke University School of Medicine

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A Journey through VHA Emergency Medicine

- What defines us?

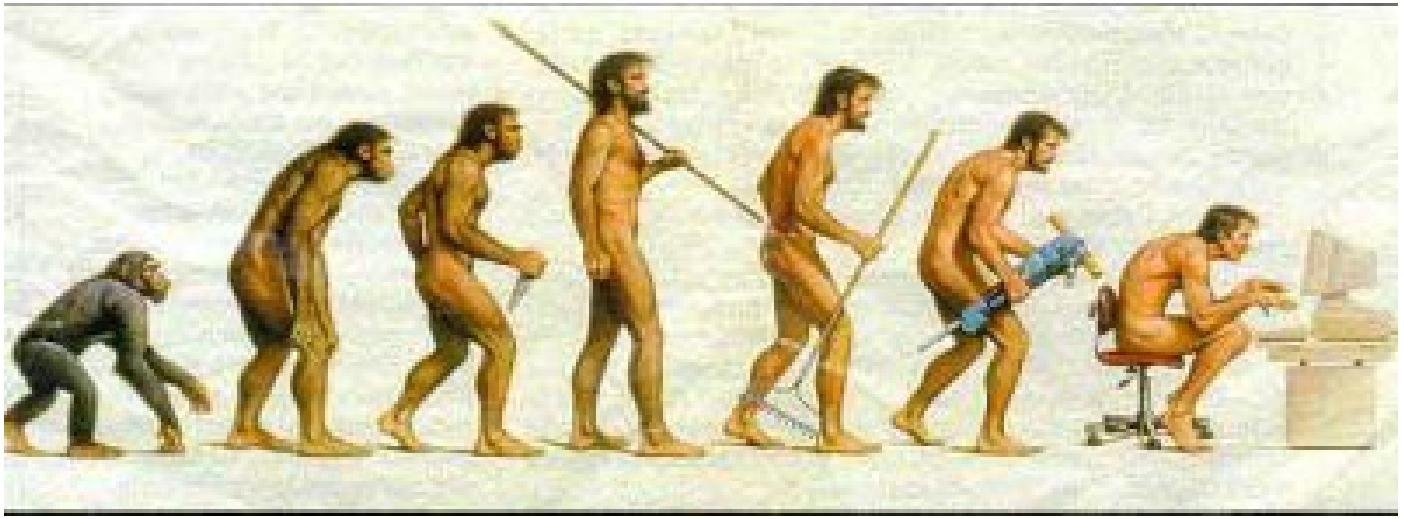
- VHA Emergency Medicine
  - Overview
  - History
  - The SOTA

What defines us?

- After it rains, when is the road its slickest?
- When do most planes most commonly crash?
- What sets the tone for every great James Bond movie?

"Emergency Medicine is the 1st 5 minutes of every specialty!"

VHA EM History



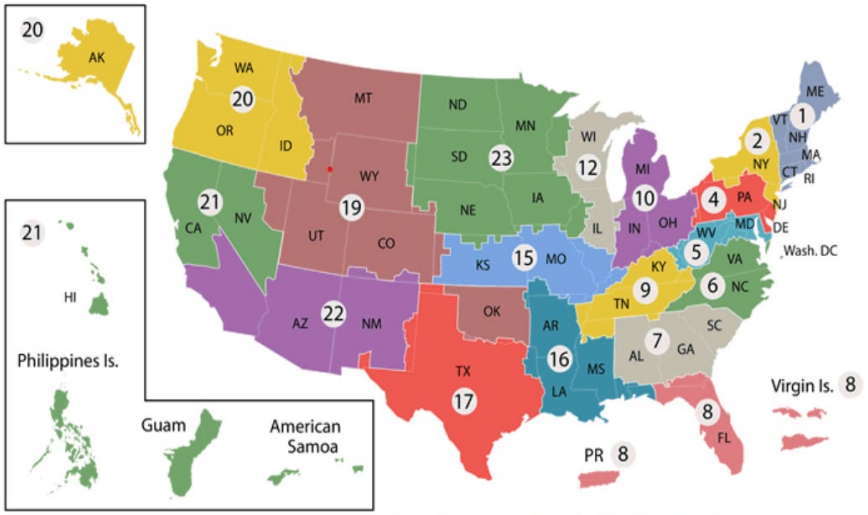
Front Porch of the Neighborhood

What was…

What is…

VHA Health Care System

- 145 VA VAMC with Acute Inpatient Care Sites
- 171 VA VAMC with Outpatient Care Sites
- 1,115 VA Outpatient Only Care Sites
- 134 Community Living Centers
- 140 ED and UCCs



Click on the state or the visn number for information about facilities there.

Sources: US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. Department of Veterans Affairs Statistics at a Glance. https://www.va.gov/vetdata/docs/Quickfacts/Homepage_slideshow_9_30_21.PDF
US Department of Veterans Affairs, Interactive US Map: https://www.va.gov/directory/guide/map.asp?dnum=1

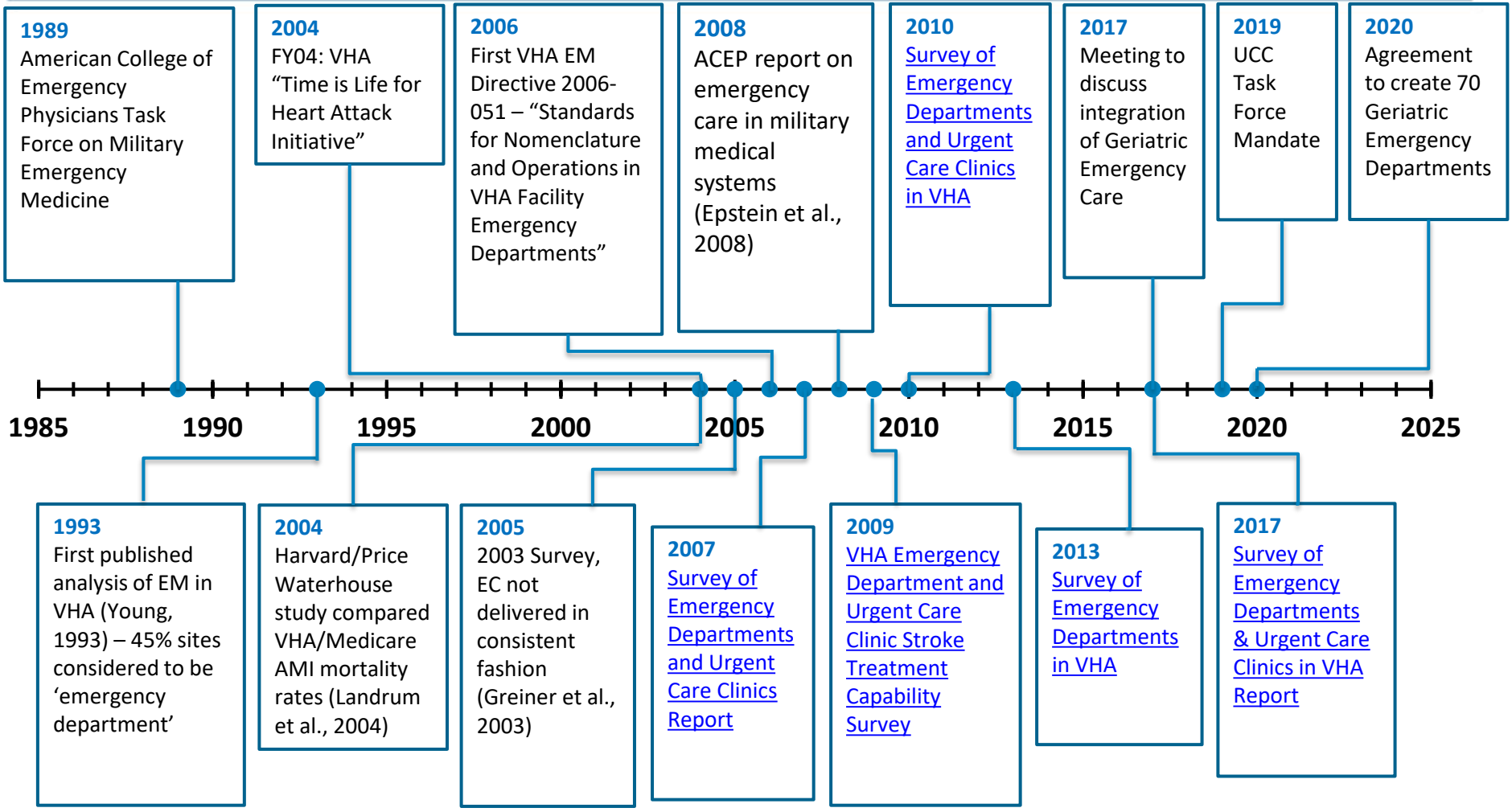
Birth of EM within the VHA

- Time is Life for Treating Heart Attack Initiative (FY 2004)
- Time is Life Conference (March 2005)
- A bag of named entities
  - ED
  - UCC
  - Life Support Unit
  - Assessment and Evaluation Unit
- No standards existed
- Created a blue-ribbon panel

Birth of EM within the VHA: 2005

- 140 “areas” locations identified
- 95 Emergency Departments
- 23 Urgent Care Centers
- 16 combos
- 6 other
- Most aligned under primary care

History of VHA Emergency Medicine - Timeline



VHA Emergency Medicine - Today

Single largest integrated health care system in the US

- 111 Emergency Departments / 29 Urgent Care Centers*
- 2.5 Million visits in FY ‘19** (Pre-Covid)
- 2.1 Million visits in FY ’21**
- 80 BC ED Directors in ’17***
- 1,947 Operational Beds/Gurneys (17.5 beds/ED)*
- 30+ Academic Affiliated EM programs in ‘21

Physician Staffing – 2017 (N = 1384 FTE) ***

– ACEP Board Certification or EM:	44%
– Full-Time ED/UCC Physicians:	62% (862 FTE)
– Part-Time ED/UCC Physicians:	11% (150 FTE)
– Contract Physicians:	11% (147 FTE)
– Fee Basis Physicians:	16% (225 FTE)

Sources: * = EM Site Directory; ** = EMMT Facility Operations Summary; *** = HAIG Survey, 2017

Departmental Alignment of EDs & UCCs

	2007 ED/UCC N=140	2010 ED/UCC N=158*	2013 ED ONLY N=118*	2017 ED/UCC N=141
Separate Departmental Status	9% (13)	11% (18)	23% (27)	25% (35)
Aligned under Medicine / Acute Medicine	36% (51)	41% (65)	53% (63)	52% (73)
Aligned under Ambulatory Care (includes Primary Care)	41% (57)	38% (60)	24% (28)	21% (30)
Other Department Aligned	14% (19)	9% (15)	0% (0)	2% (3)
Board Certified ED Director	24% (33)	32% (38)	55% (57)	57% (80)

Sources: HAIG Surveys

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Source: Healthcare Analysis & Information Group (HAIG). Survey of Emergency Departments (ED) and Urgent Care Clinics (UCC) in VHA Report. HOME » PUBLICATIONS - Healthcare Analysis & Information Group (va.gov)
NOTE: *2010 numbers taken from 2017 HAIG Survey

EM Mental Health, Geriatrics & Community Care

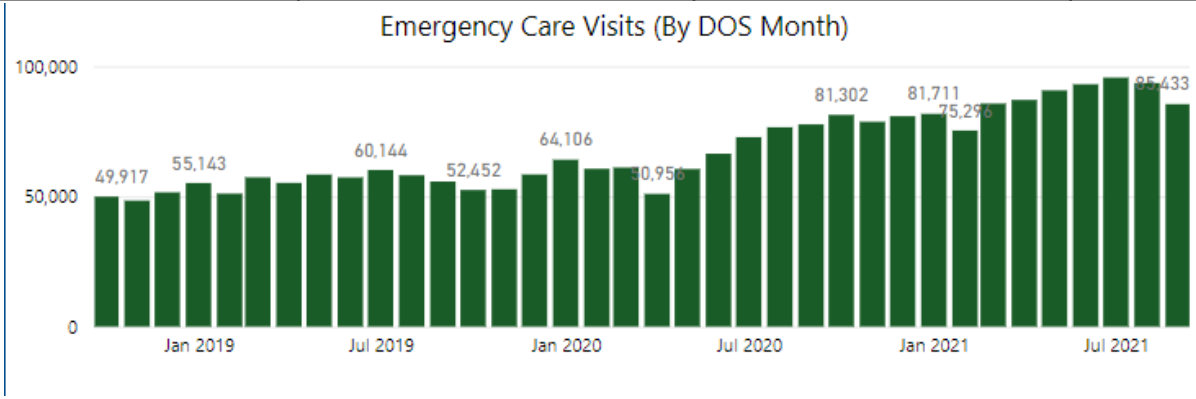
- 1st National Emergency Department (ED) opioid safety initiative
- Suicide Prevention in the ED (SPED)
- Geriatric ED Initiative
  - 51 VA EDs are involved in Geriatric ED Initiative
  - 16 VA EDs are ACEP GEDA Accredited

EM Mental Health, Geriatrics & Community Care

- **Care Optimization in the Emergency Department (CO-ED)**
  - In some cases, Veterans are relying on community emergency departments (EDs) for non-emergent and preventive care, with some considered frequent utilizers of more than 4 visits in the past year.
  - Utilization of community EDs for non-emergent care leads to disjointed, uncoordinated care and suboptimal chronic disease management
  - VA's community care expenditures are high, so the potential for impact is high.
- **CO-ED Goals:**
  - Optimize VA resources to facilitate execution of **value-based care** that results in the right care, at the right place, at the right time for Veterans.
  - **Streamline care navigation** processes to make it simple for Veterans to choose VA for their acute care needs.
  - **Repatriate Veterans to VA** through enhanced partnerships and communication with local community emergency departments and hospital systems.

Community Emergency Care Utilization (CO-ED)

	FY2019	FY2020	FY2021
Total Veterans	420,996	494,553	634,030
Total Payments	2,265,965,891	3,936,233,406	**5,171,795,641**
Total Visits	658,227	754,282	1,028,893
Visits without Admission	510,923	532,677	754,169
Number of Admissions	147,304	221,606	274,724
Costs per Visit	$3,442.53	$5,218.52	$5,026.56



Source: CO-ED Non-PHI Dashboard (Data as of 12/31/2021 extracted 1/06/2022)

Examples of Recent EM Relevant Publications

Discharge Information and Support for Patients Discharged from the Emergency Department: Results from a Randomized Controlled Trial

Susan N. Hastings, MD, MHSc[1,2,3,4,5], Karen M. Stechuchak, MS[1], Cynthia J. Coffman, PhD[1,6], Elizabeth P. Mahanna, MPH[1], Morris Weinberg, Courtney H. Van Houtven, PhD[1,5], Kenneth E. Schmader, MD[1,2,3,4], Cristina C. Hendrix, DNS, GNP-BC, FAAN[3,9], Chad Kessler, MD[1,2], Jaime M. Hughes, PhD, MPH, MSW[1,4,5], Katherine Ramos, PhD[1,3,4,8], G. Darryl Wieland, PhD, MPH[3,4], Madeline Weiner, RN[3], Katina Robinson, I Eugene Oddone, MD, MHSc[1,2]

Implementation of Telehealth for Psychiatric Care in Departments and Urgent Care Clinics

Michael J. Ward, MD, PhD, MBA,[1–3,i] John L. Shuster, Jr., MD,[3] Nicholas M. Mohr, MD, MS,[4–7] Peter J. Kaboli, MD, MS,[4,5] Amanda S. Mixon, MD, MS, MSPH,[1,3] Jennifer Kemmer, NP,[3] Corey Campbell, DO,[3] and Candace D. McNaughton, MD, PhD[1,3]

Spreading the Veterans Health Administration's emergency department rapid access clinics (ED-RAC) innovation: Role of champions and local contexts

Lauren S Penney [1], Jessica L Moreau [2], Isomi Miake-Lye [2], Davis Lewis [3], Adrian D'Amico [3], Kelli Lee [4], Brianna Scott [5], Susan Kirsh [6], Kristina M Cordasco [7]

Research and Applications

Validation of an electronic trigger to measure missed diagnosis of stroke in emergency departments

Viralkumar Vaghani,[1] Li Wei,[1] Umair Mushtaq,[1] Dean F. Sittig,[2] Andrea Bradford,[1] and Hardeep Singh[1]

Exploring differential response to an emergency department-based care transition intervention

Justine Seidenfeld MD [a, b], Karen M. Stechuchak MS [a], Cynthia J. Coffman PhD [a, g], Elizabeth P. Mahanna MPH [a], Micaela N. Gladney MPH [a], Susan N. Hastings MD, MHSc [a, c, d, e, f]

CASE REVIEW

Suicide Screening and Risk Assessment in the Emergency Department: Case Review of a Suicide Attempt Survivor

Avery Z. Laliberte BA, Brandon Roth BA, Beau Edwards BS, Jason I. Chen PhD

Emergency Department Utilization and Readmissions Following Major Surgery: A Retrospective Study of Medicare Data

Sharmistha Dev MD, MPH [a, c, f], Andrew A. Gonzalez MD, JD, MPH [b, c, i], Amir A. Ghaferi MD, MS [d, h], Brahmajee K. Nallamothu MD [d, e], Keith E. Kocher MD, MPH [d, g]

The Enhancing Quality of Prescribing Practices for Older Veterans Discharged From the Emergency Department (EQUIPPED) Potentially Inappropriate Medication Dashboard: A Suitable Alternative to the In-person Academic Detailing and Standardized Feedback Reports of Traditional EQUIPPED?

