ORIGINAL RESEARCH

Utilization and Cost of Veterans Health Administration Referrals to Community Care-Based Physical Therapy

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Background: The Veterans Health Administration (VHA) provides health care in rural communities through the Telerehabilitation Enterprise-Wide Initiative (TR-EWI) and other community care (CC) programs. Telehealth may allow clinicians to overcome challenges associated with CC, but there is a lack of understanding of the use of CC for rehabilitation services.
Methods: This study explores CC physical therapy (PT) referral use and cost trends for 7 Veterans Integrated Services Networks (VISNs) with TR-EWI sites, using US Department of Veterans Affairs Corporate Data Warehouse and VHA Support Service Center referral data, as well as cost data from the VHA Community Care Referral Dashboard. We used descriptive statistics to analyze data. This study also qualitatively analyzed provisional diagnosis data to ascertain which PT diagnosis groups were most frequently referred to CC.
Results: There were 344,406 PT referrals to CC from fiscal year (FY) 2019 to FY 2022. Referrals decreased from FY 2019 to FY 2020 but increased from FY 2020 to FY 2022, most notably in VISNs 19 and 22; VISN 8 consistently had high PT referrals over time. More referrals were made for veterans living in urban communities (56.2%) than rural communities (39.8%) and for those aged 60 to 69 years (20.7%) and aged 70 to 79 years (26.9%). There were 200,204 PT referrals with cost data from FY 2020 to FY 2022, totaling about $221 million in selected VISNs. Referral costs nearly doubled from FY 2020 to FY 2021, but only slightly increased from FY 2021 to FY 2022.
Conclusions: This study highlights the variations in PT referrals and costs across VISNs and eligibility reasons for CC referral. Cost trends underscore the financial commitment to provide PT to veterans. Understanding the factors driving cost is necessary for the VHA to optimally provide and manage the rehabilitation resources needed to serve veterans through traditional in-person care, telehealth, and CC while ensuring timely, high-quality care.

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The Veterans Health Administration (VHA) is the largest US integrated health system, providing care to veterans through VHA and non-VHA practitioners and facilities.[1,2] Providing high-quality, timely, and veteran-centric care remains a priority for the VHA. Legislative efforts have expanded opportunities for eligible veterans to receive care in the community purchased by VHA, known as community care (CC).[1] The Veterans Access, Choice, and Accountability Act of 2014 came in response to reports of long wait times and drive times for patients.[3-5] The MISSION Act of 2018 expanded access to CC by streamlining it and broadening eligibility criteria, especially for veterans in rural communities who often experience more barriers in accessing care than veterans living in urban communities.[1,6-10] Since the implementation of the Choice and MISSION Acts, > 2.7 million veterans have received care through community practitioners within the VHA CC network.[11]

BACKGROUND

Increased access to CC could benefit veterans living in rural communities by increasing care options and circumventing challenges to accessing VHA care (ie, geographic, transportation, and distance barriers, practitioner and specialist shortages, and hospital closures).[5,9,10,12,13] However, health care system deficits in rural areas could also limit CC effectiveness for veterans living in those communities.[3] Other challenges posed by using CC include care coordination, information sharing, care continuity, delayed payments to CC practitioners, and mixed findings regarding CC quality.[5,8,13,14] VHA practitioners are specifically trained to meet the multifaceted needs unique to veterans' health and subculture, training CC practitioners may not receive.[5,15]

CC offers services for primary care and a broad range of specialties, including rehabilitation services such as physical therapy (PT).[6] PT is used for the effective treatment of various conditions veterans experience and promote well-being and independence.[16] US Department of Veterans Affairs (VA) databases reveal a high prevalence of veterans receiving PT services through CC; PT is one of the most frequently used CC outpatient specialty services by veterans living in rural communities.[14,17]

TELEREHABILITATION ENTERPRISE-WIDE INITIATIVE

VHA has greatly invested in delivering care virtually, especially for veterans living in rural communities.[18] In 2017, the VHA Office of Rural Health funded the Telerehabilitation Enterprise-Wide Initiative (TR-EWI) in partnership with the Physical Medicine and Rehabilitation Services national program office to increase access to specialized rehabilitation services for veterans living in rural communities by leveraging telehealth technologies.[18-21] This alternative mode of health care delivery allows clinicians to overcome access barriers by delivering rehabilitation therapies directly to veterans' homes or nearby community-based outpatient clinics. TR-EWI was conceived as a hub-and-spoke model, where rehabilitation expertise at the hub was virtually delivered to spoke sites that did not have in-house expertise. In subsequent years, the TR-EWI also evolved to provide targeted telerehabilitation programs within rural-serving community-based outpatient clinics, including PT as a predominant service.[19,20]

