How the VA is Quietly Innovating and Leading in Virtual Care and Remote Patient Monitoring

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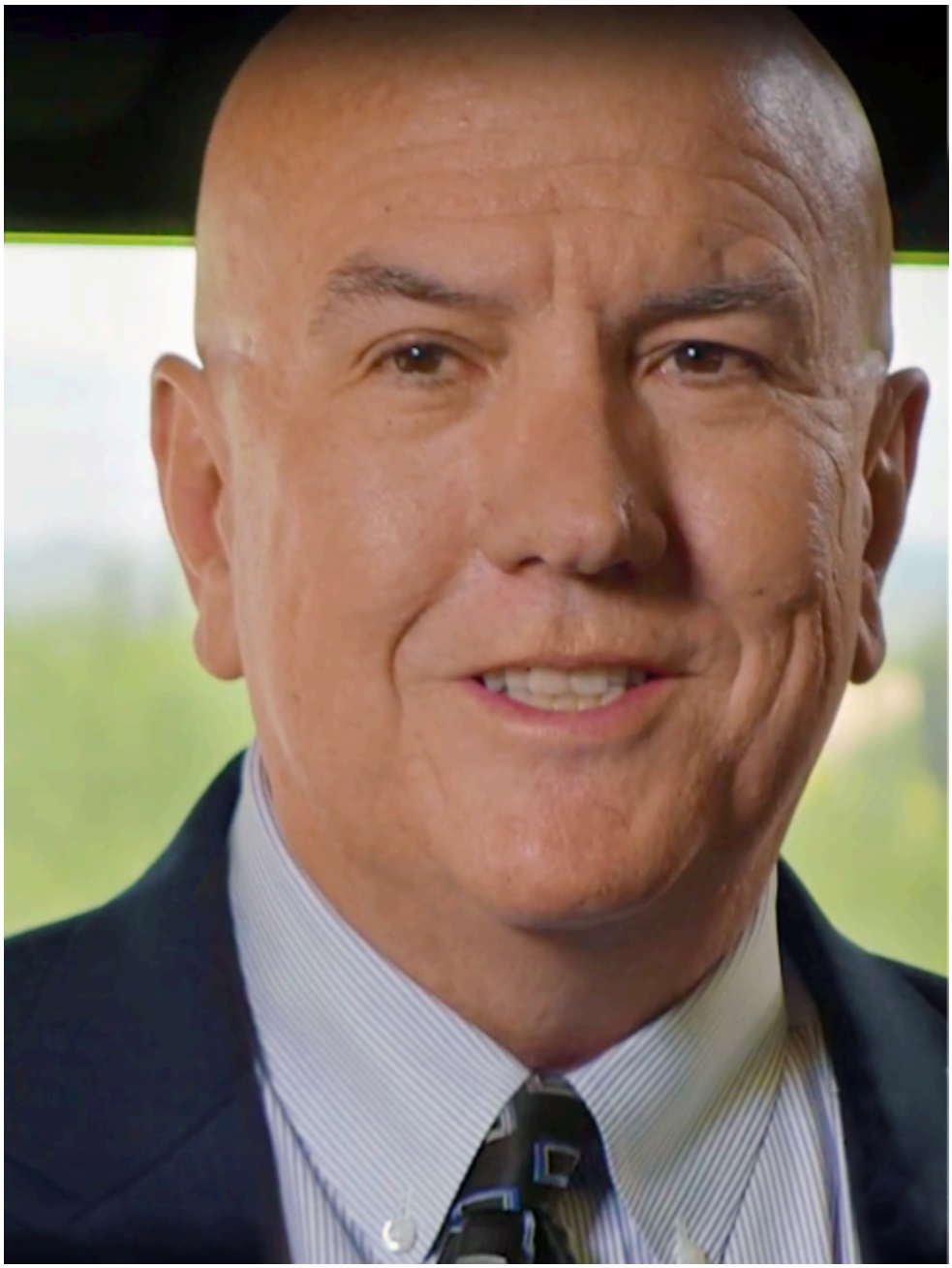

Commentary

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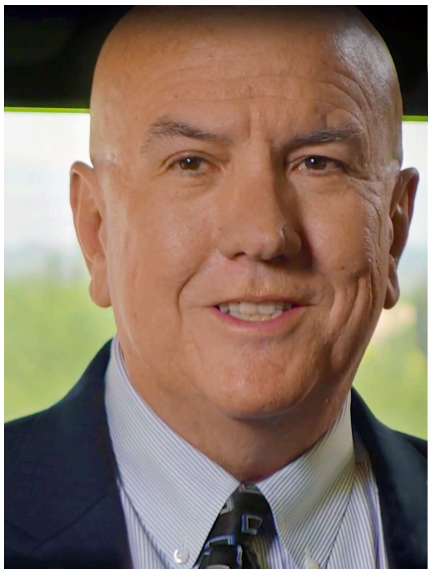
The US Department of Veterans Affairs (VA) and its Veterans Health Administration (VHA)—the country's largest integrated health care provider—have implemented several innovative programs in recent years to expand access to care and improve outcomes for former military personnel.



