Practitioner Forum

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The Current State of Affairs of VA Emergency Medicine

Once viewed widely as an outdated, poorly funded, and impractical health care delivery system, the VHA has undergone a system-wide reorganization over the past 15 years that has catapulted it into the forefront of U.S. health care. In addition to shifting from a hospital-based, acute care paradigm to one focused more on outpatient, preventive care, this transformation has involved the adoption of a multidimensional approach to quality of care that places increased emphasis on performance measures. And with these improvements in methods for measuring quality of care has come an enhanced ability to detect and address underlying problems.

In conjunction with these positive changes, the VHA undertook the ambitious task of implementing a standardized, integrated computerized patient record system (CPRS) at all VA health care facilities in the late 1990s—an initiative well ahead of the private sector.[1] This system has aided in the efficient transmission of clinical knowledge and streamlining of diagnostic evaluations, including the avoidance of unnecessary duplication of imaging and laboratory tests.[2] The advantages of having electronic records available throughout the VA system comes into play daily as veterans—often with complicated medical problems and long medication lists—transfer from one VA facility to another.[3] These benefits were witnessed on a large scale immediately after Hurricane Katrina, when the electronic records of veterans displaced from the New Orleans area remained intact and immediately accessible by other VA facilities where the veterans presented for care.[1]

Today, the dividends of these efforts are becoming increasingly clear. In this column, after reviewing some of the clinical areas in which the VA currently is excelling, we take a closer look at VA emergency medicine—exploring how it has changed in recent years, what further improvements can be made, and what it might take for the VHA to realize its full emergency medicine potential.

VA QUALITY IMPROVEMENT EFFORTS PAY OFF

In recent years, research has demonstrated the VA to be ahead of other health care systems in several aspects and areas of health care.[2,4] Recent cross-sectional comparisons of health care on various quality outcome endpoints have ranked the VA higher than Medicare. One study found that the VA met performance standards for the treatment of myocardial infarction (MI) in more of their patients than did Medicare, which may have contributed to improved survival rates in the VA.[5] Another study demonstrated that, while VA patients had a greater overall disease burden and more severe MIs compared with Medicare patients, there was no significant difference in the rates of 30-day mortality between the two groups.[6] These results could be related to the fact that more VA patients were discharged with prescriptions for aspirin, angiotensin converting enzyme inhibitors, and beta-blockers.[6] They also may reflect the aggressive preventive health care measures, including cholesterol screening and smoking cessation programs, that have been implemented in VA primary care settings.[7]

The VA has further distinguished itself through its ability to provide standardized care across racial and financial barriers. Health care disparities among racial groups have been studied extensively in the general population, and results typically have indicated poorer quality of care and worse outcomes among racial and ethnic minorities. For instance, studies have revealed higher rates of poststroke mortality in black patients compared with white patients. A recent study of patients discharged from VA medical centers after ischemic stroke, however, actually found "marginally lower" 30-, 60-, and 180-day mortality rates among black patients than among white patients.[8] These lower mortality rates could be related to the higher rates of outpatient resource utilization among black patients at VA hospitals.[8] Prior studies on racial and ethnic disparities have shown no differences in the use of stroke-related services and rehabilitation after stroke among VA patients.[8]

Among the VA's other achievements in recent years has been a rate of medication errors (1%) that is well below reported national averages (3% to 8%).[9] Moreover, the VA has made strides in the delivery of preventive health care services, using evidence-based approaches to meet national guidelines, such as Healthy People 2010.[7] Taken together, all of these accomplishments demonstrate the ability of a large, federal health care system to change—despite its

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size and complexity[5]—while keeping costs at or below those in the private sector. In fact, the VA's centralized organizational structure has worked in its favor,[10] allowing for, among other things, easier dissemination of information to clinicians and patients throughout the system.

RECENT CHANGES IN VA EMERGENCY MEDICINE

Although the aforementioned examples offer a glimpse into the vast improvements that have occurred in the VA, there have been very few studies exclusively focused on the state of emergency medicine in the VA. Yet, as change has perpetuated throughout the VA system, there is evidence of significant changes within emergency medicine.