As TR-EWI progressed—and in conjunction with the uptake of telehealth across VHA during the COVID-19 pandemic—there has been increased focus on PT telerehabilitation, especially for the 4.6 million veterans in rural communities.[18,22,23] Because health care delivery system deficits in rural areas could limit the effective use of CC, many TR-EWI sites hope to reduce their CC referrals by providing telehealth PT services to veterans who might otherwise need to be referred to CC. This strategy aligns with VHA goals of providing high-quality and timely care. To better understand opportunities for programs like TR-EWI to provide rehabilitation services for veterans and reduce care sent to the community, research that examines CC referral trends for PT over time is warranted.

This study examines CC from a rehabilitation perspective with a focus on CC referral trends for PT, specifically for Veterans Integrated Service Networks (VISNs) where TR-EWI sites are located. The study's objectives were to describe rehabilitation PT services being referred to CC and examine associated CC costs for PT services. Two research questions guided the study. First, what are the utilization trends for CC PT referrals from fiscal year (FY) 2019 to FY 2022? Secondly, what is the cost breakdown of CC for PT referrals from FY 2020 to FY 2022?

METHODS

This study was conducted by a multidisciplinary team comprised of public health, disability, rehabilitation counseling, and PT professionals. It was deemed a quality improvement project under VA guidance and followed the SQUIRE guidelines for quality improvement reporting.[24,25] The study used the VA Common Operating Platform (Palantir) to obtain individual-level CC referral data from the HealthShare Referral Manager (HSRM) database and consult data from the Computerized Patient Record System. Palantir is used to store and integrate VA data derived from the VA Corporate Data Warehouse and VHA Support Service Center. Referrals are authorizations for care to be delivered by a CC practitioner.

TR-EWI is comprised of 7 sites: VISN 2, VISN 4, VISN 8, VISN 12, VISN 15, VISN 19, and VISN 22. Each site provides telerehabilitation services with an emphasis on reaching veterans living in rural communities. We joined the referrals and consults cubes in Palantir to extract PT referrals for FY 2019 to FY 2022 for the 7 VISNs with TR-EWI sites and obtain referral-specific information and demographic characteristics.[26] Data were extracted in October 2022.

The VHA Community Care Referral Dashboard (CC Dashboard) provided non-individual level CC cost data.[27] The CC Dashboard provides insights into the costs of CC services for VHA enrollees by category of care, standardized episode of care, and eligibility. Data are based on national-level HSRM referrals that are not suspended or linked to a canceled or discontinued consult. Data were aggregated by VISN. The dashboard only includes referrals dating back to FY 2020; therefore, PT data from FY 2020 through FY 2022 for VISNs with TR-EWI sites were collected. Data were extracted in December 2022.

This study examined CC referrals, station name, eligibility types, clinical diagnoses (*International Classification of Diseases, Tenth Revision* codes), and demographic information in the Palantir dataset. Six eligibility criteria can qualify a veteran to

TABLE 1. Community Care Physical Therapy Referrals by Year

Criteria	FY 2019	FY 2020	FY 2021	FY 2022	Total
VISN, No.					
2	3985	3134	2637	3066	12,822
4	15,654	13,047	13,491	12,345	54,537
8	20,644	15,252	19,163	21,417	76,476
12	10,795	9496	9163	8669	38,123
15	14,848	11,303	9926	11,096	47,173
19	5872	5934	19,925	21,182	52,913
22	5650	7450	22,852	26,410	62,362
Rurality, No.					
Rural	29,807	27,733	38,820	40,844	137,204
Urban	40,278	34,834	56,657	61,807	193,576
Insular isle	190	153	151	133	627
Unknown	335	60	9	37	441
Missing	6838	2836	1520	1364	12,558
Total, No.	77,448	65,616	97,157	104,185	344,406

Abbreviations: FY, fiscal year; VISN, Veterans Integrated Services Network.