For example, the Veterans Community Care Program enables veterans to obtain care from unaffiliated providers when wait times at VA facilities exceed designated limits. This program, however, appears to be bursting at the seams, considering it accounts for nearly 40% of the VA's contractual expenses—a 30-percentage point growth in only 5 years.
The care-access challenge is increasingly urgent, as, in 2021, approximately half of veterans were aged 65 or older, and three-quarters were aged 50 or older. On average, medical expenses more than double between ages 70 and 90, meaning that more veterans will require many more care services for the next several decades. Yet, many of these patients live in rural areas, far from any health care facility.

Fortunately, the VA is stepping up to the challenge by expanding its decades-old successful remote patient management (RPM) program and deploying advanced technologies to not only react to care needs but also predict them. In turn, the VA is simultaneously expanding care access while reducing costs through preventive and proactive action focused on chronic condition management and identifying the earliest signs of urgent health problems.

An RPM Pioneer

Tech-enabled RPM and telehealth have been among the most discussed and adopted programs in health care since the COVID-19 pandemic forced providers to reimagine and overhaul how they deliver care. However, since 2003, under its "Home Telehealth" program, the VA has used remote care technology and workflows for managing chronic conditions. In 2023, more than 2.4 million unique veterans received virtual care, representing approximately 40% of the veteran patient population.

Moreover, the 132 000 veterans participating in the VA's Remote Patient Management-Home Telehealth (RPM-HT) program experienced a 41% reduction in hospital admissions, and the length of their hospital admissions reduced by approximately 70%. RPM-HT participants, who expand by approximately 20 000 annually, input vital signs, such as temperature, blood glucose levels, blood pressure, and heart rate, and share these data with a remote clinician who uses data analytics technology to identify potential problems and intervene before more critical care is required.

Transforming Care

Despite this success, the VA faces an older, sicker, and predominantly rural patient population. One-third of veterans who receive care from the VHA live in rural areas, compared to only about one-fifth of all Americans. At the same time, approximately 42% of older veterans report a disability, compared with 33% of older nonveterans. Similarly, veterans living in rural areas are more likely to have more complex medical conditions and are more likely to be diagnosed with diabetes, hypertension, and heart conditions than veterans residing in urban areas.

Such physical and geographic barriers to receiving in-person care threaten veterans' safety and health while potentially driving up care costs through more frequent emergency care and hospitalizations.

To prevent these outcomes, the VHA's Office of Connected Care (OCC) announced in 2021 a $1-billion expansion of its RPM and virtual care program. As it did decades ago, the VHA, through the OCC, is embracing a decentralized approach by offering access to more clinics in rural areas. It is also embracing new and proven technologies and remote-care workflows to transform care delivery from a reactive model to a proactive and preventive strategy.

Data-Driven Interventions

Preventive is one of the four "P's," along with predictive, personalized and participatory, recommended by health care visionaries Leroy Hood, MD, PhD, and Nathan Price, PhD, who described this paradigm shift in their book, *The Age of Scientific Wellness*. They envision a health care system in which providers can identify early disease indicators before symptoms appear and deliver precise treatments to prevent the illness from progressing.

Aligning with these principles, the OCC's RPM and virtual care expansion leverages real-time data aggregation and analysis supported by emerging artificial intelligence (AI) tools. Instead of trying to distribute hundreds of thousands of health-monitoring devices to veterans around the country, the OCC is investing in small, wearable biosensors and everyday home medical devices, such as blood pressure cuffs and weight scales. These connected devices supply data that is combined with information from the VA's electronic health records for automated data analytics. Some of these tools will be AI-powered and use machine learning

to notify clinicians if veterans at home may require support. This intervention could be a live provider encounter or an automated digital “nudge” to, for example, take their medications or answer health-related questions. Ultimately, however, expert human clinicians will review, approve, or modify any such interventions based on their knowledge and experience.

Fighting for Veterans and All Patients

The VA’s example of adopting a decentralized approach and implementing innovative technology to care for a challenging patient population should inspire other health care organizations. By embracing care transformation as the VA has, provider organizations can improve clinical outcomes and care quality while reducing costs and provider burden—goals that all stakeholders are fighting for.