Zachary Burningham [1], George L Jackson [2], Jessica Kelleher [3], Melissa Stevens [4], Isis Morris [5], Joy Cohen [6], Gerald Maloney [7], Camille P Vaughan [4]

Monitoring Diagnostic Safety Risks in Emergency Departments: Protocol for a Machine Learning Study

Moein Enayati [1]; Mustafa Sir [2]; Xingyu Zhang [3]; Sarah J Parker [4]; Elizabeth Duffy [4]; Hardeep Singh [5]; Prashant Mahajan [4]; Kalyan S Pasupathy [1]

Feasibility Study of a Quasi-experimental Regional Opioid Safety Prescribing Program in Veterans Health Administration Emergency Departments

Nathalie Dieujuste [1], Rachel Johnson-Koenke [1], Melissa Christopher [2], Elise C Gunzburger [1], Thomas Emmendorfer [3], Chad Kessler [4], Jason Haukoos [5 6 7], Jason Smith [8], Comilla Sasson [1 6 7]

Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries

[illegible]a Hwang [1 2], Scott M Dresden [3], Carmen Vargas-Torres [4], Raymond Kang [5], [illegible]elissa M Garrido [6 7], George Loo [4], Jeremy Sze [8 9], Daniel Cruz [3], Lynne D Richardson [4], [illegible]mes Adams [3], Amer Aldeen [10], Kevin M Baumlin [11], D Mark Courtney [12], Stephanie Gravenor [13], [illegible]orita R Grudzen [8], Gloria Nimo [4], Carolyn W Zhu [4], [illegible]eriatric Emergency Department Innovations in Care Through Workforce, Informatics, and Structural [illegible]hancement (GEDI WISE) Investigators

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Examples of HSR&D Funded EM Relevant Research

PROJECT NO.	TITLE	PI	FUNDING END	STATUS
CDA 19-076	Development and Testing of a Veteran-Centered Lethal Means Safety Suicide Prevention Intervention	Simonetti, Joseph	6/30/2025	CURRENT
IIR 18-146	Evaluating the VA Make-or-Buy Decision in Emergency Care	Chan, David	12/31/2024	CURRENT
IIR 17-068	Hearing Impairment, Strategies, and Outcomes in Emergency Departments	Chodosh, Joshua	9/30/2024	CURRENT
IIR 16-235	Improving Outcomes for Emergency Department Patients with Alcohol Problems	Blow, Frederic	3/31/2023	CURRENT
IIR 17-065	Rapid Referral to Suicide Specific Intervention in Psychiatric Emergency Care	Depp, Colin	3/31/2023	CURRENT
IIR 17-236	Reducing Potentially Inappropriate Medication Prescribing for Older Patients: Enhancing Quality of Provider Practices for Older Adults in the Emergency Department (EQUIPPED)	Vaughan, Elizabeth	9/30/2022	CURRENT
IIR 16-266	Veteran Access to Emergency Care	Vashi, Anita	5/31/2022	CURRENT
CDA 15-061	Understanding and Improving Decision-making in Pneumonia with Informatics	Jones, Barbara	3/31/2022	CURRENT
PPO 18-258	Assessing Feasibility of Measuring Veterans' Experiences and Receipt of Follow-Up Care after VA Emergency Department Treat-and-Release Visits	Cordasco, Kristina	9/30/2021	COMPLETED
PPO 18-278	Emergency Departments Treating Veteran for Suicide (ED-VeTS)	Waliski, Angie	3/31/2021	COMPLETED
IIR 12-106	Analgesic safety and effectiveness in older Veterans with arthritis	Hwang, Ula	6/30/2020	COMPLETED
IIR 12-331	Understanding Dual Use and Other Potential Determinants of Heart Failure Outcomes	Axon, Robert	11/30/2017	COMPLETED
IIR 12-052	Discharge Information & Support for Patients Receiving Outpatient Care in the ED	Hastings, Susan	11/30/2016	COMPLETED
PPO 14-384	Emergency Care Sensitive Conditions in the VA	Vashi, Anita	4/30/2016	COMPLETED
SDP 12-178	Quality of Care for Veterans with TIA and Minor Stroke	Bravata, Dawn	9/30/2015	COMPLETED
RRP 11-374	VISN Implementation of VA Acute Stroke Care Centers: Formative Evaluation	Damush, Teresa	10/31/2013	COMPLETED
RCD 06-019	Improving Care for Older Veterans Discharged from Emergency Treatment	Hastings, Susan	3/30/2013	COMPLETED
SDP 06-004	Development and Pilot Test of Implementing a Stroke Quality Improvement Decision Support System (SQUIDSS)	Kent, Thomas	3/31/2012	COMPLETED
PPO 09-273	Studying veteran ED pain care with an electronic pain care abstraction tool	Hwang, Ula	8/31/2011	COMPLETED
PPO 09-267	Measuring the Quality of Emergency Department Discharge Medications	Hastings, Susan	3/31/2011	COMPLETED
RRP 09-182	Feasibility of Screening Swallowing in the Emergency Department	Daniels, Stephanie	2/28/2011	COMPLETED

QUESTIONS/COMMENTS

Chad.Kessler@va.gov

VHA EM SOTA Opening Plenary

VA Geriatric Emergency Medicine Initiative

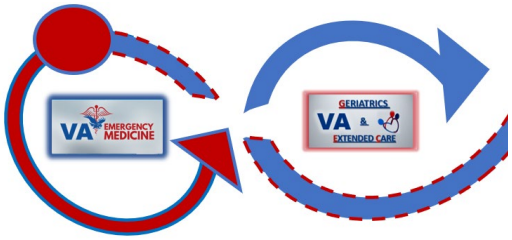
Speakers:

Erica Gruber, *A-GNP, BCEN*

National VA Geriatric Emergency Department Core Team Lead

Jill Huded, MD

Geriatrician, Founder of GERI-VET



January 12th, 2022

U.S. Department of Veterans Affairs

Agenda

1. Why VA and specialized geriatric emergency care?
2. GEM history: Strategic Partnerships and VA
3. Geriatric ED Core Team
4. VA Geriatric ED Care Progress
5. How is VA Leading the Field of Geriatric Emergency Medicine?
6. Future

Why VA and Specialized Geriatric Emergency Care?

>1,191,000

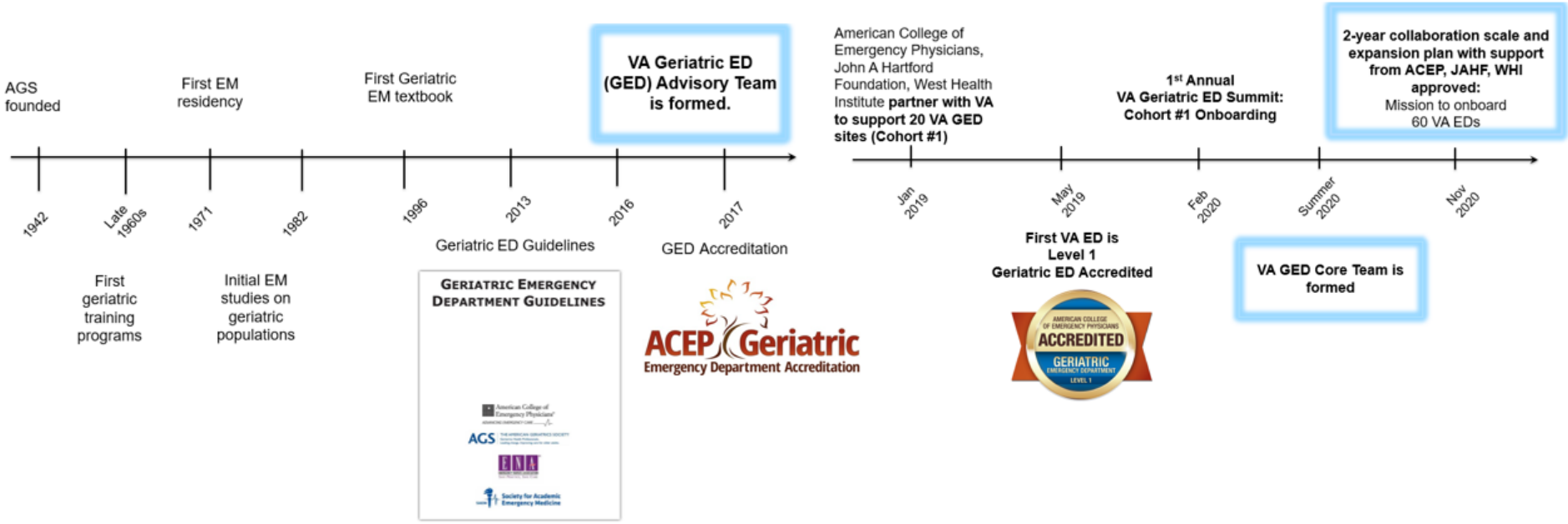
VA		Community	
ED Census		**ED Census**	
≥ 65:	49.8%	≥ 65:	17.9%
≥ 75:	21.3%	≥ 75:	9.6%
Admissions		**Admission**	
Average rate all ages:	19.0 %	Average rate all ages:	12.4%
Average rate ≥ 65:	23.8 %	Average rate ≥ 65:	23.5%
Average rate ≥ 75:	26.2 %	Average rate ≥ 75:	31.4%

https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf.

EDIS_GeriatricsAgeReport_v3 - Report Viewer (va.gov)

VA | U.S. Department of Veterans Affairs

GEM History and VA Geriatric ED Timeline



National Geriatric Emergency Department Core Team

ACEP Geriatric Emergency Department Accreditation

The John A. Hartford Foundation

westhealth

GEDC

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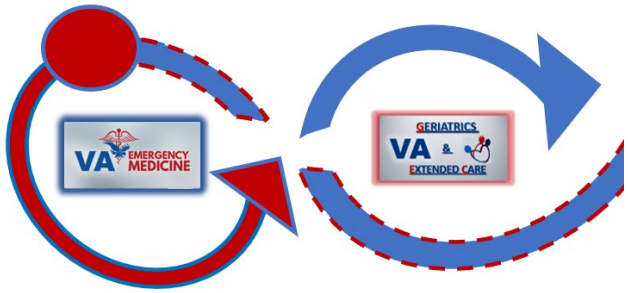
Dual Reporting to National Offices



National Office of Emergency Medicine

Dr. Chad Kessler,
National Director

Dr. Neil Patel,
Deputy Program Director

Josh Geiger,
Executive Officer

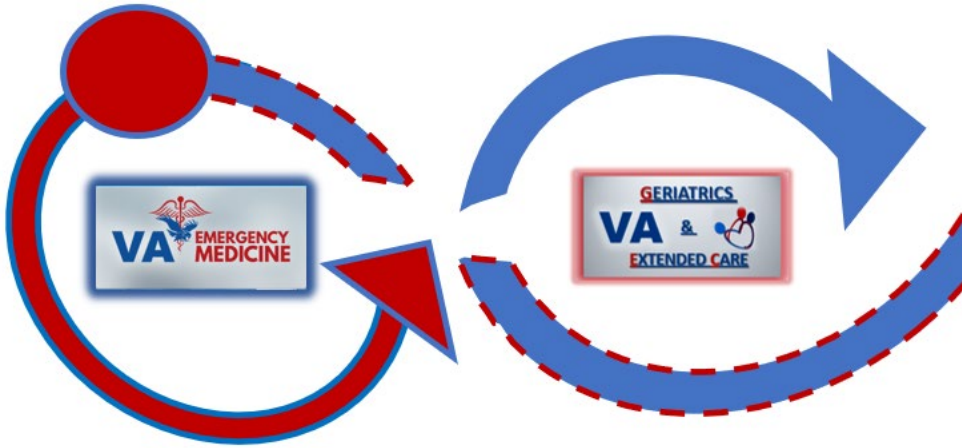
National Office of Geriatric & Extended Care

Dr. Scotte Hartronft,
Executive Director

Dr. Tom Edes,
Senior Medical Advisor

Mission

Enhancing geriatric-focused care in VA emergency departments throughout the nation via education, standardization, environmental enhancement, and promotion of a comprehensive care model.



Creating interdisciplinary service synergy within the ED and pathways to strong follow up are essential to equity and access of high-quality geriatric care across settings.

VA Specialized Geriatric Emergency Care

January 2016 – January 2022

VA | U.S. Department of Veterans Affairs

January 2016: VA Geriatric Emergency Department Programming

110 VA EDs

- National VA Geriatric ED Advisory Team formed by Dr. Jill Huded of Louis Stokes Cleveland, OH.
- GERI VET program initiated

1 (0.01%) of 110 VA EDs engaged

5.55 % VISN engagement

May 2019: VA Geriatric Emergency Department Programming

110 VA EDs

- 1st VA ED received ACEP GEDA Level 1: Louis Stokes Cleveland, OH
- 2 additional EDs seeking ACEP GEDA
- Collaborative grant proposal approved to support 20 VA ED Application Fee Waivers

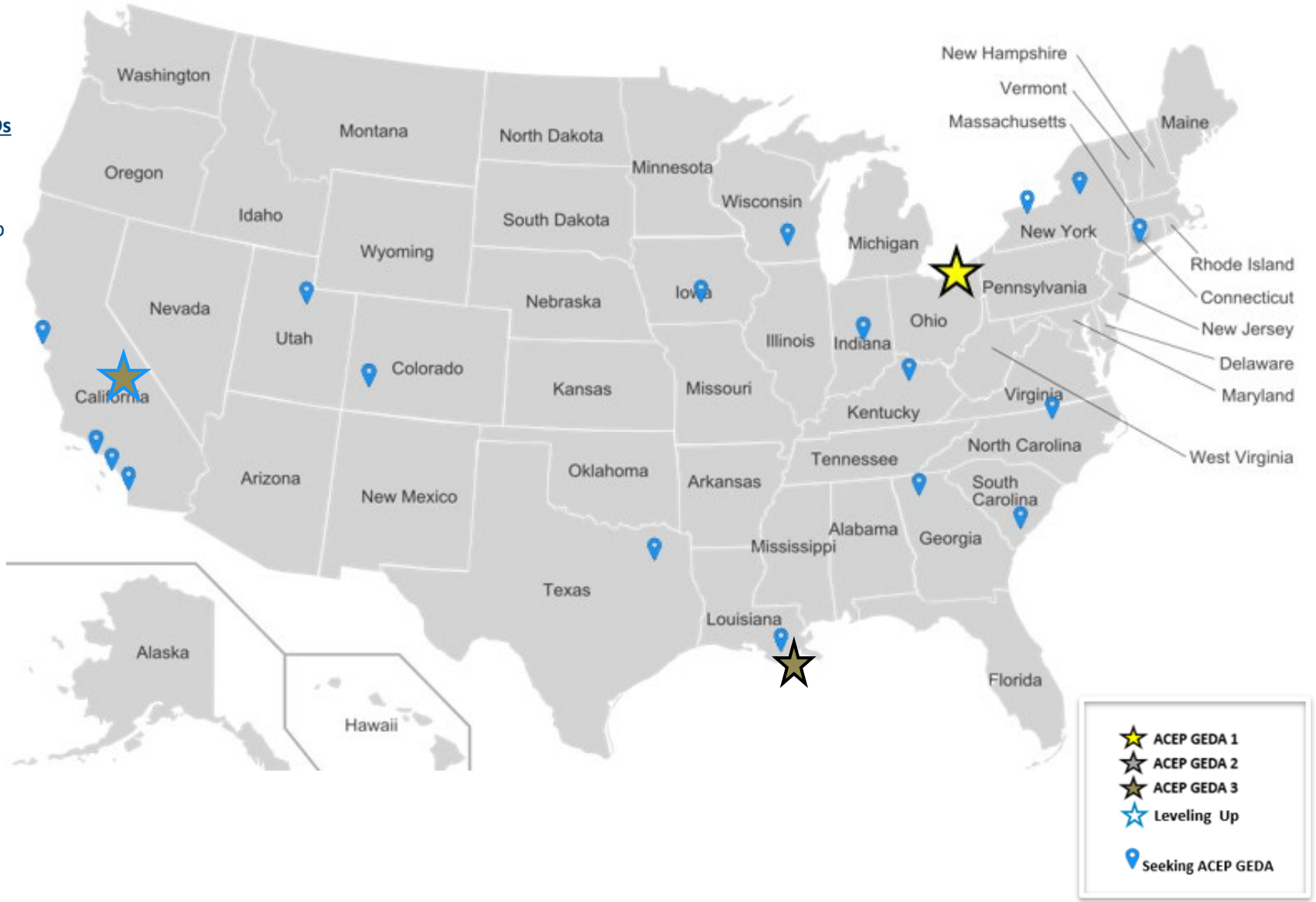
1 (0.03%) of 110 VA EDs engaged
16.7 % VISN engagement

February 2020 Cohort #1: VA Geriatric Emergency Department Programming

110 VA EDs

Cohort #1: 20 EDs

- 20 EDs onboarded
  1 leveling up
  2 rural



20 (18.2%) of 110 VA EDs engaged

72.22% VISN engagement

January 2022 Cohort #1, #2: VA Geriatric Emergency Department Programming

111 VA EDs

Cohort #1: 20 EDs

- 20 of 20 VA EDs able to apply for ACEP GEDA
- 16 out of 20 accredited!!

