State of the Art Conference
VA Emergency Medicine (SAVE)

Closing Plenary Agenda

1:00pm – 1:05pm **Welcome and Agenda for the Session**
Michael Ward, MD, PhD, MBA

1:05pm – 2:35pm **Work Group Presentations/Discussion**
Each work group will have 20 minutes for presentation followed by 10 minutes of full group Q&A and discussion

1:05pm – 1:35pm *Emergency Care for Older Veterans*
Nicki Hastings, MD
Ula Hwang, MD

1:35pm – 2:05pm *Emergency Care for Acute Mental Health Conditions*
Jason Chen, PhD
Christine Timko, PhD

2:05pm – 2:35pm *Emergency Care Provided to Veterans in the Community*
Anita Vashi, MD, MPH
Kristin Mattocks, PhD, MPH

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Closing Plenary Agenda ctd.

2:35pm – 2:50pm **Response from Research Co-Chairs**

Michael Ward, MD, PhD, MBA
Dawn Bravata, MD

2:50pm – 3:30pm **Panel Discussion**

Carolyn Clancy, MD
Assistant Under Secretary for Health
Discovery, Education and Affiliate Networks

David Atkins, MD, MPH
Director, HSR&D

Chad Kessler, MD
VA National Program Director for Emergency Medicine

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Geriatric Emergency Medicine

Work Group Co-Chairs:
S. Nicole Hastings, MD, MHS
Ula Hwang, MD, MPH

February 17, 2022

Geriatric Emergency Medicine Work Group Members

Lauren Abbate
Erica Abel
Cynthia Brandt
Dawn Bravata
Kenneth Boockvar
Thomas Edes
Erica Gruber
Jin Ho Han
S. Nicole Hastings
Christian Helfrich
William Hung
Ula Hwang
Orna Intrator
Michael Malone
Colleen McQuown
J. Michelle Moccia
Luna Ragsdale
Justine Seidenfeld
Sandra Simmons
Jennifer Sullivan
Katren Tyler
E. Camille Vaughan
Michael Ward
Seong Kim – PFS Services
Uroosa Anwaar – PFS Services
Karen Bossi - CIDER
Gerald O'Keefe – CIDER

THANK YOU to work group members for your expertise and great discussion sessions!!!!

Priority Foci & Questions

1. Gaps, variation, and measurement:

   Where are the greatest gaps in quality care for older adults in the ED?

2. Interventions, VA implementation, assessments, and outcomes:

   What evidence-based interventions or policies should be implemented to improve care of older persons in the ED?

3. ED expanded role – telehealth & community care coordination:

   How could the ED's role be expanded to help older adults meet their goals of ED care?

GED ESP Scoping Reviews & Inventories

- ESP reviews – Hughes multi-strategy interventions in ED with positive impact on patient function, mixed impact on utilization.
- ESP Inventories
  - Assessments: 1. General risk, 2. Falls/mobility, 3. Cognitive Assessment, 4. Delirium. 5. short-term risk/triage
  - Telehealth: 1. Pre-ED / triage, 2. ED telehealth care, 3. post-ED care coordination
- Notable papers (Kennedy GEDA variability, Shankar patient priorities, Hwang Medicare costs)
- Growing number of studies, descriptive

Priority Question #1

1. **<u>Gaps, variation, and measurement:</u>**
   a. Where is the greatest variation in processes of care and outcomes for older adults discharged from the ED?
   b. Are existing metrics that are being used as quality benchmarks for older adults in the ED sufficiently patient- and family-centered or are new measures needed? If so, what new measures are needed?

