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

POLICY BRIEF

May 2024

Effects of VHA's Referral Coordination Initiative on Referral Patterns and Waiting Times

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Bottom Line Up Front

Veterans Health Administration (VHA) launched the Referral Coordination Initiative (RCI) to assist Veterans in choosing whether to access the care they need in house or from a community care (CC) provider. In a national evaluation of the effects of RCI implementation, there was no evidence that RCI had a significant impact on CC referrals or VHA or CC appointment waiting times. These findings do not support concerns that RCI impedes Veteran access to CC providers.

Introduction

Congress passed the Choice Act in 2014 and the MISSION Act in 2018 to improve timely access to care for Veterans Health Administration (VHA) enrollees[1,2] However, by allowing enrolled Veterans to obtain care from community care (CC) providers paid for by VHA, the options for choosing a care setting became more complex. As a result, VHA launched the Referral Coordination Initiative (RCI) in 2019 to assist Veterans in navigating the various care options available to them, improve scheduling timeliness, and reduce administrative burden for referring providers.[3,4]

Referral Coordination Initiative (RCI)

RCI creates Referral Coordination Teams (RCTs), teams of trained clinical and administrative staff who oversee specialty care referrals and manage consults. These teams schedule appointments in real time while the Veteran is on the phone or in clinic. RCTs are required to review provider referral requests for eligibility and clinical appropriateness. RCI also mandates that referral teams provide CC-eligible Veterans with the opportunity to still choose to receive their care in house at a local VHA facility, if available. Facilities organize their referral teams using one of three staffing models: centralized, decentralized, or hybrid.

Possible Unintended Consequences

Although one of the goals of RCI is to help Veterans make informed decisions about their care options, there have been concerns from lawmakers and policy experts that the referral process dissuades Veterans from using CC providers, undermining a main tenant of both the Choice and MISSION Acts.[5] These concerns are mainly focused on the additional administrative steps now required before sending eligible referrals to CC providers. It has been unknown whether these additional steps lead to unintended increases in waiting times for VHA or CC appointments or fewer referrals to the community.

Referral Coordination Teams (RCT)
Clinical and administrative staff who oversee specialty care referrals and manage consults.

RCI Staffing Models

Decentralized

Clinical and administrative staff **have other responsibilities** and report to **their respective service line managers**.

Hybrid

Administrative staff are **fully dedicated** to the **referral team** and report to the **RCI manager**, while clinical staff have **other responsibilities** and report to their **respective service line managers**, or vice versa.

Centralized

Clinical and administrative staff are **fully dedicated** to the **referral team** and report to the **RCI manager**.

Evaluation

Approach

The Partnered Evidence-based Policy Resource Center (PEPReC) evaluated whether RCI is associated with changes in the proportion of VHA specialty care referrals completed by CC providers and changes to mean appointment waiting times for VHA and CC providers.[6] PEPReC's evaluation was the first to investigate effects of RCI implementation across multiple specialties nationwide.

PEPReC used a staggered difference-in-differences approach to evaluate RCI's effects on referral patterns and waiting times.[7] They categorized facilities into high and low RCI use based on the proportion of total referrals managed by the RCTs. Evaluators then stratified the analysis by **specialty** and the **staffing model** adopted by high RCI users. While implementing RCI was not optional, low RCI use facilities encountered challenges during the implementation process (see Implications for Clinical and Policy Practice section) and were used as controls for the analysis.

High RCI Use

Facilities with RCTs who manage **at least 10%** of referrals in a given month and sustain or increase implementation level in following months.

Low RCI Use

Facilities with RCTs who manage **less than 10%** of referrals during the entire sample period.

