



## Chapter 3

### Utilization

#### Background

The VA, like other health care systems, continues to move towards an outpatient-based model of service delivery. In response to the move away from inpatient care, the Veterans Eligibility Reform Act of 1996 (Public Law 104-262) was passed, requiring the Under Secretary for Health, Department of Veterans Affairs, to receive annual reports on the VHA's capacity to effectively meet the treatment and rehabilitation needs of severely chronically mentally ill veterans. The First Annual Report submitted by the Committee on Care of Severely Chronically Mentally Ill Veterans Affairs "stresses the need to ensure that adequate community based programs are made available for the severely chronically mentally ill veteran" (Committee on Care of Severely Chronically Mentally Ill Veterans, 1997).

Research suggests that cost-efficient care for patients with long-term disability requires an optimal mix of acute care, extended care, residential services, and outpatient clinical services (Rothbard, Kuno, Schinnar, Hadley, & Turk, 1999). The VA has sought to integrate service provision. The goal of coordinated care is that interventions are provided "when they will have their greatest effectiveness and in a way that promotes efficiency" (Kizer, 1996). To inform the VA on the current ability of the system to provide this array of services, we report specific utilization data for a wide range of 24 hour institutional services (hospital based medical and psychiatric care, residential rehabilitation, domiciliary and nursing home care), as well as a variety of outpatient care settings (general psychiatry, psychiatric case management and day treatment, substance abuse and PTSD and psychiatric vocational rehabilitation).

Although the ECA reveals that 1/3 of all mental visits are made by patients without a DIS psychiatric diagnosis, individuals with SMI use considerably more services than the general population. 18% had a mental health encounter within a 6-month period, half of these visits to a specialist. In general, women utilize more mental services, as do younger patients (Shapiro et al., 1984). A more recent study (Dickerson et al., 2003) found that all patients with mental health conditions are also more to see a medical doctor than the general population (OR=2). Echoing the ECA and other research, Husaini and colleagues confirm that a variety of factors affect utilization patterns among SMI patients (e.g. race, gender, age, etc.), and substantial variation is expected across multiple treatment domains (Husaini et al., 2002).

McFarland documented how SMI patients within large, integrated healthcare systems (such as HMOs) tend to maintain contact with their providers and receive appropriate care to the same extent as other patients (McFarland et al., 1996). In addition, previously noted ethnic differences in mental health utilization rates (including specialty visits) are steadily decreasing, along with improving positive attitudes toward psychiatric care among minority clients (Cooper-Patrick et al., 1999).

Reflecting increased concerns regarding medical care for VA patients with psychosis, this report now includes two measures regarding primary care utilization. These are: 1) the percentage of patients with psychoses who had at least one primary care stop during the fiscal year, and 2) the mean number of outpatient visit days that included a primary care stop, among patients who had some primary care. Since many preventive screenings are recommended annually for older

people, with a populations whose average is 54 one would strive for close to a 100% incidence of an annual primary care stop. The CDC's "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 1997" found that 81% of adults see a doctor or other health care professional (although the type of care sought is not specified) in a year (Centers for Disease Control, 2002). This percentage jumps to 91% for people over 65. We would expect the NPR percentages to be in the same range or higher since they, unlike the CDC population, have already sought health care.

Changes in service use rates following impact of the *Millennium Bill* should be interesting from a policy and planning perspective. In particular, long-term care (LTC) and outpatient medication utilization are directly associated with the new bill.

All utilization data were obtained from the nationwide VA Patient Treatment File (PTF) and Outpatient Care Files (OPC) located at the Austin Automation Center in Austin, Texas.

