VA HEALTH ECONOMICS BULLETIN

A VA Health Services Research & Development Resource Center

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Inside

The VA Health Economics Bulletin is a quarterly publication of the Health Economics Resource Center (HERC) to bring VA researchers updates on datasets and data sources.

For more information on VA datasets, visit the HERC web pages for Guidebooks and Technical Reports.

For economics-related questions, please view our Methods web pages.

For economics advice, please call the HERC consulting service at (650) 617-2630 or email us at herc@va.gov.

Dedicated to improving the quality of health economics research

Costing Telehealth Interventions

New communication technologies are being used to improve health care access. Telehealth services are rapidly expanding, and now include synchronous videoconferencing, remote monitoring, telephone follow-up, call center advice lines, email, and web-based systems. Recent reviews have found a growing literature evaluating these services, but that the quality of cost-effectiveness studies in this area remains low.[1, 2] To ensure consistency and comparability of cost analyses across telehealth interventions, there are some important considerations researchers should take into account when costing these interventions.

The choice of perspective is especially important for telehealth interventions. Key benefits of telehealth interventions include their ability to improve access and decrease time cost for patients and families. Excluding these potential benefits can have a significant impact on the conclusions of a telehealth cost analysis. Wade et al. (2010), for instance, reviewed cost-effectiveness literature for real time videoconferencing. The authors found that when the patient perspective was included, telehealth was found to be cost-saving, whereas when the payer perspective alone was considered, the proportion reporting cost savings reduced to half.[3] Given these differences, researchers may want to consider a societal perspective in addition to a payer perspective when conducting cost analyses for telehealth interventions.

Researchers also need to consider that telehealth interventions often have significant upfront equipment costs. These costs should be amortized over the expected lifetime of the equipment to reflect the depreciation and opportunity cost of capital.[1]

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New Dataset for Veterans Choice Program Care

VA has created a new data source about care provided through the Veterans Access, Choice, and Accountability Act. Jenaya Lee of the VA Office of Community Care described the new Veterans Choice Program (VCP) data in an HSR&D Cyberseminar conducted July 25.

The Choice data table includes data on services, patients and providers. It is based on monthly reports submitted by VCP contractors TriWest and Health Net. These reports are validated by the VA Office of Community Care and then made available for analysis. The table allows VA to track authorizations for veterans to receive VCP care, the time it takes to process authorizations, and the time it takes for veterans receive care. The data are used for a data dashboard that allows managers to track VCP performance.

The Choice data table is distinct from the claims data in the Community Care (formerly Fee Basis or Purchased Care) dataset. Unlike the Community Care dataset, the new dataset identifies the specific provider for each service. It is also more up to date than the Community Care dataset. One drawback to the new data stems from the difficulty to link it to other data sources. Some patients in the dataset set may not be found in the VA Corporate Date Warehouse file of patient identifiers. There is no simple way to link records in the new data to the records in the Community Care dataset.

The Community Care dataset, a record of VA payments to providers, is a separate source that also includes information on VCP care. VCP care can be distinguished from other community care claims by accounting code (Fund Control Point) or by the vendor identifier for the two contractors that are providing VCP services. The Community Care dataset is created by VA and is linkable to the file of patient identifiers in the VA Corporate Data Warehouses. The Community Care data are not as up to date as the Choice data table and they do not identify the specific provider, only the contractor.

HSR&D researcher Evan Carey presented a brief review of his work identifying geographic areas in which VCP care has improved Veteran access to VA sponsored service. He also identified questions about VCP care that might by answered by health services researchers using the new Choice data table.

The full talk can be viewed on the archives of the VA Cyberseminar program.

Review of Interventions to Reduce Low-Value Care

Although wasteful spending in healthcare has been well-documented, the U.S. continues to provide low-value healthcare services across the country. In response, a growing field of research has focused on strategies to reduce low-value healthcare. In a new Medical Care Research and Review paper, Carrie Colla PhD, and team systematically review the literature on these low-value care interventions. They found that interventions with the greatest potential to reduce low value care are those with multiple components that address both patient and provider roles. Dr. Colla and team identify common research topics as well as promising interventions which have, thus far, been under-researched. As research into low-value care continues to grow, investigations into these additional interventions will a valuable contribution to the discussion.