Cohort#2: 35 EDs

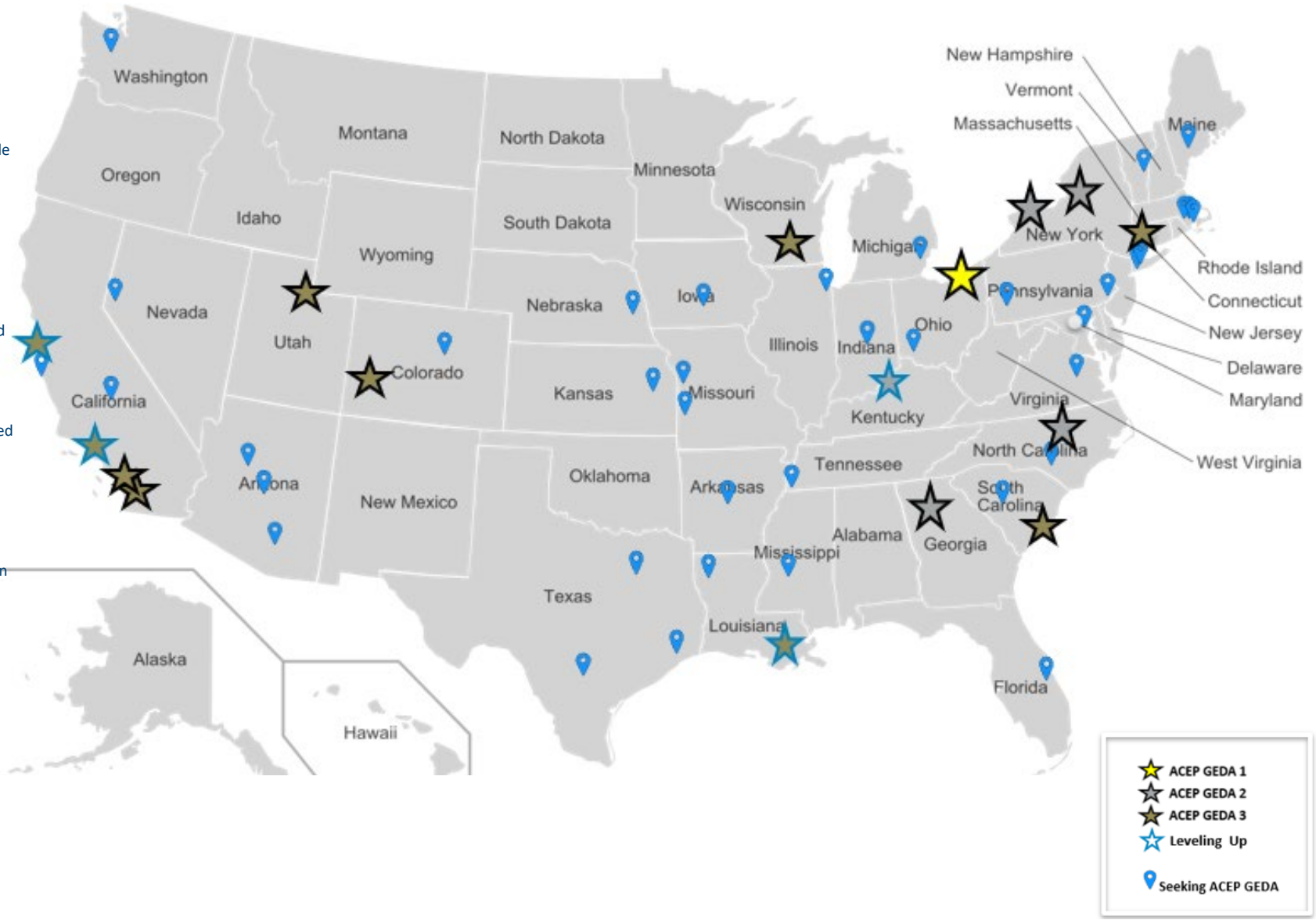
- **Goal:** 30 sites
  35 sites applied
- **32 new sites**
  3 leveling up
  5 rural

Status

- 25 sites have applied
- 10 sites pending submission

Cohort #3:

- Goal: 30 sites
- VA Cohort application released 12.6.2021

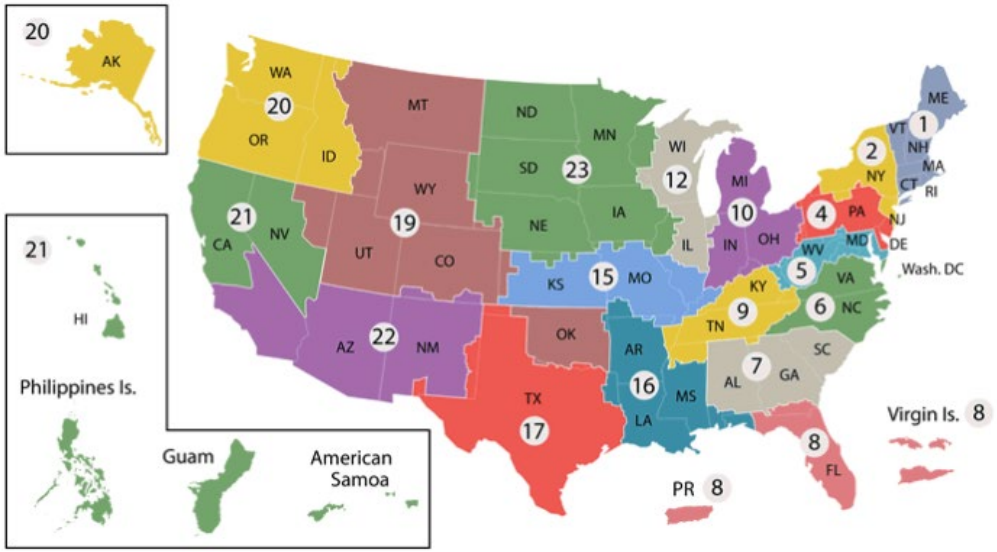


52 (46.8%) of our 111 VA EDs engaged

100% of our VISNS

VISN: Veterans Integrated Service Network

VISN	1	2	4	5	6	7	8	9	10	12	15	16	17	19	20	21	22	23
# of EDs Engaged	4	4	2	1	3	3	1	1	4	2	3	6	2	3	1	4	6	2
Total EDs in VISN	5	8	5	6	6	6	8	5	7	5	7	7	4	7	3	6	8	7
% Geriatric ED Engagement	80%	50%	40%	16.7%	50%	50%	12.5%	20%	50.1%	40%	42.9%	85.7%	50%	42.9%	33.3%	66.7%	75%	28.6%



ACEP Geriatric Emergency Department Accreditation

The John A. Hartford Foundation

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GEDC

VA Launches Program to Improve Emergency Care for Nation's Older Veterans

September 9, 2021

Public-private partnership aids VA in becoming the largest integrated health network with specialized geriatric emergency care

The Department of Veterans Affairs (VA) has launched a nationwide movement to improve emergency department (ED) care for older Veterans treated in VA Medical Centers and become the nation's largest integrated health network with specialized geriatric emergency care.

The VA Geriatric Emergency Department Initiative is a public-private collaboration between the VA, the American College of Emergency Physicians (ACEP), The John A. Hartford Foundation, and the West Health Institute to establish 70 of the VA's EDs as accredited geriatric emergency departments (GEDs). GEDs are better equipped to treat older adults with complex conditions, catch unmet care needs, and develop teamwork strategies to better coordinate emergency and follow-up care. **Recent studies** have found GEDs can decrease hospital admissions and lower total healthcare costs.

According to leadership at the VA, the initiative promotes Veteran goals of care, home safety, community emergency risk mitigation and preservation of Veteran independence.

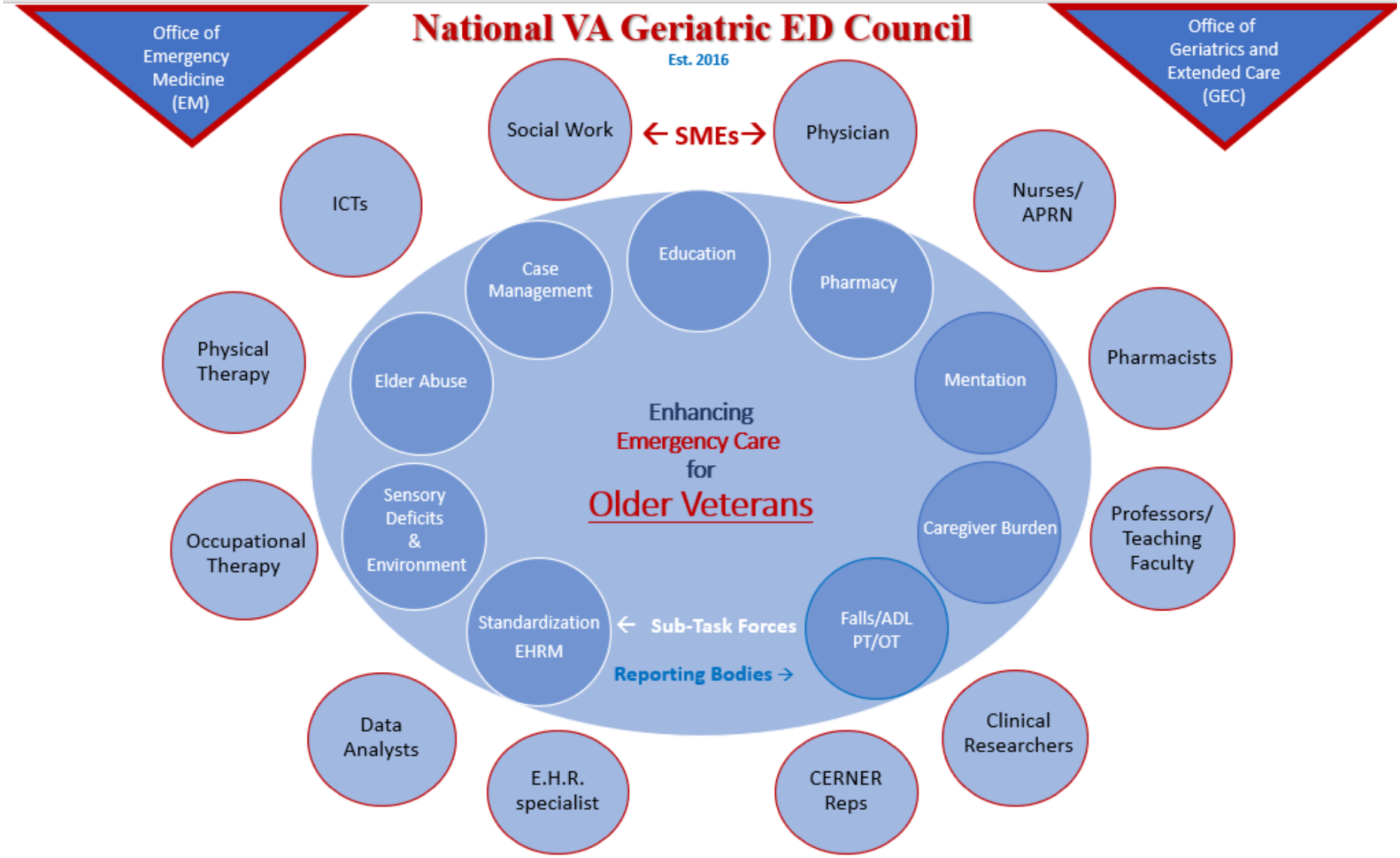
How is VA Leading the Field of Geriatric Emergency Medicine?

- ❑ Large Scale, System Wide Implementation
- ❑ Local Implementation
- ❑ Innovative Support Programs
- ❑ Innovation in Progress

How is VA Leading the Field of Geriatric Emergency Medicine?

Large Scale, System Wide Implementation

Large National Council with Engaged Interdisciplinary SMEs



Tap Into Frontline Staff

Listen

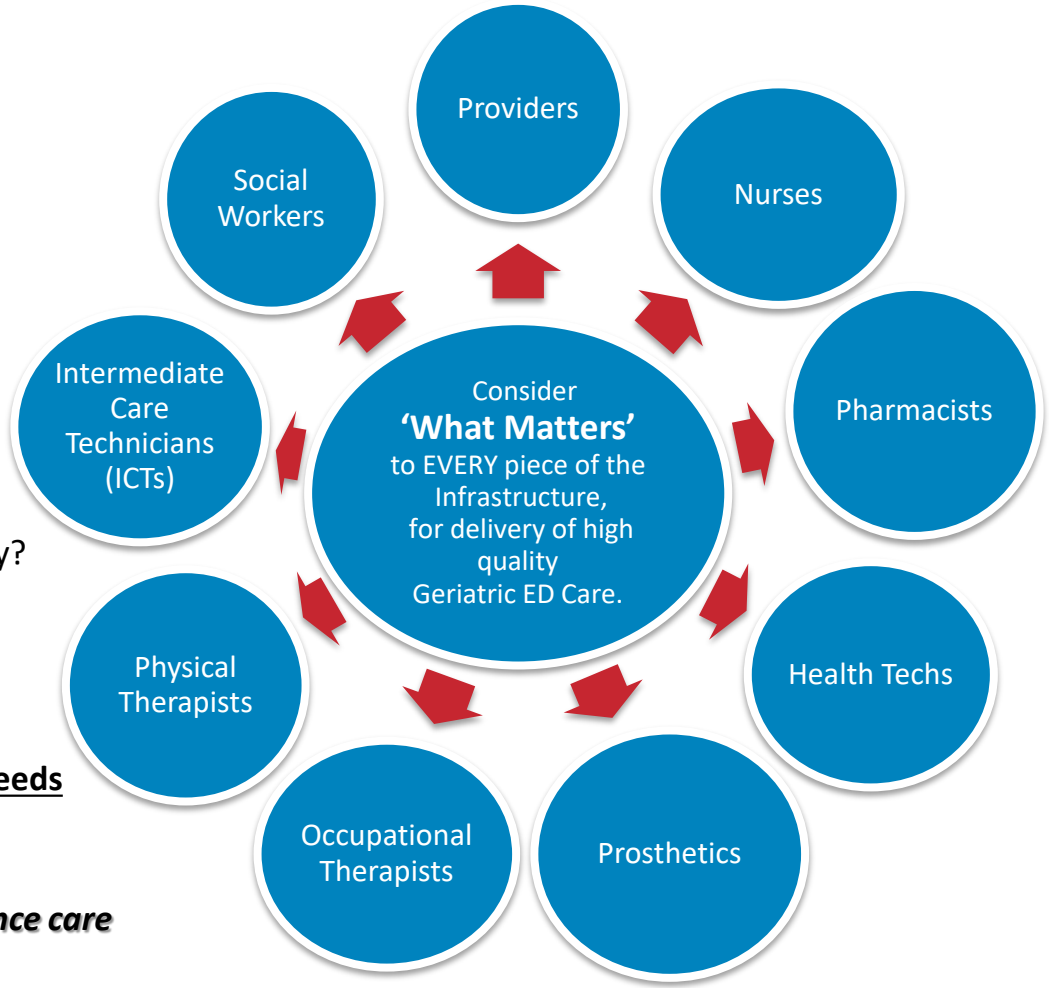
- ❑ Frustration points
- ❑ Barriers
- ❑ Compassion stressors

Elicit their Why?

- ❑ Why do they work at the VA?
- ❑ Why do they want to engaged in this initiative?
- ❑ What do they need to do their job more effectively?
- ❑ What needs streamlined?

Create a plan that matches your frontline values and needs

- ❑ ***Frontline voices are the 'Why' to our initiative***
- ❑ We create tools that ***allow frontline staff to enhance care*** of Geriatric Emergency Department patients



Standardization, Dissemination and Implementation

September 2021 Release:

Standardized National CPRS Geriatric ED Template

Geri-ED Screens:

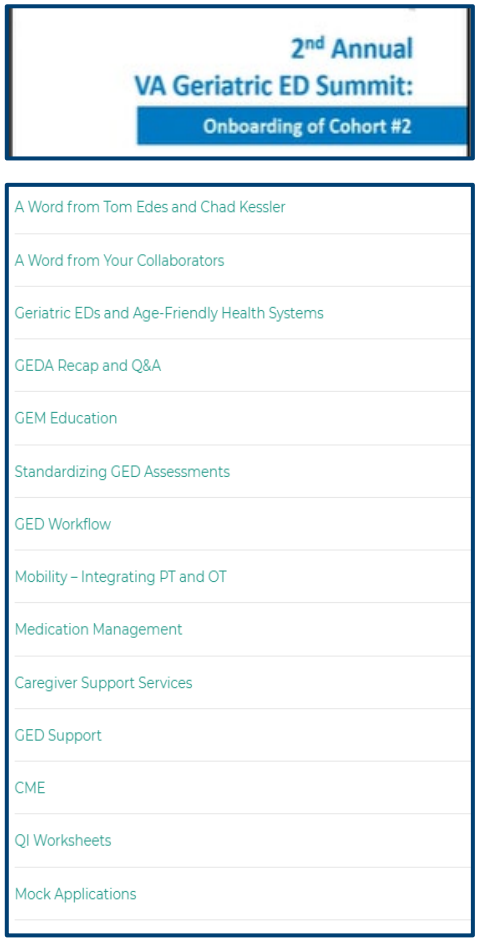
- ☐ Identification of Seniors at Risk (ISAR)
- ☐ Delirium Triage Screen (DTS)
- ☐ Delirium - Brief Confusion Assessment Method (BCAM)
- ☐ Cognitive Impairment Screen (Mini-Cog)
- ☐ KATZ Activities of Daily Living (ADLs)
- ☐ Falls - Stopping Elderly Accidents, Deaths & Injuries (STEADI)
- ☐ Caregiver Burden - Modified Zarit Burden Interview short-form 4 (ZBI-4)
- ☑ Screening time:

VA ED Site Adoption:

❑ **ISAR:**	**15**
❑ **Delirium**	
DTS:	11
bCAM:	11
❑ **Mini Cog:**	11
❑ **ADL:**	10
❑ **Falls:**	**22**
❑ **Caregiver Burden:**	**11**
❑ **Screen time:**	16

As sites onboard these screens, the National Geriatric ED Dashboard will populate data.