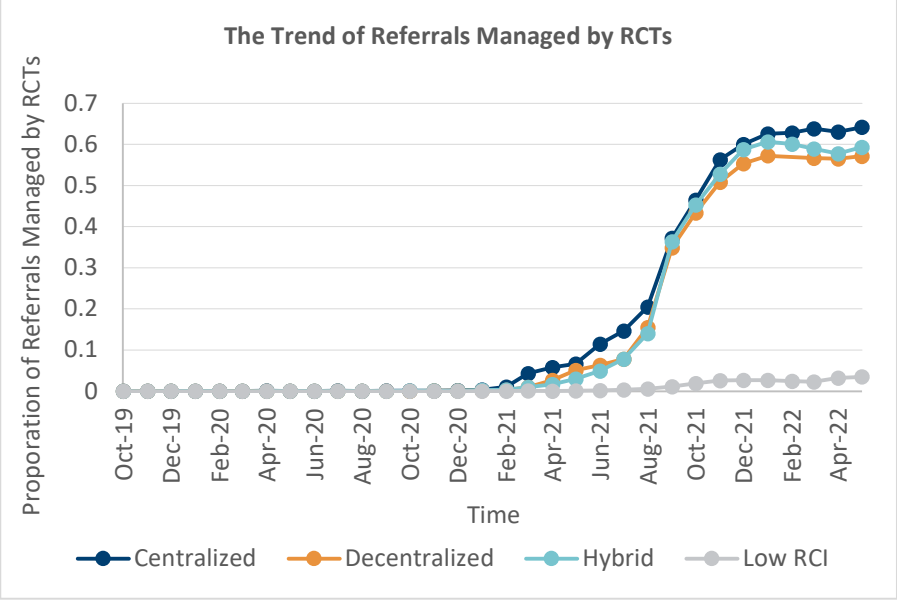
Data Sources

The study used VHA administrative data on RCI implementation, referral rates, and waiting times from the Corporate Data Warehouse. Evaluators collected monthly facility level data on over 22,000 specialty care referrals for eight high-volume specialties from October 1, 2019 to May 30, 2022. Qualitative survey data from the Office of Integrated Veteran Care (IVC) from June 2022 to September 2022 was also used.

Findings

Trends in RCI Implementation

Although RCI launched in 2019, uptake was **minimal** until March 2021, after which facility implementation began to steadily increase.[8] (The reason for this remains unknown.) Then, the proportion of referrals managed by RCTs steadily increased, rose sharply, and plateaued in January 2022. By May 2022, 53.6% of all referrals were managed by RCTs across all high RCI use facilities, with the centralized staffing model managing the most referrals (facility-level, 63.9%). In contrast, RCTs in



low RCI use facilities only managed 3.4% of facility-level referrals by May 2022. All following results are for high RCI use facilities unless otherwise noted, as low RCI use facilities were used as controls.

RCI Implementation and CC Referral Rates

There was **no evidence that RCI implementation had a significant impact** on CC referral rates in any of the specialties in either the centralized or hybrid staffing model groups. However, among the decentralized staffing model group, RCI implementation was associated with **small increases** in CC referral rates in cardiology and podiatry (4 and 9 percentage points respectively).

No significant impact on referral rates to CC providers.

RCI Implementation and Waiting Times

RCI implementation had **no significant impact** on VHA or CC appointment waiting times. The one exception to this finding was physical therapy in a high RCI use facility with a centralized staffing model: RCI implementation was associated with a 2-day increase in CC waiting times.

No significant impact on appointment waiting times for either VHA or CC providers.

Implications for Clinical and Policy Practice

While there is no evidence that CC referral rates are impacted by RCI, it remains unclear whether this is due to unchanged Veteran preferences for VHA or CC providers or limitations in the implementation of RCI itself. (Some limitations previously noted by the Office of Inspector General and others include a lack of the following: staffing, standardized triaging tools, training completion, and coordination with IVC.[8,9])

Facilities who adopted the decentralized staffing model had lower RCI implementation compared to those that employed the centralized staffing model, potentially reflecting higher opportunity costs associated with the decentralized staffing model.[9] Because the decentralized staffing model uses employees who have other responsibilities as well, their time spent with the RCTs comes at the expense of their other responsibilities. In contrast, members of RCTs in the centralized staffing model do not need to balance their time between RCT and non-RCT work.

Conclusion

Going forward, VHA could improve the value of RCI by asking RCTs to compare VHA and CC waiting times before approving referrals. Studies have shown that waiting times for specialty care with CC providers tend to be longer than those for VHA providers, underscoring a shortage of specialists at CC providers across the country.[10-11] By comparing waiting times before referrals are approved, RCI may help minimize overall waiting times and improve Veteran access to care.

In its initial years, RCI did not have a measurable effect on waiting times or CC referral rates, diminishing concerns that RCI might be impeding Veteran access to CC providers.[12,13]

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ABOUT PEPReC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPReC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.