Priority Question #1

- Variability
  - Measures and definition, identification of “high risk” patients
  - ED Resources (staffing, services)
  - Outcomes - facility (e.g., utilization) vs. patient
  - VA ED model includes urgent care
- Existing measures
  - Utilization-based

- <u>Knowledge gaps/barriers</u>
  - What variation is most meaningful
  - Shift to measures of patient and caregiver priorities
  - Comparison of VA non-VA
  - Measuring change results in change/impact of additional quality measurement
  - Metrics for specific patient populations
  - Lack of data infrastructure for some patient-centered outcomes (e.g. function)

Priority Question #1

Research Priorities

- Understand which care processes and other sources of variation (e.g. staffing) drive outcomes for GED patients
- Evaluate discharge process and outcomes/transitions/longitudinal care from the ED
- Study implementation of new clinical processes to understand impact on patients, care partners, ED staff; human centered design, usability, audit & feedback, perceived value of change

Priority Question #1

Policy/Implementation Recommendations:

- VA data to characterize and variation in GED care (patients, staffing, processes)
- For any new measures, prioritize 4Ms and patient-centered outcomes ("what matters" to them)

Priority Question #2

2. <u>Interventions, VA implementation, assessments, and outcomes:</u>
   a. What interventions are effective for improving quality and outcomes of older persons in the ED?
   b. What innovative programs are currently being implemented in VA and what evidence (if any) is needed to evaluate their impact?
   c. What is the clinical impact of geriatric risk assessments in the ED?
   d. How has Geriatric ED Accreditation influenced quality and outcomes for older adults and costs of care?

Priority Question #2

- Multi-strategy interventions – identify high risk patients/provide referrals, f/u
- Screening successfully implemented in EDs
- Multiple VA GED innovations in progress (e.g. EQUIPPED, VIONE, VA ICT model; Geri-Vet, SCOUTS)
- Geri ED assoc with reduced costs

<u>Knowledge Gaps/Barriers:</u>

- Identifying risk
  - Who to screen
  - Best tools?
- Which assessments (falls, medications, elder mistreatment, care transitions)
- Variable staffing

Priority Question #2

Research priorities

- Who/what to screen/assess?
  - High risk, Meds, Mobility/falls, Cognitive (delirium/dementia), Elder mistreatment
  - All vs. Targeted
  - Feasibility/usability
  - Leveraging informatics/EHR (AI, ML, VA existing risk scores)
- Transdiscip/longitudinal/x-setting impact (ED / post-ED care)
- Do GED dashboards improve outcomes?
- GED Accreditation - Does it matter?
- Support multicenter evaluation of ongoing GED initiatives /patient-caregiver outcomes / evaluation of clinician facilitators-barriers

Priority Question #2

<u>VA Policy/Implementation Recommendations:</u>

- Enhance data sharing, standardization, Cerner
- Key clinical processes – Identifying/targeting complex care needs patients, medication review/safety, transitions
- Standardizing processes risk assessment (screen/assess/action)

Priority Question #3

3. <u>ED expanded role – telehealth & community care coordination:</u>
   a. What is the effectiveness of telehealth interventions used in the emergency setting for older adults?
   b. Are there best practices for integration of families, assessment of social needs, or partnerships with community agencies that warrant further research into their effectiveness?

Priority Question #3 - Telehealth

Many potential applications

- Direction (ED support→Other, Consult→ED)
- Setting (widened access)

Knowledge Gaps/Barriers:

- Preferences/needs/value for various use cases
- Workflow
  - Feasibility, infrastructure, staffing
- Safety and quality; Measures?
- GED transdisc telehealth (SW, pharm, etc.?)

Priority Question #3 - Telehealth

Research priorities

- Evaluating telehealth implementation/context/use cases
- Evaluating patient perspective/ acceptability/needs
- Evaluating quality, safety, and effectiveness of telehealth

(transdiscip/longitudinal/x-setting)

  - Does it work? Improve care? Impact on workload? Impact on equity?

- Telehealth to support acute care in NH is promising/warrants further study
- Telehealth to promote improved access (when limited); SW, Pharm, PT?