Education as Dissemination Tool

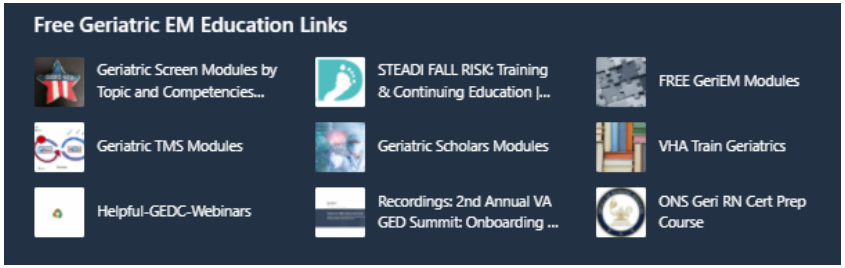


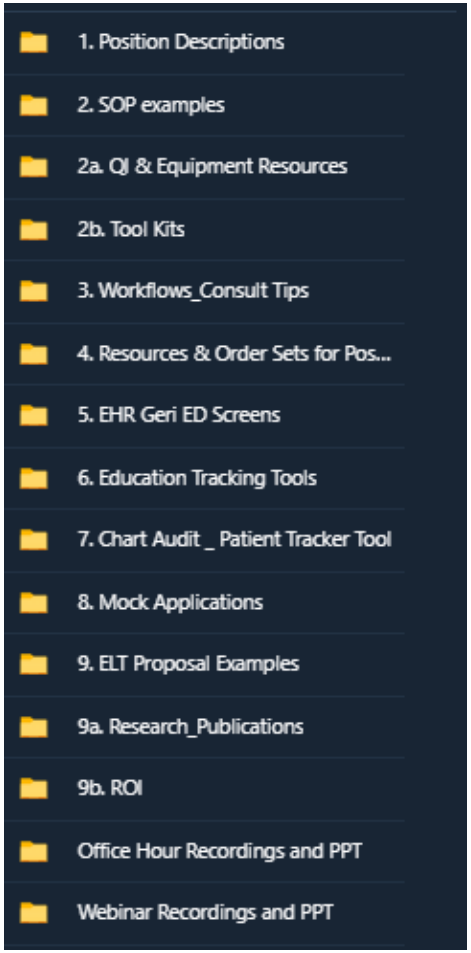
1. **Annual VA Geriatric ED Summit: Onboarding of Cohorts**

2. **Geri EM Focused webinars with multidisciplinary CEs**

3. **Geri EM Focused office hours**

4. **Geri EM SharePoint**
   a. Links to past VA Webinars and Office hours
   b. Links to free education (VA and Non-VA)
   c. Example position descriptions, policies, procedures, guides, how to videos
   d. Example workflows and how to use the E.H.R. screens





A Multi-Sector Approach to Promoting Geriatric Emergency Medicine programming at US Department of Veterans Affairs Emergency Departments

Colleen McQuown MD; Luna Ragsdale MD,MPH; Ethan Jetter MPH; Ula Hwang MD, MPH; Tessa Runels MPH; Erica Gruber A-GNP, BCEN US Dept VA

14TH ANNUAL CONFERENCE ON THE SCIENCE OF DISSEMINATION AND IMPLEMENTATION IN HEALTH

AcademyHealth

NIH National Institutes of Health

BACKGROUND

US Dept of Veterans Affairs (VA) developed a strategic plan to achieve Geriatric Emergency Department Accreditation (GEDA) through the American College of Emergency Physicians (ACEP) at all 110 VA EDs

GEDA Requirements

Multi-Phase Implementation

- 2019 • Pilot Site
- 2020 • Cohort One: 19 VA EDs
- 2021 • Cohort Two: 30 VA EDs
- 2022 • Cohort Three: 30 VA EDs

Plan Do Study Act: Input

MULTI-SECTOR APPROACH

CURRENT STATE: VA Emergency Department Programming

PDSA:OUTCOMES

Website: Samples

1.0 Deploy the VA GED Core Team.

2.0 Cohort education and mentored support with GEDC and ACEP

3.0 GEDA practice expansion via Cohort #2 (2021) and Cohort #3 (2022).

4.0 Standardize Geriatric ED clinical practice and documentation.

5.0 Collaborate with VHA non-Emergency Medicine stakeholders within the VA health care system.

6.0 Secure infrastructural and budgeted support for a national Geriatric ED office within VHA upon the conclusion of this 2 year externally funded proposal.

7.0 Evaluate impact of GEDA through quality metric tracking and evaluation.

VA U.S. Department of Veterans Affairs

Contact : VHAGEDCoreteam@va.gov

CONCLUSION

A widescale implementation program backed by a multi-sectoral partnership will affect more than one million older veterans who visit VA EDs each year. A core team engaged with stakeholders committed to PDSA allows for adoption of best practices across a largest integrated healthcare system in the US.

How is VA Leading the Field of Geriatric Emergency Medicine?

Local Implementation

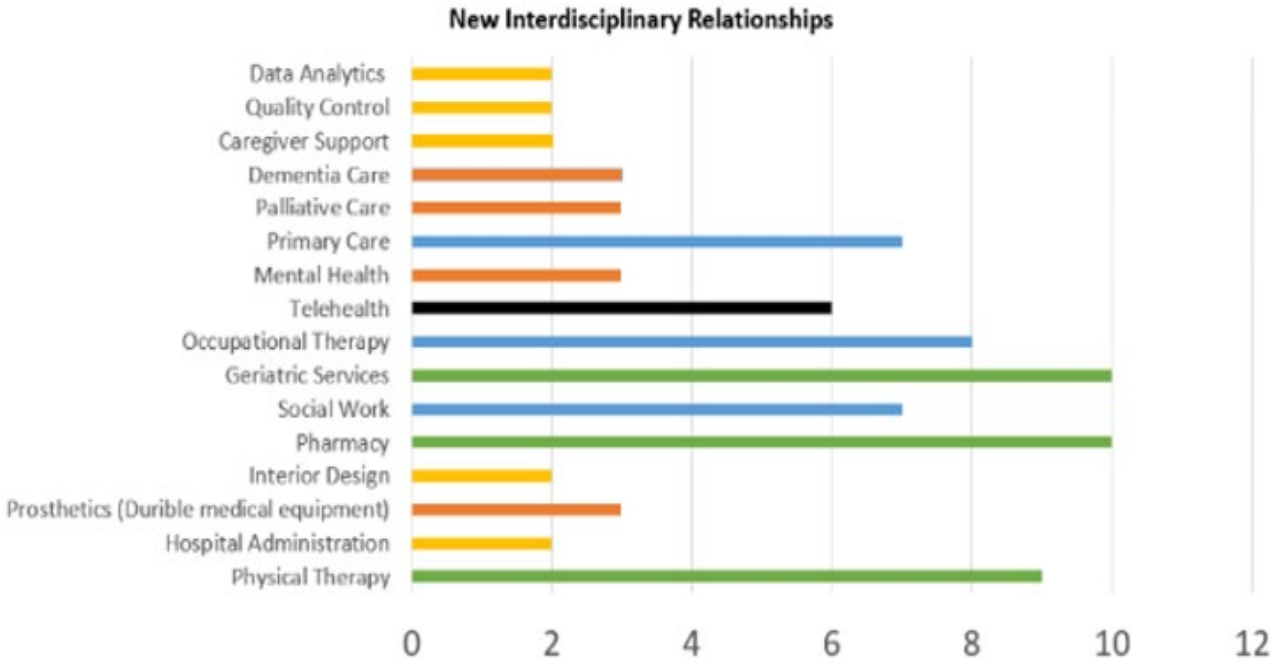
Using ACEP GEDA Criteria to Build Local Geriatric ED Model Of Care

- **Interdisciplinary team infrastructures**
  - ❑ Social Worker
  - ❑ Pharmacist
  - ❑ Physical Therapy
  - ❑ Occupational Therapy

- **A comprehensive model of care**
  - ❑ Recognize seniors at risk
  - ❑ Screen for unmet care needs/ geriatric syndromes
  - ❑ Care coordinate to meet these needs
  - ❑ Standardize pathway to follow up care
  - ❑ Monitor program for areas of quality improvement

Benefits of ACEP GEDA Process as reported by Cohort #*1*

94% (15/16) Sites described new interdisciplinary services connections



Findings from Most Senior VA Geriatric ED: GERI-VET

Geriatric Emergency Room Innovations for Veterans (GERI VET)

- Comprehensive Level 1 GED at Louis Stokes Cleveland VAMC + Innovative workforce
- Multidisciplinary service consult in ED
- Multidisciplinary supportive consults for post ED follow up
- Reduced rates of admission from ED
- Reduced 30-day hospitalization

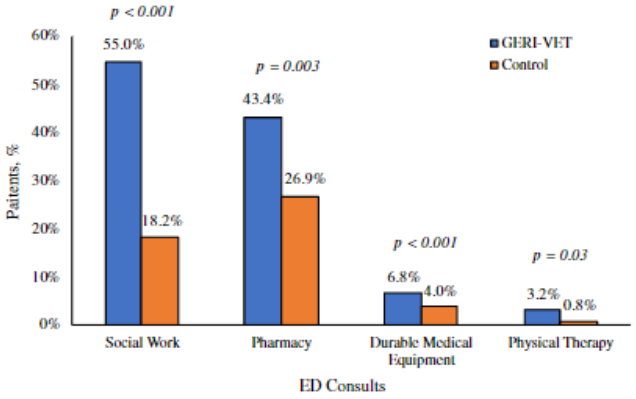
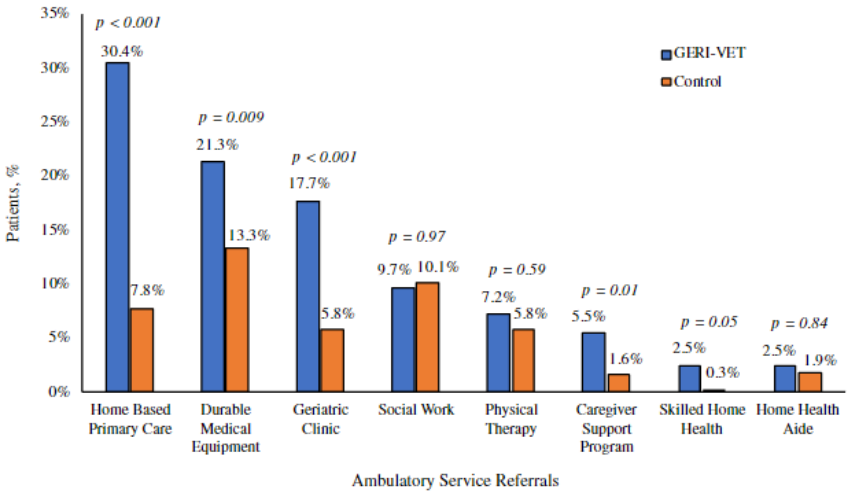


FIGURE 2 Consults performed in the Emergency Department for GERI-VET patients ($n = 725$) and matched control patients ($n = 725$). ED, Emergency Department; GERI-VET, Geriatric Emergency Room Innovations for Veterans

FIGURE 3 Referrals to outpatient and home VA resources for GERI-VET patients ($n = 362$) and matched controls ($n = 308$) discharged from the ED. ED, Emergency Department; GERI-VET, Geriatric Emergency Room Innovations for Veterans



Huded JM et al. JAGS Nov 2021. Association of a geriatric emergency department program with healthcare outcomes among veterans - Huded - - Journal of the American Geriatrics Society - Wiley Online Library

U.S. Department of Veterans Affairs

Reduced Rates of: Admission from ED and 30-day Hospitalization when receiving care from GERI-VET liaison + standard ED care.

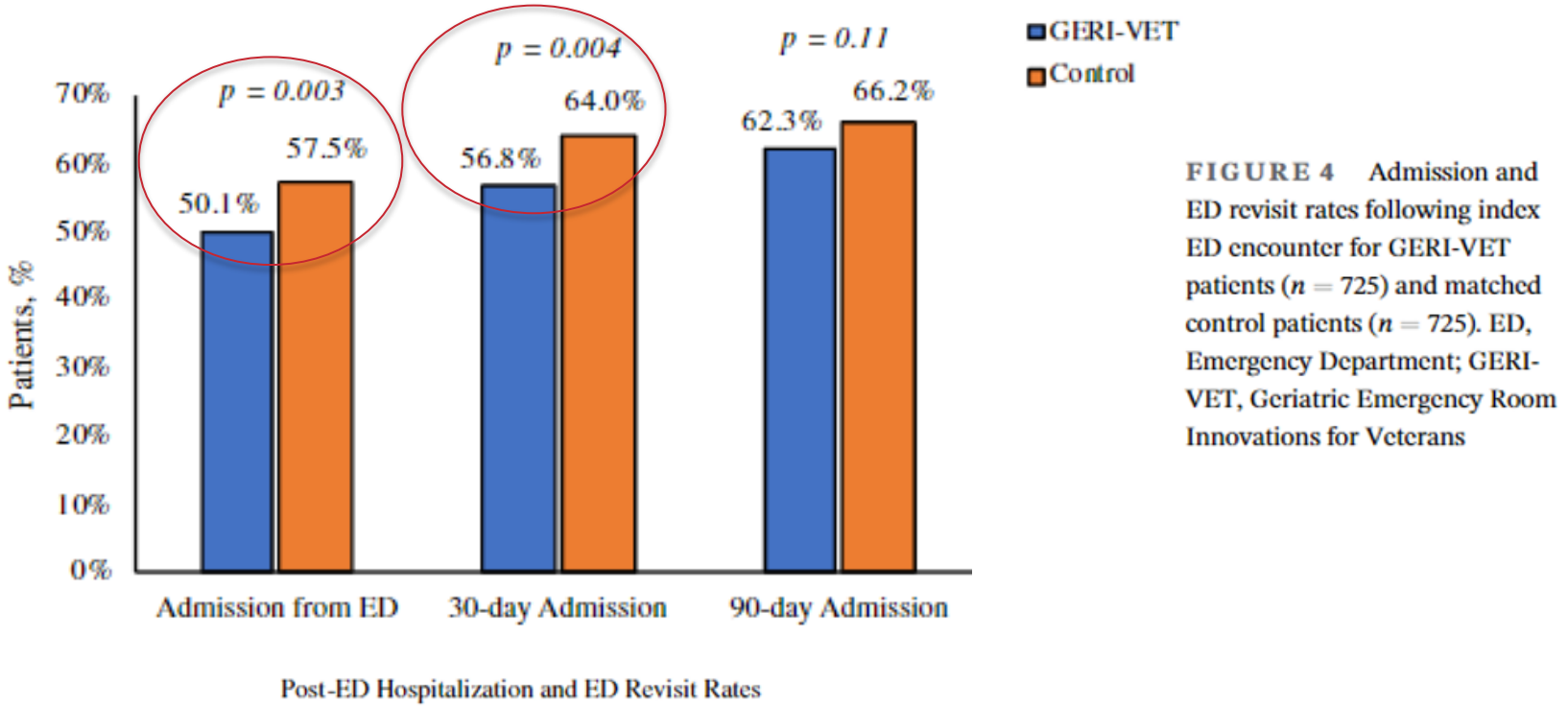


FIGURE 4 Admission and ED revisit rates following index ED encounter for GERI-VET patients ($n = 725$) and matched control patients ($n = 725$). ED, Emergency Department; GERI-VET, Geriatric Emergency Room Innovations for Veterans

Potential for Cost-Savings

Original Investigation | Emergency Medicine

Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries

Ula Hwang, MD, MPH; Scott M. Dresden, MD, MS; Carmen Vargas-Torres, MA; Raymond Kang, MA; Melissa M. Garrido, PhD; George Loo, DrPh; Jeremy Sze, MA; Daniel Cruz, BS; Lynne D. Richardson, MD; James Adams, MD; Amer Aldeen, MD; Kevin M. Baumlin, MD; D. Mark Courtney, MD, MSc; Stephanie Gravenor, MBA; Corita R. Grudzen, MD, MSHS; Gloria Nimo, RN, NP; Carolyn W. Zhu, PhD; for the Geriatric Emergency Department Innovations in Care Through Workforce, Informatics, and Structural Enhancement (GEDI WISE) Investigators

Conclusions

Innovative models of care have been implemented over the past decade to improve the quality of emergency care, improve health outcomes, and reduce costs for older ED patients. In this study, GED care from a TCN and/or an SW was associated with lower total Medicare costs at 30 and 60 days after the index ED visit. The estimated cost savings projected in this study may be used by health care payers when considering savings for potential reimbursement models that are associated with GED programs.

Key Points

Question Is there an association between geriatric emergency department (ED) programs and total costs of care for Medicare?

Findings In this cross-sectional study of 24 839 Medicare fee-for-service beneficiaries at 2 EDs, there was a significant association with reduced total costs of care after being seen by either a transitional care nurse and/or social worker trained to deliver geriatric emergency care. Per beneficiary, these savings were as much as $2905 after 30 days and $3202 after 60 days of the index ED visit.

Meaning These findings suggest that geriatric emergency department care programs may be associated with savings value to hospitals and payers.

How is VA Leading the Field of Geriatric Emergency Medicine?