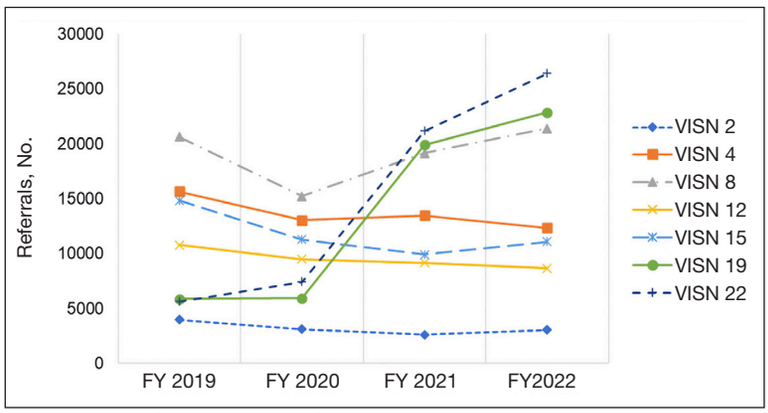

FIGURE 1. Community Care Physical Therapy Referrals by VISN

Abbreviations: FY, fiscal year; VISN, Veterans Integrated Services Network.

receive CC.[28] Within clinical diagnoses, the variable of interest was the provisional diagnosis. Patient demographics included age, gender, and rurality of residence, as determined by the Rural-Urban Commuting Area system.[29,30] Rural and highly rural categories were combined for analysis. For the CC cost dataset, this study examined CC referrals, referral cost, and eligibility type.

Analysis

For the first research question, we examined referral data from FY 2019 to FY 2022 using the Palantir dataset, performed descriptive statistical analysis for all variables, and analyzed data to identify trends. Descriptive statistics were completed using IBM SPSS Statistics for Windows Version 29.0.0.0.

A qualitative analysis of provisional diagnosis data revealed what is being referred to CC for PT. A preliminary overview of provisional diagnosis data was conducted to familiarize coders with the data. We developed a coding framework to categorize diagnoses based on anatomical location, body structure, and clinical areas of interest. Data were reviewed individually and grouped into categories within the coding framework before meeting as a team to achieve group consensus on categorization. We then totaled the frequency of occurrence for provisional diagnoses within each category. Qualitative analyses were completed using Microsoft Excel.

For the second research question, the study used the CC cost dataset to examine the cost breakdown of CC PT referrals from FY 2020 to FY 2022. We calculated the number and cost of PT referrals across eligibility groups for each FY and VISN. Data were analyzed using SPSS to identify cost trends.

RESULTS

There were 344,406 referrals to CC for PT from FY 2019 to FY 2022 for the 7 VISNs analyzed (Table 1). Of these, 22.5% were from FY 2019, 19.1% from FY 2020, 28.2% from FY 2021, and 30.3% from FY 2022. VISN 8 and VISN 22 reported the most overall PT referrals, with VISN 8 comprising 22.2% and VISN 22 comprising 18.1% of all referrals. VISN 2 reported the least overall referrals (3.7%). VISN 4 and VISN 12 had decreases in referrals over time. VISN 2 and VISN 15 had decreases in referrals from FY 2019 to FY 2021 and slight increases from FY 2021 to FY 2022. VISN 19 and VISN 22 both saw slight increases from FY 2019 to FY 2020 and substantial increases from FY 2020 to FY 2022, with FY 2022 accounting for 40.0% and 42.3% of all referrals for VISN 19 and VISN 20, respectively (Figure 1).

For FY 2019 and FY 2020, VISN 8 had the highest percentage of referrals (26.7% and 23.2%, respectively), whereas VISN 22 was among the lowest (7.3% and 11.4%, respectively). However, for FY 2021 and FY 2022, VISN 22 reported the highest percentage of referrals (23.5% and 25.3%, respectively) compared to all other VISNs. VISN 2 consistently reported the lowest percentage of referrals across all years.

TABLE 2. Community Care Physical Therapy Referrals by Rurality and VISN

Rurality	VISN 2	VISN 4	VISN 8	VISN 12	VISN 15	VISN 19	VISN 22	Total
Rural	5417	18,908	13,114	19,803	33,659	28,627	17,676	137,204
Urban	5920	33,825	59,218	17,003	9790	23,972	43,848	193,576
Insular isle	1	1	612	1	1	5	6	627
Unknown	5	92	180	21	73	30	40	441
Missing	1479	1711	3352	1295	3650	279	792	12,558
Total	12,822	54,537	76,476	38,123	47,173	52,913	62,362	344,406

Abbreviation: VISN, Veterans Integrated Services Network.