Priority Question #3 – Expanded ED role

- Care partners are essential
- Social needs are common and often unaddressed

<u>Knowledge Gaps/Barriers:</u>

- Scope of ED care/What should be initiated in/out of ED?
- Patient/caregiver priorities vs. clinician/health system
- How to improve shared decision making?
- Barriers in information exchange with community
- What is best practice for post-ED care transitions? (ED vs. primary care)
- How can ED best address SIOH

Priority Question #3 – Expanded ED role

Research Priorities:

- Best practices for incorporating inclusion of care partners
- Evaluating patient perspective/ acceptability/needs
- SIOH/streamlining ED workflow (ED vs. defer to outpatient)
- Incorporating care transitions and evaluating transdisciplinary coordination

Priority Question #3

<u>VA Policy/Implementation Recommendations:</u>

- Encourage ED documentation of care partners
- All VA EDs should incorporate process to support post-ED care transitions
- Explore use of telehealth to expand access to Pharm, SW

VA Recommendations – Cross-cutting

- VA support for GED initiatives
  - **centralized GED Program/Office** (education, clinical care, research)
  - Encourage all VA EDs to integrate GED best practices (GED Accreditation)
  - Recommend all EDs have a physician and nurse GED champion
- Prioritize **CPRS to Cerner** transition to support geriatrics principles of care
  - GED **assessment tools** (risk, SIOH) and processes of care
  - Inclusion of **patient and caregiver** outcomes
- Leverage telehealth to provide **expanded reach** and **equitable access** to pharmacy and SW and to *INFORM* GED care using 4Ms

State of the Art Conference
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Emergency Care for Acute Mental Health Conditions Work Group

February 17, 2022

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

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WORK GROUP MEMBERS – THANK YOU!

Erica Abel, PhD
Peter Britton, PhD
Christian Helfrich, PhD
Jan Lindsay, PhD
Fernanda Rossi, PhD
Carolyn Turvey, PhD
Emmy Betz, MD, MPH
Brian Fuehrlein, MD, PhD
Gayle Iwamasa, PhD, HSPP
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Angie Waliski, PhD
Dawn Bravata, MD
Richard Griffith, MHA
Keith Kocher, MD
Pam Owens, PhD
John Shuster, MD
Michael Ward, MD, PhD

Representing VA and university operations, clinical practice, and research

Work Group session recording, note-taking by Prometheus Federal Services

Evidence Synthesis: Effectiveness of Mental Health Interventions in the Emergency Department

- Multicomponent interventions for suicidality (risk assessment, safety planning, follow-up care coordination, other components) appear effective in ED/UCC settings. However, effects are not sustained over time.
- Barriers to MH screening and assessment have been identified, e.g., insufficient time, privacy, challenges with integration into ED/UCC workflows.
- Interventions for opioid overdose appear to have limited evidence.
- Paucity of literature on non-opioid substance use and psychosis management in the ED/UCC setting.

Key Issue #1

Improve Access to Emergency Mental Health Care for Veterans

- How can we best facilitate implementation of evidence-based practices?

Evidence

-- Good evidence for multicomponent interventions for suicidality that span within- and post-ED/UCC care.

-- Some evidence that telemental health approaches may improve MH care access in ED/UCC settings.

-- Little evidence suggesting brief interventions for substance use are effective in ED/UCC settings.

Policy Recommendations

- Enhance and support implementation of telemental health modalities in ED/UCC settings to increase access to care both during- and post-ED/UCC visits.

Research Recommendations

-- Improve understanding of barriers, facilitators, harms, and benefits associated with telemental health modalities and their impact during- and post-ED/UCC MH care.

-- Identify workforce development models to improve emergency mental health care: workflow analysis, embedded MH staff, retention and recruitment, regional differences (e.g., rural, urban), role (e.g., Peer Specialist, social worker).

-- Determine mechanisms impacting effectiveness of brief substance use interventions in ED/UCC settings to inform implementation.

Data Needs

- Real-time characterization of the VHA emergency mental health workforce for identifying effective organization strategies for enhancing ED/UCC MH capacity.