Innovative Support Programs

Supporting
Community
Outpatient
Urgent Care
&
Telehealth
Services

Serves as a post ED care model where Intermediate Care Technicians (ICT) (former military medics) :

- ❑ Perform in-home screenings based on the 4Ms of age friendly health systems 48-72 hours after an ED visit in which the older Veteran is identified as high risk
- ❑ Reinforce ED discharge instructions and deploy care services to support Veterans' remaining in home
- ❑ Assist with healthcare navigation and connection to Primary Care Team
- ❑ Act as a tele-presenter during a video or telephone visit with Acute Care Team
  - Post ED follow up for worsening of condition
  - Promote an action plan to address unmet care needs or home safety risk

EQUIPPED

[Enhancing Quality of Prescribing Practices for Older Adults Discharged from the Emergency Department]

Quality improvement program to enhance safe prescribing towards older adults in the ED setting that is feasible to implement across multiple health systems.

- ❑ Order Sets
- ❑ Education
- ❑ Clinical decision support
- ❑ Individual Provider Prescribing Practice Feedback

How is VA Leading the Field of Geriatric Emergency Medicine?

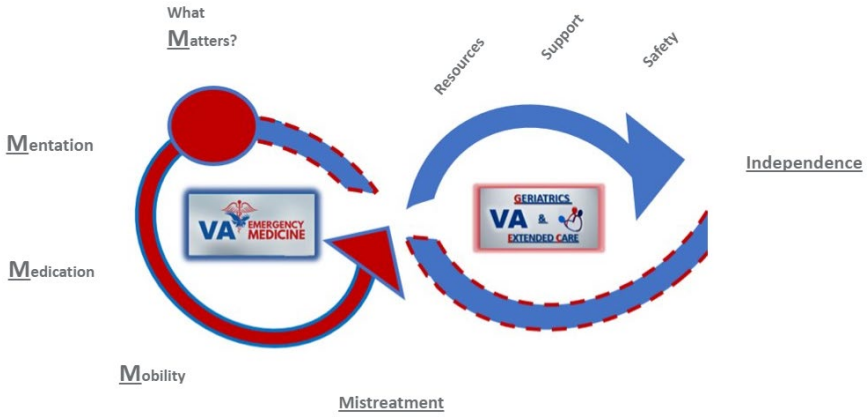
Innovation in Progress

Strategic initiatives for 2022 and post 2022 sustainment

- ❑ **'Identified Seniors at Risk Potentially Inappropriate Medication Review Note':**
  - Communication tool for ED pharmacists and primary care team towards safe prescribing/deprescribing
  - Goal: mitigate cause of current, recurrent ED visits and medication risk post ED visit.
  - 3 sites piloting note now
  - Plan to move towards national standardization

- ❑ **Tele-Services INTO ED**: Importing otherwise physically absent services **into** ED (rural focus) via Teleservices to support emergency care and care coordination of the geriatric Veterans
  - Social Work
  - Pharmacy

- ❑ **Urgent Care Interest:** expressed interest in parallel UC track to onboard program toward IHI AFHS Recognition Criteria.



- ❑ **Multisite program analysis** utilizing the National Geri EM Dashboard

- ❑ **D & I of Geriatric ED Programming** to the remaining 41 VA EDs

- ❑ **Funding to sustain local infrastructure/practice and National Office Geriatric ED Leadership**

Post 2022 Possibilities: VA Geriatric Emergency Department (*Urgent Care*) Programming

111 VA EDs

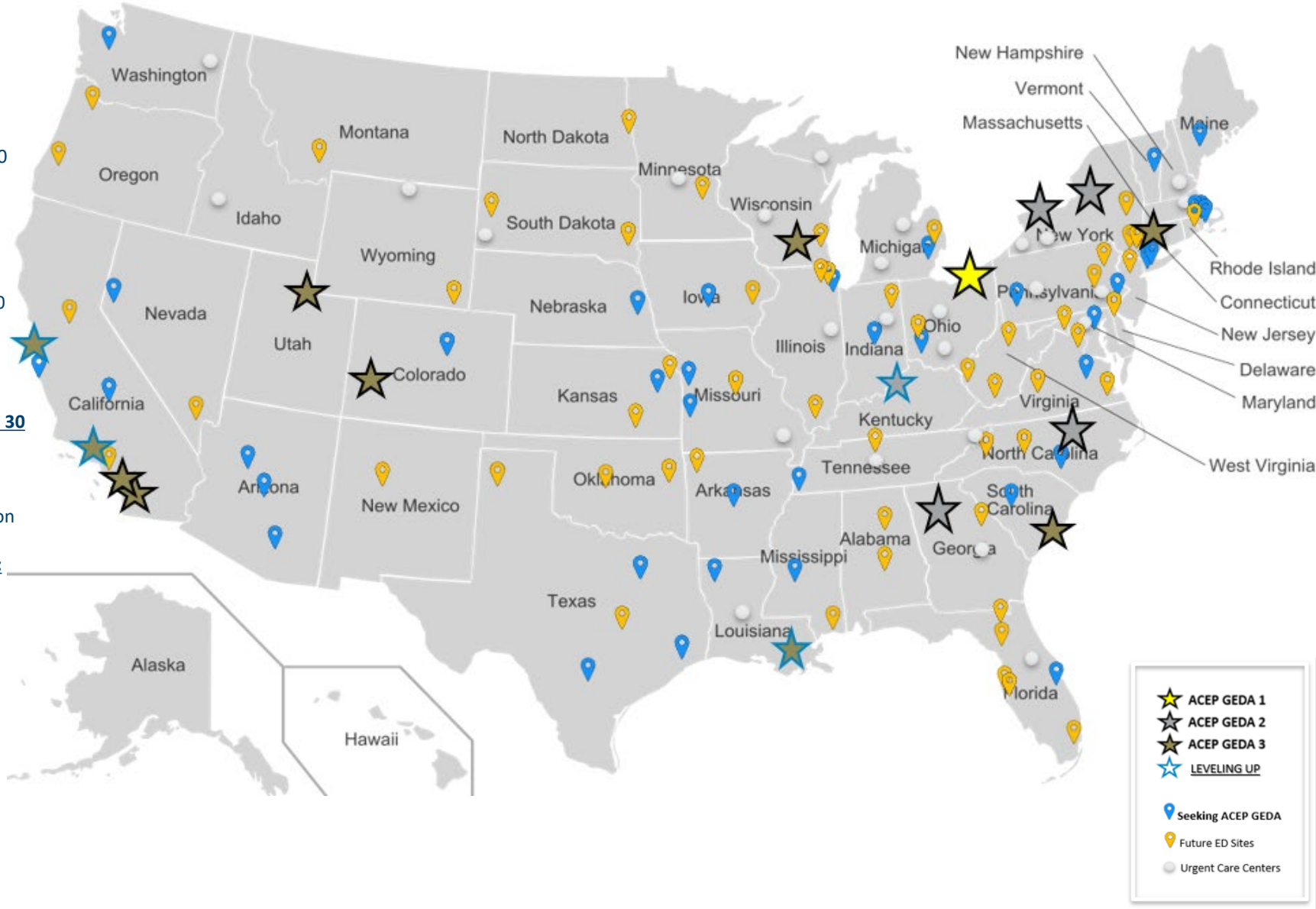
Cohort #1:
- 20 out of 20 accredited

Cohort#2:
- 30 out of 30 accredited

Cohort #3: goal 30
- 30 applied pending accreditation

Remaining EDs:
- **41**

Urgent Cares:
- **29**



41 (37%) of our 111 VA EDs, at least, **still to recruit, onboard, and mentor**
29 Urgent Cares with possibility of onboarding practice to meet IHI AFHS criteria

VA | U.S. Department of Veterans Affairs

Take-A-Ways

- ❑ Center your program around the frontline staff's "Why"
- ❑ Create a community of innovation and possibilities
- ❑ Interdisciplinary subject SME engagement
- ❑ Streamline processes and create tools that allow FRONTLINE staff to enhance care & innovate
- ❑ Make access to your team and tools easy
- ❑ Create education specific to their needs

Thank you!


service
veterans
honor
innovation
pride
respect
collaboration
resources
mission
veteran
healthcare
family
care
gratitude
excellence
opportunity
patients
serve
help
love
integrity
patriotic
compassion
emergency department
different
helping
access to care
serving
to the community
eldercare
duty
ula
thankfulness
exceptional care
privilege
staff family
grateful
hired
stories
erica
interprofessional
team work
jesus
patriotism
geriatric
rewarding
healthcare for all
collaborative
thankful
unique
make a difference
wonderful mission
love the vets
support
great colleagues
dignity
appreciation
dedication
opportunities
give back
quality
flexible
passion
everyday
geriatrics
learn
altruistic
challenge
purpose
cohesive
passionate
colleagues
country
advocate
community
innovative
mission- driven
veteran serving veterans
innovation support
commitment to veterans
sacrifice
luna
retirement
elders
love the people
environment
values
happiness
commitment
proud
team
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mom of vet
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Appendix

A. ACEP GEDA LEVEL 3

B. ACEP GEDA LEVEL 2

C. ACEP GEDA LEVEL 1

Appendix A

Level III

Good/Entry level geriatric specific ED care

- At least one MD and one RN with evidence of geriatric focus (champions)
- Staff physician education related to 8 domains of geriatric EM
- Evidence of geriatric focused care initiative (SOP, Guideline)
- Mobility aids
- Food & drink 24/7

Level II

Advanced geriatric ED care

- Physician & nurse champions (medical/ nurse director) with focus on geriatric EM
- Geriatric-focused case manager **56** hours/ week
- Geriatric assessment team: **2 of** PT, OT, SW or Pharmacy available in ED
- At least 1 executive / administrative sponsor supervising geriatric ED program
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least **10** policies and protocols
- QI process for selected policies
- Tracking at least **3** outcome measures[3 on EMMT Age Report!]
- Access to **3** additional equipment/supplies and food/drink 24/7

Level I

Center of excellence in geriatric ED care

- Physician & nurse champions (medical/nurse director) with focus on geriatric EM **+ patient advisor**
- Geriatric-focused case manager 56 hours/ week
- Geriatric assessment team: **4** of PT, OT, SW or Pharmacy available in ED
- At least 1 executive / administrative sponsor supervising geriatric ED program
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least **20** policies and protocols
- QI process for selected policies
- Tracking at least **5** outcome measures
- **10** Physical supplies, food/drink , and space modifications

PCSS Providers Clinical Support System

Psychiatric Emergency Room at VA Connecticut

Providing care to a vulnerable population while keeping up with trends

Brian Fuehrlein, MD, PhD
Yale School of Medicine
VA Connecticut Healthcare System

VA Connecticut PER

- Dedicated and locked, 24/7/365
- One of only several nationally at a VA
- Capacity of 14, able to provide extended observation
- Mostly voluntary patients
- Staffed by ~30 MDs, all required to have a buprenorphine waiver

Psychiatric ERs

- Most VA emergency rooms have a mental health "area"
- This is staffed by the emergency medicine attending
- Psychiatry consults, often a resident with an attending at home
- A separate PER requires in house attending psychiatrists 24/7
- This comes with a budget >$1M for MDs
- Space and other staffing requirements

Tracking Fentanyl

	Fentanyl	Opioids	Cocaine
Total Urines	383	380	380
Positive	60	63	102
Percent Positive	15.67%	16.58%	26.84%

Elmarasi, M, Garcia-Vassallo, G, Campbell, S and **Fuehrlein, B**. Rates of Fentanyl use among Psychiatric Emergency Room Patients. *The American Journal on Addictions*, 2020, https://doi.org/10.1111/ajad.13087

Fentanyl

- Fentanyl – Total positive = 60
- Of the 60, 41 positive for opioids = 68.33%
- Of the 60, 29 positive for cocaine = 48.33%
- Of the 60, 24 positive for opioids AND negative for cocaine = 40%
- Of the 60, 12 positive for cocaine AND negative for opioids = 20%
- Of the 60, 5 negative for cocaine AND negative for opioids = 8.33%

- Of the 63 positive for opioids, 41 positive for fentanyl = 65.08%
- Of the 102 positive for cocaine, 29 positive for fentanyl = 28.43%

- Of the 41 positive for opioids AND negative cocaine, 24 positive for fentanyl = 58.54%
- Of the 80 positive for cocaine AND negative opioids, 12 positive for fentanyl = 15%

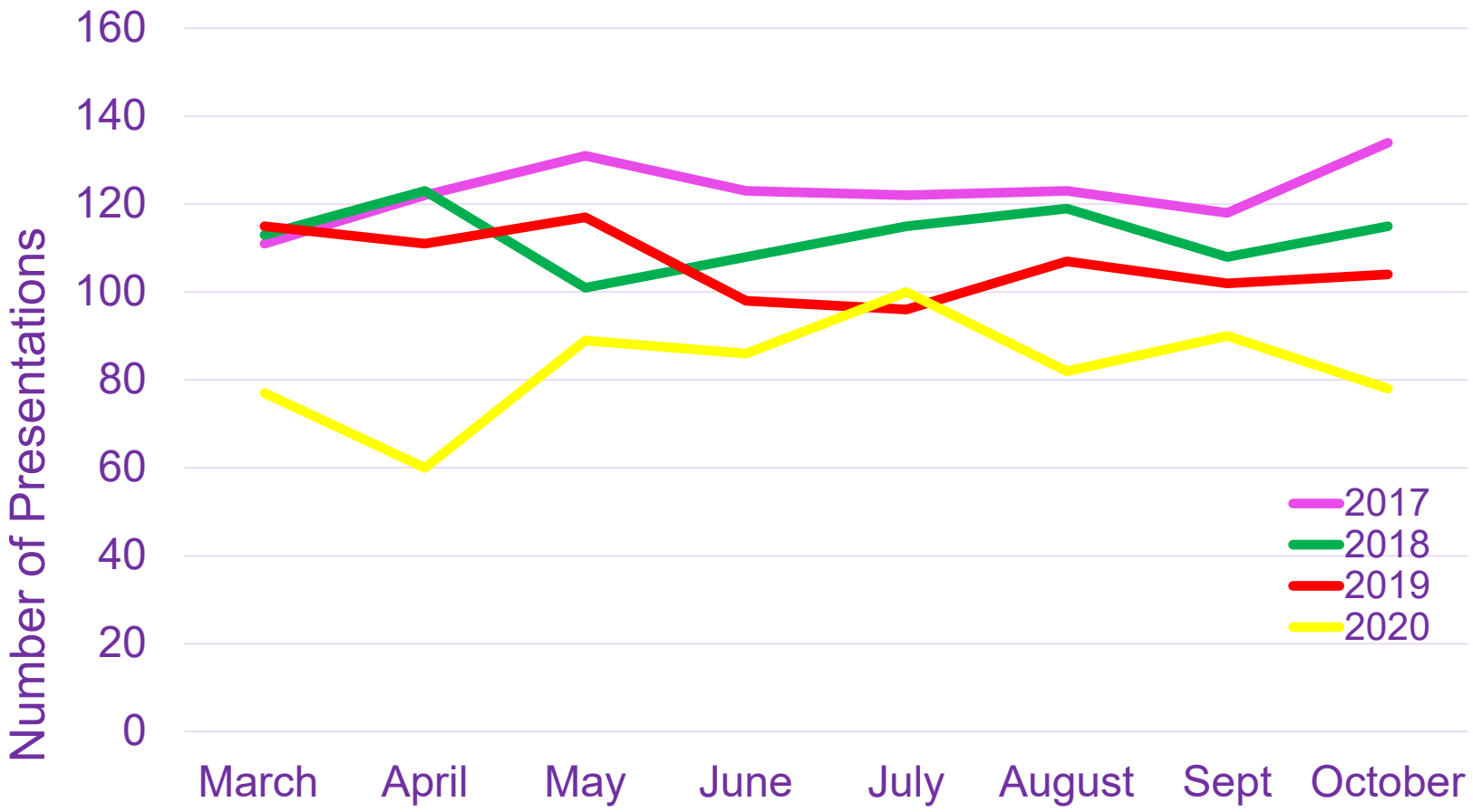
Elmarasi, M, Garcia-Vassallo, G, Campbell, S and **Fuehrlein, B**. Rates of Fentanyl use among Psychiatric Emergency Room Patients. *The American Journal on Addictions*, 2020, https://doi.org/10.1111/ajad.13087

Initiation of Buprenorphine

- Hold in the PER, full history and PE, UDS, COWS
- 2-4mg driven by patient history or COWS
- Up to 8mg day 1 and 16mg day 2
- Patients typically stabilized by day 2 and we will often hold them in the PER until stabilized, even if it takes 2-3 days
- Our contracted “detox” facility generally does not detox patients with OUD, instead initiates and stabilizes on buprenorphine
- We then refer to buprenorphine clinic with ambulatory detox team to bridge the gap, if needed
- We generally will always recommend inpatient treatment or the day program

Jaeger, S and **Fuehrlein, BS**. Buprenorphine Initiation to Treat Opioid Use Disorder in Emergency Rooms. *Journal of Neurological Sciences,* 411 (116716), 2020.

COVID-19



Mitchell, L and **Fuehrlein, BS.** Patient Volume and Dispositions in a VA Psychiatric Emergency Room During COVID-19. *Community Mental Health*. In Press, 2021.

PCSS Providers Clinical Support System

COVID-19

Rates of referrals to residential rehab decline during the peak

	March	April	May	June	July	August
2017-2019 Average	7.7%	8.1%	9.1%	8.6%	7.4%	8.2%
2020	7.8%	3.3%	3.4%	5.8%	10.1%	7.3%

- Residential settings closed during pandemic
- Urgent service gap

Mitchell, L and **Fuehrlein, BS.** Patient Volume and Dispositions in a VA Psychiatric Emergency Room During COVID-19. *Community Mental Health*. In Press, 2021.