### Inpatient

Key findings:

- Overall hospital use:
  - Total IP days dropped significantly again, down 11.2% to a mean of 23.71; this is a 32.3% decrease over 4 years.
  - Long admissions of 100+ days continued to drop rather sharply, with only 2.6% of patients requiring such extended hospital visits last year (down from 4.8% in FY99)
- Medical:
  - Percent of patients admitted continues to rise, up to 14.3% from 8.9% in FY99.
- Psychiatric:
  - Total IP days decreased another 13.3% last year to 16.43, a total substantial drop of 38.6% since FY99.
  - 17.5% of NPR patients had some inpatient psychiatric care, and for those with an inpatient stay, there were an average of 1.04 admissions and an average stay of 16.43 days.
  - Percentage of SCH with stays of 100+ and 150+ days was almost four times higher than that for BP.
- Other institutional:
  - Despite a small decrease last year in percentage of NPR patients with this type of care (8.4%), this number is still well above FY99 total of 6.4%.
- Residential rehabilitation:
  - 1.7% of NPR patients had some residential rehabilitation
  - SCH spent more time in residential rehabilitation (46.2 vs. 36.7 days) and 100+ day stays were two times higher.
  - 100+ days up again to 6.2%, a large increase from 2.7% in FY99.
- Domiciliary:
  - 3% of NPR patients had some domiciliary care
  - SCH had more total days in domiciliaries (105.6 vs. 84.2 days).
  - Total days down approximately 10% since FY99.
- Nursing home:
  - 4.2% of NPR patients had some nursing home care

- Veterans with Other Psychoses had much higher use because of the higher age in this group
- SCH had twice as much use as BP.
- Despite less use, SCH total days much higher than Other Psychoses (153.6 vs. 66.1), and than BP (103.1).
- Nearly half (48%) of SCH have stays of 100+ days.

### Outpatient

- Overall stops:
  - Almost all patients had at least one OP stop (99.1%).
  - The decline over time of total stops slowed last year (39.09 average), although this variable has still dropped 29.6% since FY99.
  - SCH had more overall stops (42.6) than BP (38.3) or Other Psychoses (32.0)
  - Average total *stops* demonstrated high variability across VISNs: from 28.10 to 57.76 with notable ranges observed for *psychiatric* (8.89-33.30), *case management* (0.21-4.16), *day treatment* (0.28-8.86), and *vocational training* (0.22-4.74).
- Psychiatric stops:
  - Patients had an average of 18.93 psychiatric stops.
  - Steady decline in psychiatric stop continues with 22.4% drop since FY99.
  - SCH had more psychiatric stops than BP (19.3).
- Primary care:
  - Over 75% of the patients received at least one primary care visit.
  - Other Psychoses had the most overall use of primary care(82.3%), then BP (77%) and SCH the lowest (71%)
  - Patients having at least one *primary care* visit during FY02 ranged across VISNs from 67.3% to 82.8%
- Other care:
  - Consistent with Dual Dx rates, BP had more Sub Abuse stops than SCH (4.6 vs. 3.0).
  - There was very little case management, an average of only 1.44, although for those who received some, the average number of visits was higher for SCH than for BP (2.6 vs 0.6).
  - Decrease in day treatment, substance abuse and vocational stops continues.

### **Tables**

For each group (Global, All Diagnoses by VISN, Schizophrenic by VISN, Bipolar by VISN and Other Diagnoses by VISN) the utilization tables are organized as follows. For exact stop codes and bed sections, see Appendix C.

1. Hospital based utilization, (based on the patient's bed section at discharge)
  - a. psych and non-psych- reported for those with some hospital based utilization

- i. non-psych- reported for those with some hospital based utilization
    - ii. psych- reported for those with some hospital based utilization
  - 2. Other 24 hour institutional care (based on the patient's bed section at discharge)
    - a. res rehab- reported for those with some res rehab
    - b. dom and voc- reported for those with some dom or voc
    - c. nursing home- reported for those with some nursing home
  - 3. Outpatient care- all variables reported for those with some outpatient care
    - a. annual clinic stops
    - b. non-psych clinic stops
    - c. psych clinic stops
      - i. general psych clinic stops
      - ii. psych case management clinic stops
      - iii. psych day treatment clinic stops
      - iv. substance abuse clinic stops
      - v. psych vocational clinic stops
      - vi. PTSD clinic stops
      - vii. psych homeless clinic stops

Table 3A	FY01 Patients w/ Psychosis, Utilization, by Diagnosis Grouping	81
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