- Monitoring of existing initiatives and their effectiveness within ED/UCC settings (e.g., Integrated Care Coordination, Opioid Safety Initiative, SPED, SBOR).

Key Issue #2

What evidence-based policies or interventions should be implemented to improve care of Veterans presenting with mental health symptoms in the ED/UCC?

Goal: Implement evidence-based care strategies for Veterans with mental health conditions in ED/UCCs

A. Triage and screening
B. Symptom management
C. Care coordination

A. SCREENING

Policy Recommendations

-- All ED/UCC patients with mental health symptoms should be screened for suicidality, alcohol use disorder, and drug use (including prescription drug misuse).

-- All ED/UCC providers should be trained on how to recognize and de-escalate psychosis- or substance-induced aggression and agitation.

A. SCREENING

Research Questions

-- How should screening that is patient- and provider-centered be implemented? That is,

a. Screening seen as relevant to patient's concerns by patients and providers.

b. Screening is incorporated into the workflow.

c. Positive screens are reliable and lead to appropriate care.

-- Would screening for other mental health conditions in the ED, especially anxiety, enhance patient outcomes?
(Anxiety is in the top 3 of MH conditions seen in VA EDs.)

B. SYMPTOM MANAGEMENT

Policy Recommendations

-- All ED/UCC patients with identified suicidality or substance use concerns should receive an intervention that includes components of safety planning, brief counseling (to reduce symptoms/use and/or to seek help), linkage to subsequent care, and follow-up to ensure care was initiated.

-- All ED/UCC patients with alcohol or opioid use disorders should be offered medications for those disorders. All patients with opioid overdose and/or use disorder should receive naloxone.

B. SYMPTOM MANAGEMENT

Research Questions

-- How can bundled interventions be incorporated into the workflow and implemented?

(Facilitators: More ED MH staffing, more staff role responsibility for intervention delivery;

Barriers: scope of practice [“it’s not in my skillset”], no feedback on patient outcomes and successes; lack of prescribing capacity for MOUD)

-- Which components of bundled interventions are cost-effective?

-- Should bundled interventions for mental health be tailored to patients’ co-occurring problems such as medical conditions, trauma history, and life context (e.g., housing and food insecurity)?

B. SYMPTOM MANAGEMENT

Research Questions continued

-- What is the most effective mix of tele/video and in-person care to deliver these interventions? What are efficient models to deliver tele/video mental health intervention components, e.g., regional, national hubs?

-- Evaluate the potential for Peer Specialists to facilitate protocols for screening, counseling, linkage, and follow-up.

C. CARE COORDINATION: WITHIN VA, WITH COMMUNITY

a. Among providers during the ED episode
b. With post-ED providers

<u>Policy Recommendations</u>

--Implement centralized, comprehensive, and collaborative longitudinal care management for mental health patients that includes the ED as one care setting.

--Continue to improve VA-community information sharing pre-, during-, and post-ED/UCC care for patients with mental health/substance use conditions.

(Facilitator: Use of Health Information Exchanges)

C. CARE COORDINATION: WITHIN VA, WITH COMMUNITY

Research Questions

-- What are the most effective and cost-effective models of longitudinal care management delivery? What are the facilitators and barriers to implementing LCM?

(Facilitators: low-barrier access to post-ED services)

-- What are the acceptability and feasibility of enhancing VA-community ED/UCC mental health coordination via innovative strategies, e.g., community ED provider training, telehealth consultations, community-embedded VA MH providers, Peer Specialists, linkage from community back to VA MH?

In particular, how can Veteran patients seen in community EDs for mental health concerns be repatriated to VA care?

RESOURCE NEEDS

Real-time data on variations across VA emergency care settings on processes of mental health care, e.g., what screenings are being conducted? are patients with OUD receiving naloxone? what do VA EDs do to link patients to post-ED care?

Better methods for stakeholders to share VA dashboards and other initiatives, e.g., multiple mental health care coordination initiatives are occurring; how can they be better coordinated and disseminated so they can be used to improve patient care?