PCSS Providers Clinical Support System

COVID-19 Vaccine

Victories

- 23 veterans vaccinated with dose 1
- 21 of those successfully with dose 2

Challenges

- 6-dose vials are difficult to distribute without waste
- Length of stay too short
- Patients prioritize emergency
- Lack capacity/intoxicated
- Vaccine hesitancy

Data presented at American Academy of Addiction Psychiatry annual meeting, 2020 and under review Community Mental Health journal

Education in the PER

Trainees who rotate throughout the year

- MS2/3
- MS4
- PGY1 podiatry interns
- PGY2 pharmacy residents
- PGY2 psychiatry residents
- PGY4 psychiatry chief residents
- PGY5 addiction psychiatry fellows
- Social work fellows
- Psychology fellows

Education in the PER

- We developed a novel addiction curriculum, administered it to trainees and published in Academic Psychiatry

- We collected 6 years of student presentations and analyzed it for trends. This is accepted for publication in Academic Psychiatry.

Feeley, R., Moore, D., Wilkins, K and **Fuehrlein, B**. A Focused Addiction Curriculum and its Impact on Student Knowledge, Attitudes and Confidence in the Treatment of Patients with Substance Use Disorders. Academic Psychiatry. Doi:10.1007/s40596-017-0771-8 epub, 2017.

Data presented at the Association of Directors of Medical Student Education in Psychiatry and accepted for publication in Academic Psychiatry, 2021

Conclusions

- Psychiatric emergency rooms care for a vulnerable population and provide a valuable clinical service
- They are also ripe for quality/research initiatives and education of trainees

Community Care ED Use and Specialty Care Leakage from Veterans Health Administration Hospitals

Sivagaminathan Palani, Kertu Tenso, Steven Pizer

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

PEPReC
Partnered Evidence-based Policy Resource Center
A VA QUERI Center

QUERI VA Quality Enhancement Research Initiative
EVIDENCE INTO PRACTICE

Background

- Proportion of VA care provided in the community has been growing, increasing CC care can lead to
  - ➢high cost to VA, fragmented care, poor health outcomes

- A major driver for CC utilization is believed to be CC ED use
  - ➢CC ED visits lead to hospitalizations, outpatient follow-up care and patient leakage to the community

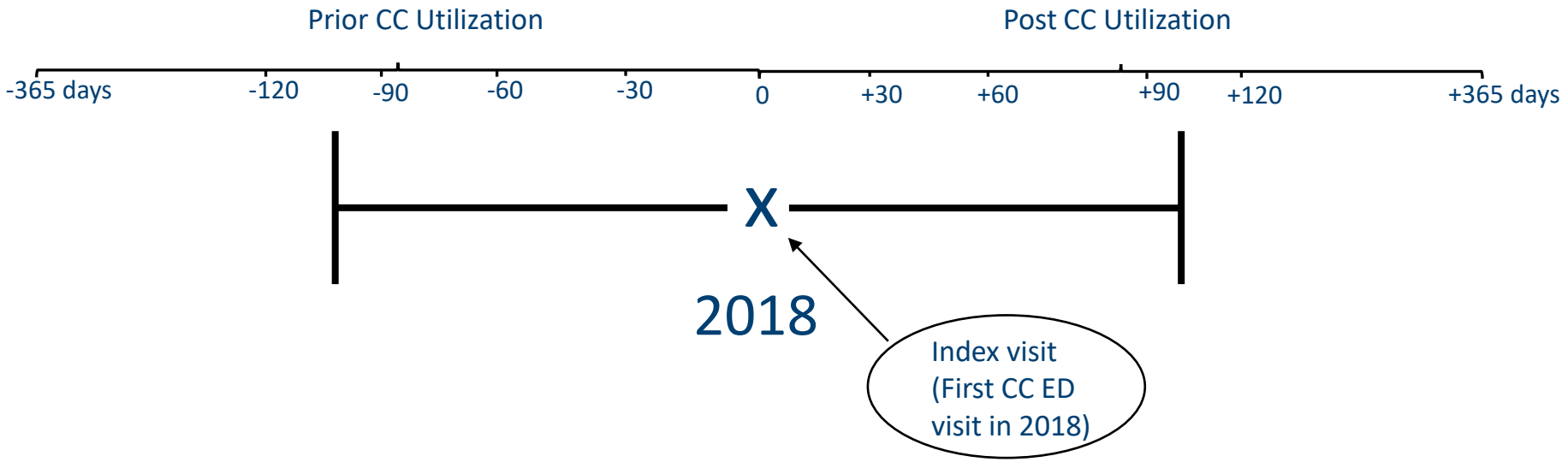
- However, there is a lack of evidence on the actual impact of CC ED use on care leakage to the community.

Research Question: Do community care ED visits increase specialty care leakage to the community?

- Preliminary findings
  - Positive association between CC ED visit and CC SC visits
  - Our current models have limitations, further modeling is underway

Study Design

Retrospective Cohort Study

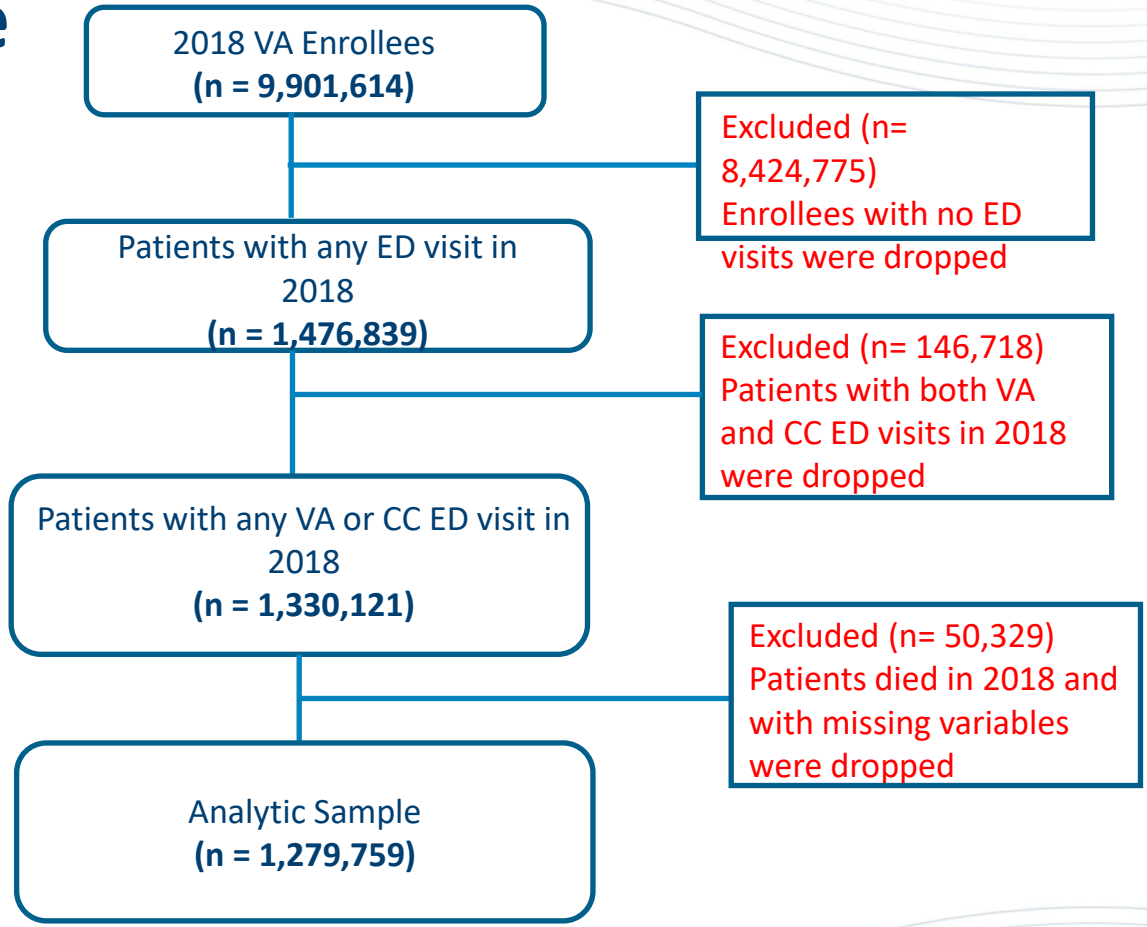


PEPReC
Partnered Evidence-based Policy Resource Center
A VA QUERI Center

Data

- 2017-2019 VA Administrative and Claims data
  - EDIS, PIT, PSSG tables in CDW

Analytic Sample



PEPReC
Partnered Evidence-based Policy Resource Center
A VA QUERI Center

Measures and Analysis

- **Outcomes**
  1. Number of CC SC visits within 30, 60, 90, 120 and 365 days from index visit
  2. Proportion of SC visits in CC within 30,60, 90, 120 and 365 days from index visit
  - ➢specialty care visits were included, inpatient hospitalizations were dropped for now

- **Predictors**
  - ➢CC ED visit (first 2018 ED visit)
  - ➢CC ED visits (index year), VA ED visits (index year)
  - ➢Gender, Age, Priority status, Comorbidity, Mission Act eligibility based on specialty and primary care drive times, specialty care drive time, primary care drive time

- **Analysis** – OLS, Negative Binomial Regression models

Summary Statistics

Variables	Patients with no CC ED visits (n = 1,049,576)	Patients with at least one CC ED visits (n= 230,183)
Gender		
Female	938,024 (**11%**)	26,664 (**12%**)
Male	111,552 (**89%**)	203,519 (**88%**)
Age		
Average	**59.84** (SD = 16.18)	**57.84** (SD = 15.98)
Below 35	107,594 (**10%**)	27,678 (**12%**)
35-65	482,454 (**46%**)	109,045 (**47%**)
65 plus	459,528 (**44%**)	93,460 (**41%**)
Drive time average		
Specialty care	**31.73** (SD = 27.11)	**67.41** (SD = 48.89)
Primary care	**18.64** (SD = 14.02)	**23.54** (SD = 20.54)
Drive distance average		
Specialty care	**26.07** (SD = 27.34)	**63.24** (SD = 50.27)
Primary care	**13.29** (SD = 13.07)	**18.05** (18.99)
Mission Act Eligible for CC		
By specialty care drive time	127,256 **(12%)**	109,598 **(48%)**
By primary care drive time	157,567 (**15%**)	58,865 (**26%**)
Priority Status (7 or 8)	129,965 (**12%**)	19,522 (**8.5%**)
Comorbidities		
Median	2	2
4 or more conditions	309, 277 (30%)	61,186 (27%)

CC SC Visits – by CC ED Visit

	Patients with no CC ED visits	Patients with at least one CC ED visits	p-value
CC SC Visits			
within 30-days			
Median	**0**	**0**	
Mean	**0.182 (SD = 0.93)**	**0.76 (SD = 1.99)**	**<0.001**
within 60-days			
Median	**0**	**0**	
Mean	**0.38 (SD = 1.66)**	**1.33 (SD = 3.14)**	**<0.001**
within 90-days			
Median	**0**	**0**	
Mean	**0.59 (SD = 2.32)**	**1.86 (SD = 4.50)**	**<0.001**
within 120-days			
Median	**0**	**0**	
Mean	**0.79 (SD = 2.93)**	**2.37 (SD = 5.56)**	**<0.001**
within 365-days			
Median	**0**	**1**	
Mean	**2.35 (SD = 6.84)**	**6.04 (SD = 12.69)**	**<0.001**

Regression Results

Table 1: OLS Regression - Outcome – Proportion of SC Visits in CC

VARIABLES	DV = Prop. SC Visits in CC within 30 days	DV = Prop. SC Visits in CC within 60 days	DV = Prop. SC Visits in CC within 90 days	DV = Prop. SC Visits in CC within 120 days	DV = Prop. SC Visits in CC within 365 days
CC ED Visit (0/1)	0.17***	0.15***	0.13***	0.13***	0.099***
	(0.0011)	(0.00095)	(0.00088)	(0.00084)	(0.00072)
R-squared	0.140	0.139	0.140	0.142	0.162
Number of Observations	1275447	1275447	1275447	1275447	1275447

Notes: Gender, Age, Priority Status (7 or 8), Comorbidities, Mission Act Eligibility for CC, Drive time to Specialty Care and Primary Care, Station FE were included as covariates in the models.

Regression Results

Table 2: OLS Regression - Outcome – Proportion of SC Visits in CC

VARIABLES	DV = Prop. SC Visits in CC within 30 days	DV = Prop. SC Visits in CC within 60 days	DV = Prop. SC Visits in CC within 90 days	DV = Prop. SC Visits in CC within 120 days	DV = Prop. SC Visits in CC within 365 days
CC ED Visit (0/1)	**0.14*** **	**0.12*** **	**0.11*** **	**0.097*** **	**0.072*** **
	(0.0018)	**(0.0016)**	**(0.0015)**	**(0.0014)**	**(0.0012)**
# CC ED Visits (in Index year)	0.018***	0.017***	0.017***	0.017***	0.016***
	(0.00097)	(0.00082)	(0.00077)	(0.00074)	(0.00066)
# VA ED Visits (in Index year)	-0.00034**	-0.00076***	-0.00085***	-0.00083***	-0.00080***
	(0.00011)	(0.000099)	(0.000094)	(0.000091)	(0.000084)
R-squared	0.141	0.140	0.142	0.144	0.164
Number of Observations	1275447	1275447	1275447	1275447	1275447

Notes: Gender, Age, Priority Status (7 or 8), Comorbidities, Mission Act Eligibility for CC, Drive time to Specialty Care and Primary Care, Station FE were included as covariates in the models.

Regression Results

Table 3: Negative Binomial Regression - Outcome – Number of CC SC Visits

VARIABLES	DV = CC SC Visits within 30 days	DV = CC SC Visits within 60 days	DV = CC SC Visits within 90 days	DV = CC SC Visits within 120 days	DV = CC SC Visits within 365 days
	IRR	IRR	IRR	IRR	IRR
CC ED Visit (0/1)	2.67***	2.10***	1.88***	1.75***	1.45***
	0.038	0.028	0.024	0.022	0.015
# CC ED Visits (in Index year)	1.10***	1.12***	1.13***	1.14***	1.14***
	0.0067	0.0066	0.0065	0.0064	0.0053
# VA ED Visits (in Index year)	1.03***	1.04***	1.04***	1.05***	1.05***
	0.0024	0.0022	0.0021	0.0020	0.0017
Number of Observations	1275447	1275447	1275447	1275447	1275447
Marginal effects	CC ED Visit (1) = 0.44 CC ED Visit (0) = 0.16	CC ED Visit (1) = 0.72 CC ED Visit (0) = 0.34	CC ED Visit (1) = 0.99 CC ED Visit (0) = 0.52	CC ED Visit (1) = 1.24 CC ED Visit (0) = 0.74	CC ED Visit (1) = 3.07 CC ED Visit (0) = 2.11

Notes: Gender, Age, Priority Status (7 or 8), Comorbidities, Mission Act Eligibility for CC, Drive time to Specialty Care and Primary Care, Station FE were included as covariates in the models.

Summary

- Preliminary findings
  - Positive association between CC ED visit and the proportion of SC visits in CC (OLS models)
  - Patients with CC ED visit were estimated to have higher rates of SC visits in CC than patients with no CC ED visit (Negative binomial models)
  - The current estimates are not causal. Positive association could be due to unmeasured health differences driving both CC ED and CC SC utilization
- Next steps
  - Developing models to isolate quasi-experimental variation in CC ED utilization through IV approach.

Thank You!