Improving emergency departments

Over the past 20 years, the VA has attempted to improve the state of its emergency departments (EDs). Until recently, for instance, characterization of EDs varied widely between the many VA medical centers.[11] Terminology was inconsistent, with most hospitals using either "emergency room (ER)" or "ED" but others using "evaluations and admissions" or "admitting office." Aside from producing confusion on a basic level, the absence of standard terminology indicated a lack of consensus on the roles and responsibilities of the ED.

To address this problem, the VA issued a 2006 directive that sought to establish uniform definitions for its EDs and to set minimal standards on the responsibilities of and level of care provided by these departments.[12] According to a recent survey by the VA's Emergency Medicine Field Advisory Committee, 120 of the VA's 153 hospitals now meet the new criteria for full ED status, and 34 have urgent care centers.[9]

Recent data suggest that only six VA medical centers carry the designation of a trauma center.[13] Many other VA medical centers, however, evaluate and treat trauma patients every day on a walk-in basis.

One of the barriers to optimal emergency care with which the VA still struggles is a lack of involvement with local emergency medical services (EMS) in some regions. For years now, it has been challenging to integrate VA hospitals into certain local EMS networks. As a result, patients with acute care needs often are taken to community hospitals, bypassing care at the VA hospital. While this situation certainly is not universal, where it does exist, it can create a financial burden for both the VA hospital and the veteran. Nevertheless, many veterans still manage to reach their destination of choice—often opting to drive many hours to the nearest VA facility rather than calling 911 to be taken to a closer community ED.[2]

Staffing issues

While not all EDs are staffed by board-certified emergency medicine physicians, recent data suggest a growing rate of emergency medicine–trained physicians in the nation's VA hospitals. Whereas a 1993 study reported a mere 19% of VA EDs employed emergency medicine–trained physicians,[14] today the percentage of VA EDs that employ board-certified emergency medicine physicians in some capacity is up to 54% (C.S. Kessler, MD, unpublished data, 2008).

And, already, emergency medicine physicians have made their presence felt by helping improve the quality of care and workflow in these often overcrowded departments. For example, one study showed that patients of internal medicine physicians had a higher rate of hospital readmission within 30 days than did patients of emergency medicine physicians (3.5% versus 1.9%, respectively; $P = .014$).[15] The rate of return visits to the ED also was higher for the patients seen by internal medicine physicians compared with those seen by emergency medicine physicians (8.9% versus 5.5%; $P = .001$). Furthermore, the internal medicine physicians' patients had lower initial hospitalization rates than did the emergency medicine physicians patients' (20% versus 43%; $P < .0001$).[15]

Research and education

Advances in emergency medicine education and research also are leading to a dynamic change in the significance of emergency medicine physicians in the VHA. At present, just over 15% of VA EDs report some form of research being conducted by or within their department.[13] This proportion is on the rise as the number of board-certified emergency medicine physicians on staff continues to increase.

Currently, many resident physicians rotate through VA EDs as part of their training in emergency medicine, internal medicine, and other residency programs. In a survey of the VA's 120 EDs, 58 (48.3%) reported having dedicated resident coverage, while the remaining 62 (51.7%) had coverage provided by attending staff only. Only nine (7.5%) of the EDs, however, had coverage provided specifically by emergency medicine residents.[15]

Given the advantages associated with ED care provided by physicians specifically trained in emergency medicine, it is reasonable to assume that the VA would benefit from increasing the proportion of emergency medicine residents that make up the pool of residents covering its EDs. In general, we can expect this proportion to rise as the number of board-certified emergency medicine attending physicians staffing VA EDs increases. But there are, surely, other proactive steps the VA can take

to attract more emergency medicine residents nationwide.

TAKING VA EMERGENCY MEDICINE TO THE NEXT LEVEL

The VHA has made great strides in improving the quality and efficiency of care delivered to its patients. Nevertheless, there are still VA departments and services—including emergency medicine—that stand to benefit from dedicated efforts at further improvements. Continued initiatives to improve outcomes for patients with conditions—such as acute coronary syndrome and stroke—that typically present through the ED should remain the focus of core improvement projects.

Fortunately, the VHA's internal system of reviews and assessment allows it to evaluate its services and make appropriate changes continually. Although the VA's fixed budget and increasing numbers of veteran patients pose obstacles to expanding care, the organization has a track record that demonstrates its ability to make gains in quality and efficiency without significant cost increases. Many of the lessons learned in the past and ongoing efforts alike have significant potential for modernizing VA emergency care and advancing it to a new national standard.

Author disclosures

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