“Interventions Aimed at Reducing Use of Low-Value Health Services: A Systematic Review” by Colla C, Mainor AJ, Hargreaves C, Sequist T, and Morden M, is available in the July 8, 2016 issue of *Medical Care Research Review*.

New Research Finds Gap between Recommendations and Practice in Supportive Care

Veterans who die with cancer may not receive formal palliative care for much of their cancer disease trajectory, suggests a new study led by HERC economist Risha Gidwani, DrPH along with investigators from VAs in Providence, Philadelphia, Palo Alto, and Eastern Colorado. Less than one-quarter of cancer decedents in the study received palliative care before their cancer treatment concluded. This indicates a departure from recommended care. The Institute of Medicine, American Society of Clinical Oncology, and National Comprehensive Cancer Institute all advise that palliative care begin soon after diagnosis of advanced cancer and that it can be provided concurrent to anti-neoplastic treatment.

This study, published online in the May 2016 *Journal of Palliative Medicine*, evaluated the receipt and timing of palliative care within VA and the receipt and timing of hospice care across three healthcare environments: Medicare, VA, and VA Purchased Care. Dr. Gidwani and team used administrative data from VA, Fee Basis, and Medicare to evaluate care for veterans aged 65 years or older who died with secondary or malignant cancer in VA in FY2012. They found that 52% of Veterans received palliative care consults in VA before death, with consults beginning a median of 38 days before death. In this cohort, 71% of Veterans received hospice before death. Hospice began a median of 20 days before death, with VA-provided hospice starting closer to death than in VA Purchased Care or Medicare.

Adjusted regression analyses found significant differences in receipt of palliative care and hospice by cancer type. Patients with brain, pancreatic, prostate, hematological malignancies, or melanoma were significantly less likely to receive hospice compared to lung cancer patients. The team also found significant differences in the duration of hospice across Medicare, VA, and VA Purchased Care, with VA patients less likely to have hospice for the minimum recommended three days.

Specialty societies recommend patients with advanced cancer receive early exposure to palliative care and exposure to hospice care. These findings indicate that there is a gap between recommendations and real-world practice for both palliative care and hospice.

"Gap between Recommendations and Practice of Palliative Care and Hospice in Cancer Patients" by Gidwani R, Joyce N, Kinosian B, Faricy-Anderson K, Levy C, Miller SC, Ersek M, Wagner T, and Mor V, can be found in the May 2016 (ahead of print) issue of *Journal of Palliative Medicine*.

HERC Releases FY2015 Inpatient Average Cost Dataset

HERC has released inpatient average cost estimates for fiscal year (FY) 2015. These datasets are estimates of each inpatient stay reported in the VA Patient Treatment Files (PTF), from FY1998-FY2015. The release includes three datasets: medical-surgical, non-medical-surgical, and discharge. The medical-surgical file contains cost estimates of all discharges from acute medical-surgical bed sections during the fiscal year, whereas the non-medical-surgical file contains cost estimates of discharges from rehabilitation, mental health and long term care bed sections. The discharge file contains the costs of all hospital stays ending with a discharge during the fiscal year. The HERC inpatient average cost files are available through VINCI.

HERC also released an updated guide to the data, *HERC's Average Cost Datasets for VA Inpatient Care*. The guidebook describes the methods used to build the dataset, underlying assumptions, and advice on how to use it. The guidebook is now a web-based publication available on the HERC website.

Using Economics to Inform Public Health Policy

It is increasingly important for policy makers to understand how to allocate limited resources or choose between competing interventions. Health economics provides practical tools to estimate costs or evaluate the risks and benefits of an intervention relative to the next. More and more, public health researchers are choosing to incorporate economic evaluation into their study design. In their May 2016 supplement "The Use of Economics in Informing U.S. Public Health Policy," the *American Journal of Preventative Medicine* presents a collection of papers highlighting strategies for using economics to answer public health policy questions.