State of the Art Conference
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Community Care Workgroup

February 17, 2022

Anita Vashi MD, MPH, MHS
Kristin Mattocks PhD, MPH

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

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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

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*)

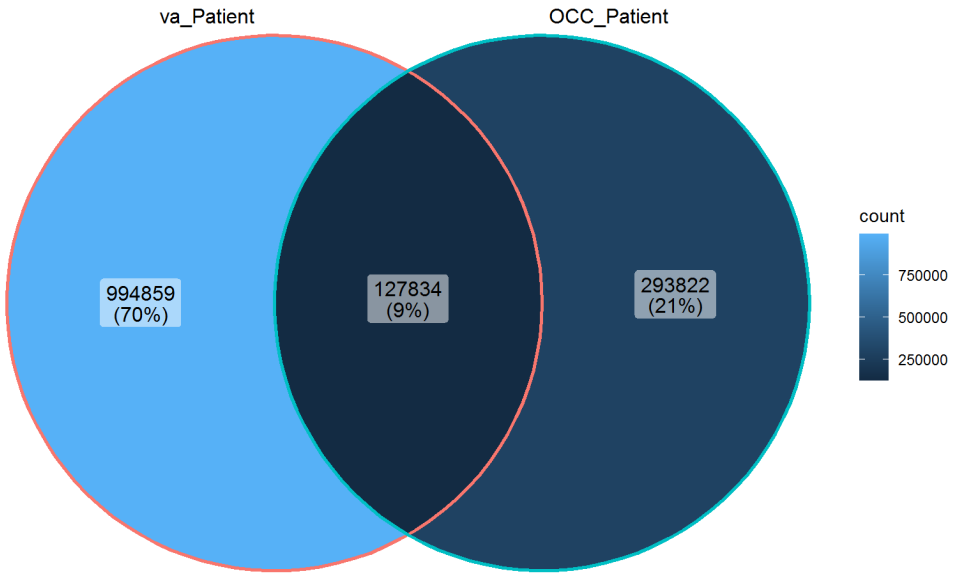
Veterans do not have ready access to VA EDs, sometimes having to rely on community EDs.

- 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

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.

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

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))?

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

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.

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

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

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 queriable 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)

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**

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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Thank you!

Dissemination of the SOTA content

1. *Academic Emergency Medicine* supplement
   Call for abstracts opens March 2022, due by April 30, 2022

2. Cyberseminar

3. Call for research proposals (David Atkins)

www.hsrd.research.va.gov/for_researchers/supplement/

Please put your suggestions for other routes for dissemination in the chat

Our impressions…

State of the Art Conference
VA Emergency Medicine (SAVE)

- Multidisciplinary workgroups: full of experts who are passionate about VA EM healthcare and research; the strength of the existing social capital is noteworthy and inspiring
- Chad Kessler is recognized an operational leader who is prepared and excited about moving evidence into practice
- Data availability: identified as a barrier to providing healthcare in real-time, conducting research, and program/policy evaluations
- Relatively little evidence is ready for policy
  - If operational or policy changes are made, evaluations are essential
- Effectiveness and implementation research is needed across topics
  - Need to balance screening practices with workflow and other implementation considerations
  - Key questions exist regarding use of telehealth to expand access while ensuring equity
  - Measuring quality and implementing performance measurement are priority areas for research

Call to Action!

Develop Capacity for VA EM Research

- **Build the pipeline of VA EM investigators**
  - Mentor junior faculty, encourage them to enter VA fellowships, CDAs
  - Collaborate with EM investigators in academic affiliates
  - Encourage non-EM investigators to submit VA EM proposals
  - Join the existing network of VA EM investigators (contact Mike Ward)

- **Invest in data infrastructure**
  - Including but not limited to validation of performance measures, sharing best practices for data science
  - Move existing data to places clinicians can use it in real-time
  - HAIG facility-level survey advisors, focused on SOTA topics (Chad Kessler)