Backup Slides

Table -1

Table 1: Models with demographics only					
Outcome - Proportion of CC SC Visits					
VARIABLES	DV = Prop. Of CC SC Visits within 30 days	DV = Prop. Of CC SC Visits within 60 days	DV = Prop. Of CC SC Visits within 90 days	DV = Prop. Of CC SC Visits within 120 days	DV = Prop. Of CC SC Visits within 365 days
CC ED Visit (0/1)	0.17***	0.15***	0.13***	0.13***	0.099***
	0.0011	0.00095	0.00088	0.00084	0.00072
Female	0.047***	0.051***	0.054***	0.056***	0.064***
	0.0010	0.00090	0.00085	0.00082	0.00072
Age (35-65)	0.0080***	0.0092***	0.011***	0.012***	0.015***
	0.0010	0.00092	0.00087	0.00084	0.00073
Age (65+)	0.0067***	0.0080***	0.0096***	0.011***	0.016***
	0.0010	0.00092	0.00088	0.00084	0.00074
Priority (7or 8)	-0.0083**	-0.0077**	-0.0079**	-0.0085**	-0.012***
	0.00077	0.00070	0.00067	0.00065	0.00057
Comorbidity (4 or more)	-0.0014**	-0.0031**	-0.0040**	-0.0044**	-0.0042***
	0.00053	0.00048	0.00046	0.00044	0.00040
Mission SC eligible (0/1)	0.0080***	0.012***	0.015***	0.016***	0.021***
	0.0023	0.0021	0.0020	0.0019	0.0017
Mission PC eligible (0/1)	0.023***	0.019***	0.018***	0.017***	0.015***
	0.0018	0.0017	0.0016	0.0015	0.0014
SC drive time (Q2)	0.0011	0.0030***	0.0035***	0.0038***	0.0046***
	0.00085	0.00077	0.00074	0.00071	0.00064
SC drive time (Q3)	0.0014	0.0052***	0.0070***	0.0078***	0.012***
	0.00090	0.00082	0.00078	0.00076	0.00068
SC drive time (Q4)	0.00086	0.0071***	0.010***	0.012***	0.021***
	0.00094	0.00085	0.00081	0.00079	0.00071
SC drive time (Q5)	0.0054*	0.014***	0.018***	0.022***	0.033***
	0.0023	0.0021	0.0020	0.0019	0.0017
PC drive time (Q2)	0.0042***	0.0040***	0.0039***	0.0043***	0.0052***
	0.00074	0.00067	0.00063	0.00061	0.00055
PC drive time (Q3)	0.0071***	0.0061***	0.0061***	0.0064***	0.0078***
	0.00093	0.00084	0.00080	0.00077	0.00069
PC drive time (Q4)	0.010***	0.0085***	0.0080***	0.0087***	0.010***
	0.00093	0.00083	0.00079	0.00077	0.00069
PC drive time (Q5)	0.011***	0.010***	0.0098***	0.010***	0.011***
	0.0018	0.0017	0.0016	0.0015	0.0014
Station FE	X	X	X	X	X
Constant	0.10***	0.11***	0.11***	0.11***	0.11***
	0.0044	0.0039	0.0036	0.0035	0.0030
R-squared	0.140	0.139	0.140	0.142	0.162
Number of Observations	1275447	1275447	1275447	1275447	1275447

Table -2

Table 2: Models with Index ED Visits					
	Outcome - Proportion of CC SC Visits				
VARIABLES	DV = Prop. Of CC SC Visits within 30 days	DV = Prop. Of CC SC Visits within 60 days	DV = Prop. Of CC SC Visits within 90 days	DV = Prop. Of CC SC Visits within 120 days	DV = Prop. Of CC SC Visits within 365 days
CC ED Visit (0/1)	0.14***	0.12***	0.11***	0.097***	0.072***
	0.0018	0.0016	0.0015	0.0014	0.0012
# CC ED Visits (in Index year)	0.018***	0.017***	0.017***	0.017***	0.016***
	0.00097	0.00082	0.00077	0.00074	0.00066
# VA ED Visits (in Index year)	-0.00034**	-0.00076***	-0.00085***	-0.00083***	-0.00080***
	0.00011	0.000099	0.000094	0.000091	0.000084
Female	0.047***	0.051***	0.054***	0.056***	0.064***
	0.0010	0.00090	0.00085	0.00082	0.00072
Age (35-65)	0.0081***	0.0093***	0.011***	0.012***	0.015***
	0.0010	0.00091	0.00087	0.00084	0.00073
Age (65+)	0.0069***	0.0082***	0.0097***	0.011***	0.016***
	0.0010	0.00092	0.00088	0.00084	0.00074
Priority (7or 8)	-0.0080***	-0.0075***	-0.0077***	-0.0083***	-0.012***
	0.00077	0.00070	0.00067	0.00065	0.00057
Comorbidity (4 or more)	-0.0023***	-0.0037***	-0.0046***	-0.0050***	-0.0048***
	0.00054	0.00049	0.00046	0.00045	0.00040
Mission SC eligible (0/1)	0.0077***	0.012***	0.015***	0.016***	0.021***
	0.0023	0.0021	0.0020	0.0019	0.0017
Mission PC eligible (0/1)	0.023***	0.019***	0.018***	0.017***	0.015***
	0.0018	0.0017	0.0016	0.0015	0.0014
SC drive time (Q2)	0.00093	0.0027***	0.0032***	0.0035***	0.0043***
	0.00085	0.00077	0.00074	0.00071	0.00064
SC drive time (Q3)	0.0012	0.0048***	0.0066***	0.0073***	0.011***
	0.00091	0.00082	0.00078	0.00076	0.00068
SC drive time (Q4)	0.00052	0.0065***	0.0096***	0.012***	0.021***
	0.00094	0.00085	0.00081	0.00079	0.00071
SC drive time (Q5)	0.0049*	0.014***	0.017***	0.021***	0.032***
	0.0023	0.0021	0.0020	0.0019	0.0017
PC drive time (Q2)	0.0042***	0.0040***	0.0039***	0.0043***	0.0052***
	0.00074	0.00067	0.00063	0.00061	0.00055
PC drive time (Q3)	0.0072***	0.0062***	0.0063***	0.0066***	0.0080***
	0.00093	0.00084	0.00080	0.00077	0.00069
PC drive time (Q4)	0.011***	0.0088***	0.0083***	0.0090***	0.011***
	0.00093	0.00083	0.00079	0.00077	0.00069
PC drive time (Q5)	0.011***	0.011***	0.010***	0.011***	0.011***
	0.0018	0.0017	0.0016	0.0015	0.0014
Station FE	X	X	X	X	X
Constant	0.10***	0.11***	0.11***	0.11***	0.11***
	0.0044	0.0039	0.0036	0.0035	0.0030
R-squared	0.141	0.140	0.142	0.144	0.164
Number of Observations	1275447	1275447	1275447	1275447	1275447

Table -3

Negative Binomial Regression					
Table 2.1: Models with Index ED Visits					
Outcome - Number of CC SC Visits					
VARIABLES	DV = CC SC Visits within 30 days	DV = CC SC Visits within 60 days	DV = CC SC Visits within 90 days	DV = CC SC Visits within 120 days	DV = CC SC Visits within 365 days
	IRR	IRR	IRR	IRR	IRR
CC ED Visit (0/1)	2.67***	2.10***	1.88***	1.75***	1.45***
	0.038	0.028	0.024	0.022	0.015
# CC ED Visits (in Index year)	1.10***	1.12***	1.13***	1.14***	1.14***
	0.0067	0.0066	0.0065	0.0064	0.0053
# VA ED Visits (in Index year)	1.03***	1.04***	1.04***	1.05***	1.05***
	0.0024	0.0022	0.0021	0.0020	0.0017
Female	1.70***	1.73***	1.74***	1.75***	1.81***
	0.019	0.018	0.017	0.017	0.014
Age (35-65)	1.53***	1.53***	1.53***	1.53***	1.52***
	0.020	0.018	0.016	0.016	0.013
Age (65+)	1.61***	1.61***	1.62***	1.62***	1.60***
	0.022	0.019	0.018	0.017	0.014
Priority (7or 8)	0.71***	0.70***	0.70***	0.70***	0.66***
	0.0083	0.0073	0.0068	0.0064	0.0050
Comorbidity (4 or more)	1.29***	1.28***	1.27***	1.27***	1.30***
	0.011	0.0094	0.0088	0.0084	0.0071
Mission SC eligible (0/1)	1.00	1.03	1.05*	1.06**	1.10***
	0.027	0.026	0.025	0.024	0.021
Mission PC eligible (0/1)	1.09***	1.05*	1.03	1.02	1.02
	0.026	0.023	0.021	0.020	0.016
SC drive time (Q2)	1.08***	1.10***	1.10***	1.10***	1.11***
	0.015	0.014	0.013	0.012	0.010
SC drive time (Q3)	1.20***	1.25***	1.28***	1.28***	1.31***
	0.017	0.016	0.015	0.015	0.012
SC drive time (Q4)	1.38***	1.47***	1.51***	1.53***	1.60***
	0.019	0.018	0.018	0.017	0.015
SC drive time (Q5)	1.60***	1.73***	1.77***	1.78***	1.85***
	0.045	0.045	0.043	0.042	0.036
PC drive time (Q2)	1.02*	1.03**	1.03***	1.04***	1.05***
	0.012	0.010	0.0098	0.0094	0.0077
PC drive time (Q3)	1.04**	1.04**	1.04***	1.05***	1.05***
	0.014	0.013	0.012	0.011	0.0094
PC drive time (Q4)	1.07***	1.05***	1.05***	1.06***	1.07***
	0.014	0.012	0.012	0.011	0.0093
PC drive time (Q5)	1.03	1.04	1.05*	1.07**	1.05**
	0.026	0.023	0.022	0.022	0.017
Station FE	X	X	X	X	X
Constant	0.15***	0.30***	0.43***	0.55***	1.37***
	0.0066	0.012	0.016	0.020	0.042
Number of Observations	1275447	1275447	1275447	1275447	1275447

Table -4

Table 3: Models with Index ED Visits and Prior CC, VA and Post VA Utilization					
Outcome - Proportion of CC SC Visits					
VARIABLES	DV = Prop. Of CC SC Visits within 30 days	DV = Prop. Of CC SC Visits within 60 days	DV = Prop. Of CC SC Visits within 90 days	DV = Prop. Of CC SC Visits within 120 days	DV = Prop. Of CC SC Visits within 365 days
CC ED Visit (0/1)	0.11***	0.094***	0.085***	0.080***	0.061***
	0.0016	0.0014	0.0013	0.0013	0.0011
# CC ED Visits (in Index year)	0.014***	0.013***	0.014***	0.013***	0.013***
	0.00084	0.00072	0.00068	0.00065	0.00057
# VA ED Visits (in Index year)	0.00056**	0.00015	0.00010	0.00015	0.00028***
	0.00010	0.000093	0.000089	0.000087	0.000081
# CC SC Visits in past 30 days	0.072***				
	0.00078				
# VA SC Visits within post 30 days	-0.010***				
	0.00016				
# VA SC Visits in past 30 days	0.0017***				
	0.00012				
# CC SC Visits in past 60 days		0.041***			
		0.00042			
# VA SC Visits within post 60 days		-0.0048**			
		0.000069			
# VA SC Visits in past 60 days		0.00083**			
		0.000056			
# CC SC Visits in past 90 days			0.030***		
			0.00026		
# VA SC Visits within post 90 days			-0.0032**		
			0.000045		
# VA SC Visits in past 90 days			0.00045**		
			0.000037		
# CC SC Visits in past 120 days				0.024***	
				0.00018	
# VA SC Visits within post 120 days				-0.0024**	
				0.000033	
# VA SC Visits in past 120 days				0.00025**	
				0.000028	
# CC SC Visits in past 365 days					0.0095***
					0.000080
# VA SC Visits within post 365 days					-0.00089***
					0.000011
# VA SC Visits in past 365 days					0.0000058
					0.000010
Station FE	X	X	X	X	X
Constant	0.10***	0.10***	0.10***	0.10***	0.10***
	0.0039	0.0035	0.0033	0.0032	0.0028
R-squared	0.291	0.263	0.253	0.249	0.253
Number of Observations	1275447	1275447	1275447	1275447	1275447

Notes: Gender, Age, Priority Status (7 or 8), Comorbidities, Mission Act Eligibility for CC, Drive time to Specialty Care and Primary Care, Station FE were included as covariates in the models.

Stepping Forward - VA Emergency Medicine Providers, Patient Care, and Research

VA Health Services Research & Development

State of the Art Conference – Emergency Medicine (SOTA EM)

January 12, 2022

Christopher Kang, MD

Overview

- Objectives
- Disclaimers
- Background
- State of Emergency Medicine
- SOTA EM Workgroup Goals
- Opportunities and Next Steps

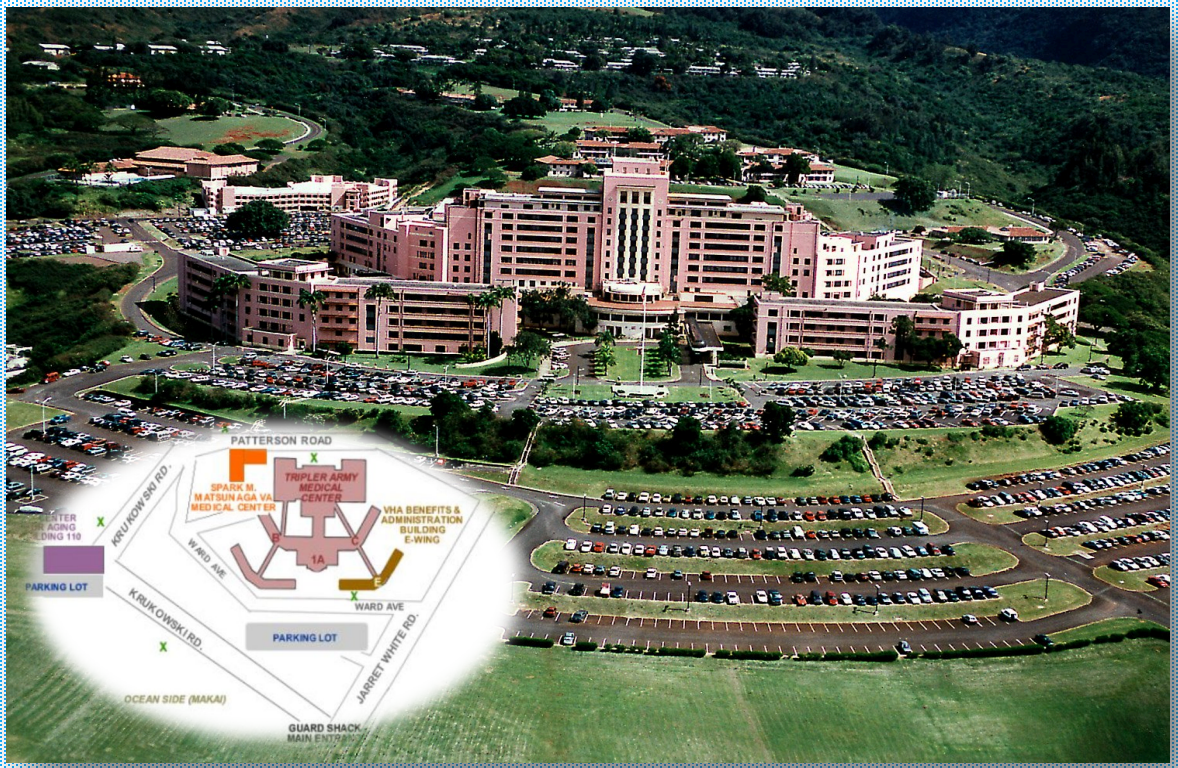
Objectives

- Enhance the context of the SOTA EM workgroups
- Accentuate pertinent aspects of the SOTA EM workgroup goals
- Stimulate discussion, innovation, collaboration, and priorities
- Recognize critical opportunities

Disclaimers

- The views and opinions expressed in this presentation are those of the presenter and do not reflect official policy or position of the Department of the Army, Department of Defense, or the US Government
- No financial relationships with commercial entities
- I have the following relationships to disclose–leadership roles,
  - American College of Emergency Physicians
  - Emergency Medicine Foundation
  - National Emergency Medicine Political Action Committee

Disclaimers



Background

Personal

Clinical Practice

EM Org

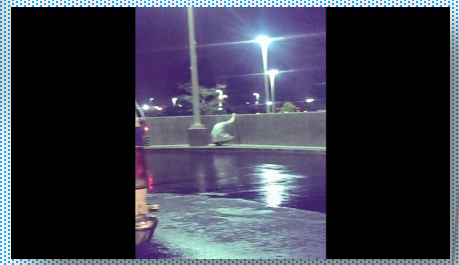
State of Emergency Medicine

State of Emergency Medicine

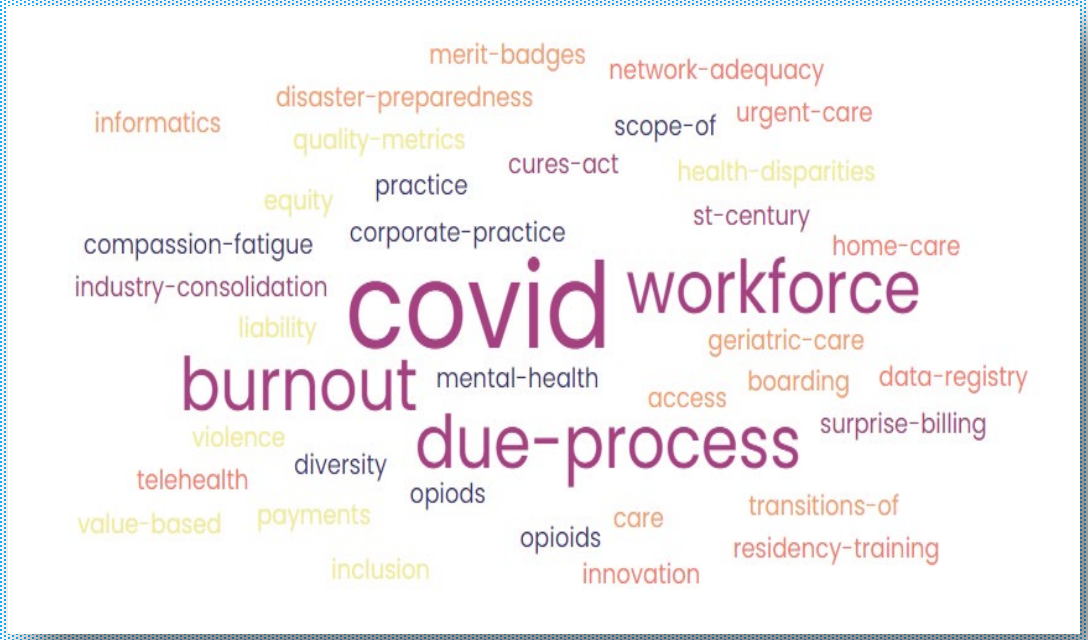
Patients wait in ERs for days as COVID-19 patients overwhelm St. Louis-area hospitals

Michele Munz Jan 7, 2022 255

State of Emergency Medicine



State of Emergency Medicine



State of Emergency Medicine

DHA set to takeover all military hospitals by end of 2021, even after transition halt during pandemic

Scott Maucione | @smaucioneWFED
February 23, 2021 4:28 pm 4 min read

After a tumultuous year of pauses and reconsiderations, military hospitals and clinics are still on track to move under the management of the Defense Health Agency by the end of the year.

How that will affect patients of those facilities may change from the original plan though, after the military's centralized medical administrator was forced to rethink what role private health care providers can play in the plan after COVID-19.