Within this supplement are examples of why and how researchers incorporate economic analysis into their studies. Readers can explore the broad range of methodological approaches, including behavioral economics, benefit-cost analysis, and experimental and quasi-experimental methods. The authors present examples of public health interventions that have included economic evaluations, from team-based care interventions for hypertension to mandatory folic acid fortification of cereal grain. These papers illustrate how economic analyses can strengthen public health research.

"The Use of Economics in Informing U.S. Public Health Policy" is available from *American Journal of Preventative Medicine*, May 2016, Volume 50, Issue 5, Supplement 1, S1-S84.

Second Panel on Cost Effectiveness in Health and Medicine

The Second Panel on Cost Effectiveness in Health and Medicine is holding a one day conference to highlight its findings and recommendations. The conference will be held on December 7, 2016 at the National Academy of Sciences in Washington D.C. It has been more than 20 years since an earlier panel established standards for cost-effectiveness analysis in the United States. Although the new recommendations have not yet been released, early reports indicate that the new recommendations are for significant change to cost-effectiveness methods. An online event page has the meeting agenda and registration logistics.

Costing Telehealth Interventions

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Evaluations should also include the cost of health care providers that support the telehealth care training, help desks, transition costs, start-up, and troubleshooting costs.[1] Finally, it is important to take into account the potential for rapid changes in telehealth technology and prices. In order to ensure that costing studies are relevant for decision makers, research design should be adapted so that it is efficient and timely.[4]

1. Bergmo, T. S. (2015). How to Measure Costs and Benefits of eHealth Interventions: An Overview of Methods and Frameworks. *J Med Internet Res, 17* (11), e254.
2. Mistry, H., Garnvwa, H., & Oppong, R. (2014). Critical appraisal of published systematic reviews assessing the cost-effectiveness of telemedicine studies. *Telemed J E Health, 20*(7), 609-618.
3. Wade, V. A., Karnon, J., Elshaug, A. G., & Hiller, J. E. (2010). A systematic review of economic analyses of telehealth services using real time video communication. *BMC Health Serv Res, 10*, 233.
4. Baker, T. B., Gustafson, D. H., & Shah, D. (2014). How can research keep up with eHealth? Ten strategies for increasing the timeliness and usefulness of eHealth research. *J Med Internet Res, 16*(2), e36.

HERC

The Health Economics Resource Center produces pioneering, rigorous health economics and related research that improves health care within and beyond VA.

Our research activities include innovation and excellence in:

- Performing cost and cost-effectiveness analyses
- Studying the efficiency of health care
- Evaluating health programs and interventions
- Planning, managing, and analyzing randomized clinical trials
- Health care decision modeling
- Assessing health-related quality of life
- Health economics and health services research

We are committed to:

- Integrity
- High quality of work
- Productivity
- Transparency
- Mutual trust and respect
- Teamwork
- Investment in people through learning and mentoring
- A flexible, supportive, and enjoyable work environment

HERC Cyberseminars

HERC cyberseminars feature presentations on a variety of health economics and health services topics. Each hourly session begins at 11:00am Pacific (2:00pm Eastern), unless otherwise noted.

Upcoming Cyberseminars

September 21, 2016

(PSI-90): Does it Affect Assessment of Hospital 2016 Performance and Financial Penalties in Veterans Health Administration Hospitals?

Qi Chen, MD, PhD
Center for Healthcare Organization & Implementation Research (CHOIR)

The AHRQ PSI Composite Measure (PSI-90) was designed to provide a single metric for tracking patient safety performance across U.S. hospitals. AHRQ recently released a new version of the PSI algorithm (version 6.0) in mid-July. A few major changes were made in the PSI-90 methodology, including the use of harm-based weights. This presentation will provide insights on how this change may impact on hospital profiles, which may be useful to quality managers and patient safety managers who are routinely using the PSI-90.

Register:
http://www.hsrd.research.va.gov/Cyberseminars
Schedule & archives:
http://www.herc.research.va.gov/include/page.asp?id=courses-seminars

Interested in presenting in the HERC Health Economics Cyberseminar Series? Contact HERC Economist Jean Yoon (Jean.Yoon@va.gov) for more information.

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