"We are absolutely on track to meet our timelines and that's our expectation with us," Dr. Brian Lein, DHA assistant director for healthcare administration, told Federal News Network.

The transition includes 721 military treatment facilities (MTFs) and 174,000 health care personnel including active-duty service members, civilian employees and contractors, which provide care to 9.5 million TRICARE beneficiaries. The facilities are clustered into 21 large markets that encompass about two-thirds of patient interactions. The rest are in 16 small market regions or stand-alone hospitals and clinics — think rural areas with a large military presence.

Congress initiated the transition in the 2017 National Defense Authorization Act as a means to better integrate health care instead of continuing the decentralized system of each military service overseeing its own MTFs.

Lack of a federal budget deal endangers veterans, VA secretary warns

By Leo Shane III Dec 22, 2021

Veterans Affairs Secretary Denis McDonough speaks during his confirmation hearing on Capitol Hill on Jan. 27, 2021. (Sarah Silbiger/Pool via AP)

SOTA EM Workgroup Goals

- Geriatric Care
- Community Care
- Mental Health

SOTA EM Workgroup Goal

- Geriatric Care

ncoa | VETERAN ISSUE BRIEF

A Profile of Older U.S. Veterans

AUTHORS:
Lauren Popham, PhD, National Council on Aging
Jane Tavares, PhD, LeadingAge LTSS Center @UMass Boston
Marc Cohen, PhD, LeadingAge LTSS Center @UMass Boston

There are more than 11 million adults aged 60 and older alive today who have served in the military,[1] representing over 15% of the 60+ population.[2] It is important to learn more about this population to identify how they are faring during retirement and to identify their needs. To pursue this goal, the National Council on Aging and the Leading Age LTSS Center @ Umass Boston analyzed data from the Health and Retirement Study (HRS) to learn about the health and economic characteristics of the older veteran population. Our analysis reveals two key findings. First, older veterans have higher incomes, yet they have less of a financial safety net in terms of savings and home equity. Second, older veterans are in worse health than civilians in the same age group.

FINANCES

$59,400
Median income for older veterans (vs. $46,300 for civilians)

$72,000
Median assets excluding net value of primary residence (vs. $80,000 for civilians)

HEALTH

57% of older veterans have at least three or more chronic conditions

31% of older veterans report fair or poor health

28% of older veterans have a functional limitation such as trouble with bathing, dressing, and walking

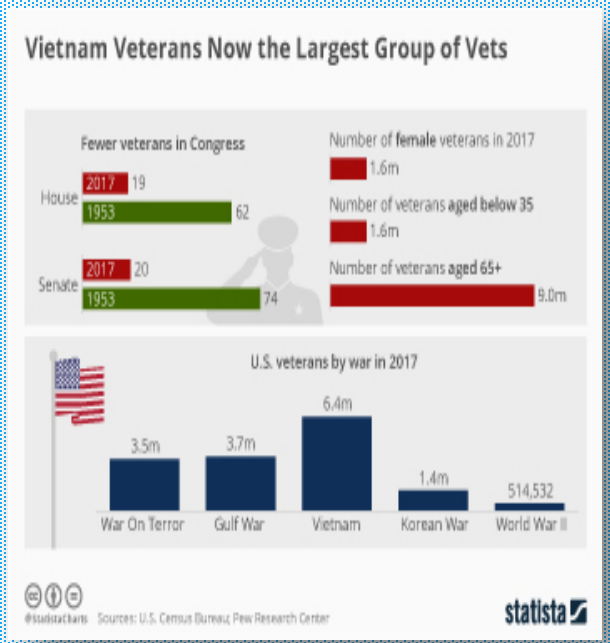
22% of older veterans suffer from feelings of depression

DEMOGRAPHIC CHARACTERISTICS

Although older veterans are more likely to be men, nearly a quarter (23%) of older adults who have served in the military are women. Eighty-five percent of older veterans are white, 12% are Black or African American, 5% are other races, and 5% are Hispanic. Although 57% of older veterans are married, 28% are widowed, and 15% are separated/divorced or never married. Among Americans age 60 and older, veterans tend to be older on average than their civilian counterparts (age 75 vs. 72, respectively).

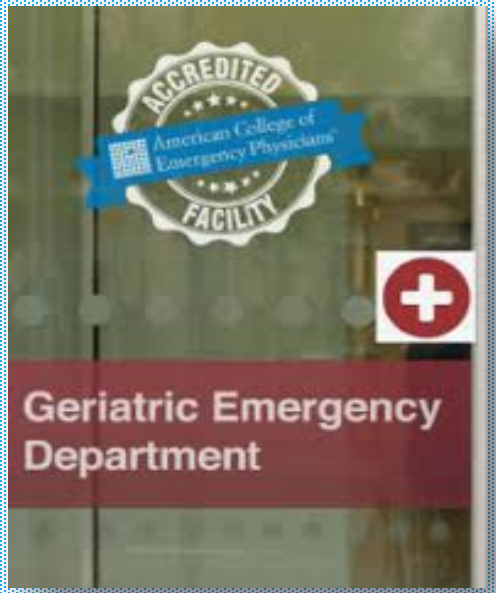
Veterans have higher incomes, but less of a financial safety net

Our analysis reveals that older veterans have higher incomes than their civilian counterparts – perhaps due to veteran pensions – but they tend to have less in savings. Older veterans have approximately 20% higher household income than older civilians, with a median of $59,400 for veterans vs. $46,300 for civilians. Despite higher incomes for veterans, looking at the whole financial picture paints a different story. Older veterans, on average, have 10% less in non-housing



SOTA EM Workgroup Goal

- Geriatric Care



Annals of Emergency Medicine
Available online 11 August 2021
In Press, Corrected Proof

Geriatrics/Original Research

Reach and Adoption of a Geriatric Emergency Department Accreditation Program in the United States

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Study objective

The objectives of this study were to describe the reach and adoption of Geriatric Emergency Department Accreditation (GEDA) program and care processes instituted at accredited geriatric emergency departments (EDs).

SOTA EM Workgroup Goal

- Community Care

› Military News

VA Intends to Pause Community Care Program During Coronavirus Pandemic

A physician-researcher with the Atlanta VA and Emory University discusses the use of a glucometer with a VA patient. (Department of Veterans Affairs)

25 Mar 2020
Stars and Stripes | By Nikki Wentling

SOTA EM Workgroup Goal

- Community Care

TURNER and Moulton Legislation SHIELDS Members of DoD from Prescription Drug Monitoring Gap

April 25, 2018

Chairman Mike Turner (OH-10) of the House Armed Services Subcommittee on Tactical Air and Land Forces and Ranking Member Seth Moulton (MA-6) of the House Armed Services Subcommittee on Oversight and Investigations introduced the Sharing Health Information to Ensure Lifesaving Drug Safety, or SHIELDS, Act, H.R. 5591, to close a gap in Department of Defense's (DoD) practice of reporting prescriptions, including regarding opioids.

"We have identified a gap that does not require DoD to report controlled substance prescriptions to prescription drug monitoring programs," **said Chairman Turner.** "These drug monitoring programs are imperative in combating the opioid epidemic, but only prevent overprescribing of medication when they have the full scope of data for a patient. This DoD reporting gap makes our nation's active duty service members, reservists, their families, veterans, and retirees vulnerable to this epidemic of addiction. Ranking Member Moulton and I have introduced legislation to immediately close this gap and prevent more individuals from falling victim to opioid addiction."

"Opioid addiction has had a devastating effect on our veterans community," **said Ranking Member Moulton.** "No one is immune to how this epidemic has plagued our country. This bipartisan effort will help our service members get the care they deserve by increasing coordination between the DoD and civilian health care providers. Together, we are taking an important step towards directly tackling the problem of opioid addiction within the armed services."

Why VA's $16B (and counting) Electronic Health Record Modernization is doomed

Ed Meagher
October 15, 2021 1:02 pm 6 min read

In Part 2, Former Veterans Affairs Deputy CIO Ed Meagher offers specific recommendations for solving this conundrum.

Although there was no formal announcement of its intention to proceed with the deployment of the currently paused Cerner based Electronic Health Record Modernization (EHRM) program, the Department of Veterans Affairs recently awarded Cerner two task orders totaling $157 million to implement its system at VA facilities in Cleveland and Detroit and to assess future sites in the Midwest.

This decision to proceed is reckless and doomed to fail.

Beginning with the fact that the two most commonly expressed justifications for proceeding with this program — VistA needs to be replaced and that the Defense Department and VA can't share data — are both false.

VistA needs to be modernized, not replaced. VistA meets all of VA's current needs. It does need to be "replatformed" and key elements need to be modernized, but those efforts were underway, at several orders of magnitude lower cost and risk, when the Cerner system was imposed on the VA.

Compounding this is the fact that the decision to impose the DoD-based Cerner system on the VA as a replacement for the current VistA system clearly indicates a lack of understanding of the role that VistA actually plays in the business processes of all aspects of the VA. VistA represents 30-years-worth of knowledge, experience, data standardization, education, integration, reliability, research, institutional memory and best practices. Much of this will be lost or degraded under the Cerner system.

SOTA EM Workgroup Goal

- Mental Health

HeraldNet
Everett, Washington

Published: Thursday, August 7, 2014, 5:57 p.m.

'Psychiatric boarding' illegal, state high court rules

By Sean Robinson, Tacoma News Tribune
OLYMPIA — Psychiatric boarding, the practice of warehousing mentally ill patients in hospital emergency rooms due to lack of available treatment space, is unlawful, according to the Washington state Supreme Court.

State law "does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities," states the court's decision, authored by Justice Steven Gonzalez.

The unanimous ruling, issued Thursday, throws a wrench into the state mental health system and forces state leaders to confront a longstanding dilemma: a shortage of mental-health treatment beds created by a series of budget cuts. The consequence: Washington ranks last or close to last in the nation for psychiatric beds, depending on the measure.

The high court upheld a series of earlier rulings that originated in Pierce County, first reported by The News Tribune last year. A group of 10 patients detained under Washington's civil commitment law petitioned the court for relief, arguing that they were being held in hospital emergency departments without the individual treatment guaranteed by state and federal law.

Testimony in those initial hearings, referenced in the Supreme Court's decision, noted that psychiatric boarding has "pretty much exploded" across the state in the past seven years. According to state numbers, 3,421 mental patients were parked in emergency departments in 2013.

The high court's decision came in 43 days after the justices heard arguments. The ruling noted that the state's civil commitment system has been "regularly overwhelmed" since the Legislature enacted the Involuntary Treatment Act in 1979. The law governs commitment procedures for people with mental illness.

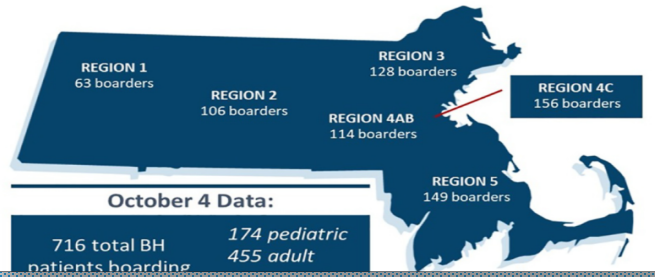
Under state law, people with mental illness who present imminent risk of harm to themselves or others can be can committed and held by the state against their will. Patients are entitled to a mental-health evaluation by a licensed professional within 72 hours. If the evaluation concludes that the individual should be detained, a court hearing follows. A patient can be detained for up to 14 days in a certified evaluation and treatment center. Longer commitments can last 90 or 180 days, and patients must be held at Western State Hospital in Lakewood, or Eastern State Hospital near Spokane.

716 psych patients are stuck in emergency rooms waiting for care, Mass. report shows

Updated October 11, 2021 | By Martha Bebinger

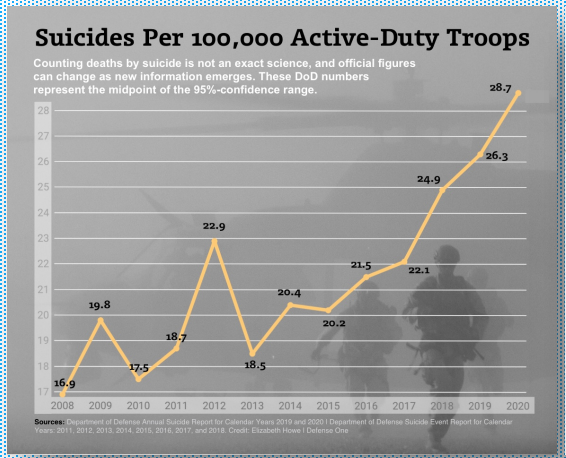
The first of what will be weekly reports from hospitals across Massachusetts shows 716 patients who need acute psychiatric care and can't get it. That's 174 children and 542 adults who showed up at an emergency room in distress and are still there because the treatment programs they need are full.

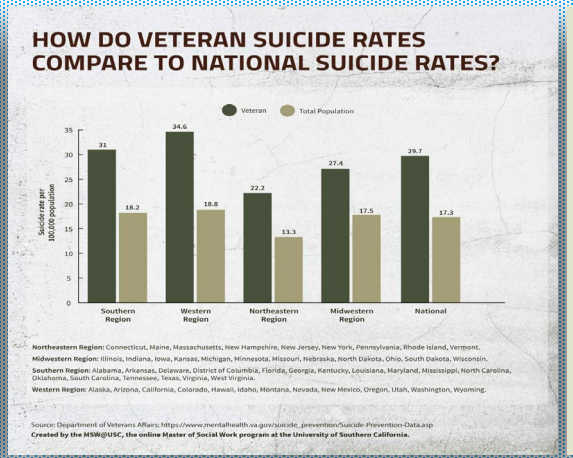
"Behavioral health has become the epidemic within the pandemic," says Leigh Youmans, who leads work on this issue at the Massachusetts Health and Hospital Association (MHA). "We have seen significant amounts of behavioral health need increasing across all acute care hospitals in the state."

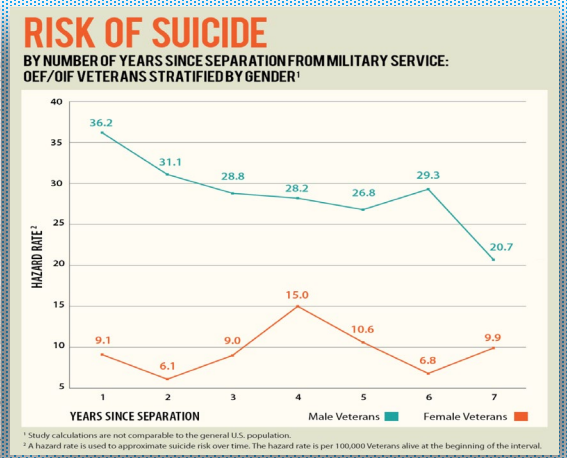


SOTA EM Workgroup Goal

- Mental Health

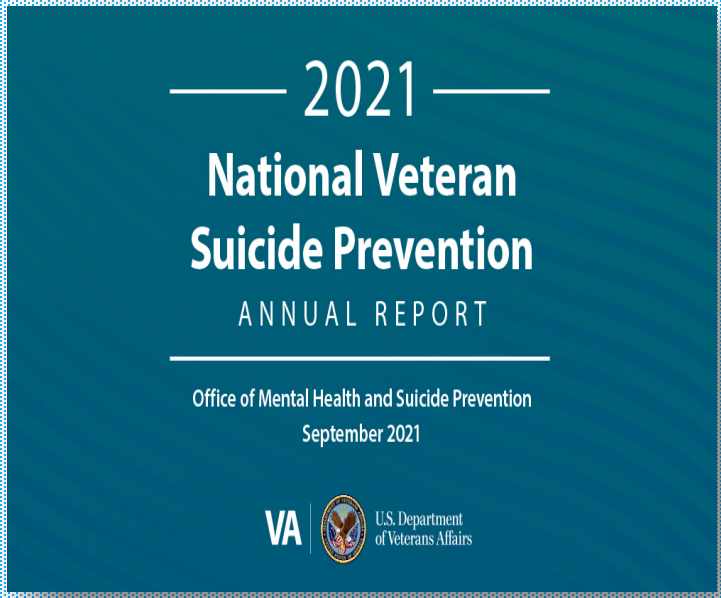






SOTA EM Workgroup Goal

- Mental Health



Opportunities and Next Steps

- Expertise and Innovations
  - Erica Gruber, A-GNP, MSN, BCEN and Jill Huded, MD
  - Sivagaminathan Palani, PhD
  - Brian Fuehrlein, MD, PhD
  - Michael Ward MD, PhD, MBA
  - Chad Kessler, MD
  - Karen Bossi, MA
  - David Atkins, MD, MPH
  - You and your VA, DHA, and EM colleagues
- Your hospitals, healthcare systems, and organizations
- Veteran Perspective
  - Josh Geiger, MPsy
  - My clinical and professional colleagues, patients, father, and I

Opportunities and Next Steps

- ckang@acep.org

State of the Art Conference
VA Emergency Medicine (SAVE)

Open Q&A and
Charge to the Work Groups

January 12, 2022

Michael Ward, MD, PhD
Dawn M. Bravata, MD

U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

Work Group Charge

Work Group Meetings

- Use a collaborative process to mine, align, and refine ideas
- Use work-group specific questions to guide you
- Refer to specific evidence to support statements
  (note: this will be important for subsequent reports)
- Come to agreement on presentation to be delivered to full SOTA group: Feb 17

Closing Plenary

- Work group leads will present summary reports
- Reaction to recommendations
- Facilitated full SOTA group discussion and next steps