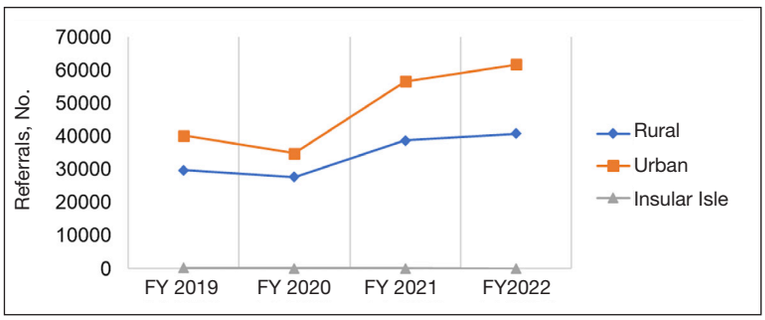

FIGURE 2. Community Care Physical Therapy Referrals by Rurality

Abbreviation: FY, fiscal year.

There were 56 stations analyzed across the 7 VISNs (Appendix 1). Nine stations each accounted for ≥ 3.0% of the total PT referrals and only 2 stations accounted for > 5.0% of referrals. Orlando, Florida (6.0%), Philadelphia, Pennsylvania (5.2%), Tampa, Florida (4.9%), Aurora, Colorado (4.9%), and Gainesville, Florida (4.4%) reported the top 5 highest referrals, with 3 being from VISN 8 (Orlando, Tampa, Gainesville). Stations with the lowest reported referrals were all in VISN 2 in New York: The Bronx, (0%), New York Harbor (0%), Hudson Valley (0.1%) and Finger Lakes (0.2%).

Rurality

Urban stations comprised 56.2% and rural stations comprised 39.8% of PT CC referrals, while 0.2% of referrals were from insular isle US territories: Guam, American Samoa, Northern Marianas, and the Virgin Islands. The sample had missing or unknown data for 3.8% of referrals. FY 2022 had the largest difference in rural and urban referrals. Additionally, there was an overall trend of more referrals over time for rural and urban, with a large increase in rural (+40.0%) and urban (+62.7%) referrals from FY 2020 to FY 2021 and a modest increase from FY 2021 to FY 2022 (+5.2% for rural and +9.1% for urban). There was a decrease in rural (-7.0%) and urban (-3.5%) referrals from FY 2019 to FY 2020 (Figure 2).

There were differences in referrals by rurality and VISN (Table 2). VISN 12, VISN 15, and VISN 19 reported more rural than urban referrals, whereas VISN 4, VISN 8, and VISN 22 reported more urban than rural referrals. VISN 2 reported similar numbers for both, with slightly more urban than rural referrals. When reviewing trends over time for each FY, VISN 12, VISN 15, and VISN 19 reported more rural than urban referrals and VISN 4, VISN 8, and VISN 22 had more urban than rural referrals. In FY 2019 and FY 2020, VISN 2 reported slightly more urban than rural referrals but almost the same number of referrals in FY 2021 and FY 2022 (Appendix 2).

Demographics

The mean (SD) age was 61.2 (15.8) years (range, 20-105). Most PT CC referrals were for veterans aged 70 to 79 years (26.9%), followed by 60 to 69 years (20.7%), and 50 to 59 years (16.4%) (Appendix 3). Trends were consistent across VISNs. There was less of a difference between rural and urban referral percentages as the population aged. Veterans aged < 49 years residing in more urban areas accounted for more referrals to CC compared to their rural counterparts. This difference was less apparent in the 70 to 79 years and 80 to 89 years age brackets.

Most PT CC referrals (81.2%) were male and 14.8% were female. About 3.6%

TABLE 3. Community Care Physical Therapy Referrals by Eligibility Group and Year

Eligibility group[a]	FY 2019, No.	FY 2020, No.	FY 2021, No.	FY 2022, No.	Total, No.
Distance to VAMC	4	23	1259	37,118	38,404
Best medical interest	1	21	1068	21,714	22,804
Timeliness of care	0	0	1219	31,925	33,144
Service unavailable	0	0	252	10,491	10,743
Presumed eligibility; HEC update[b]	0	1	32	886	919
No full-service VAMC	0	0	10	183	193
Not defined[c]	3098	2852	2477	349	8776
Total	3103	2897	6317	102,666	114,983

Abbreviations: FY, fiscal year; HEC, Health Eligibility Center; VA, US Department of Veterans Affairs; VAMC, VA medical center.
[a]Six eligibility criteria can qualify a veteran to receive community care.[28]
[b]VA eligibility not confirmed by HEC but community care needed; generally limits new enrollees.
[c]Assigned as the eligibility reason in the absence of Consult Toolbox code or Decision Support Tool code.

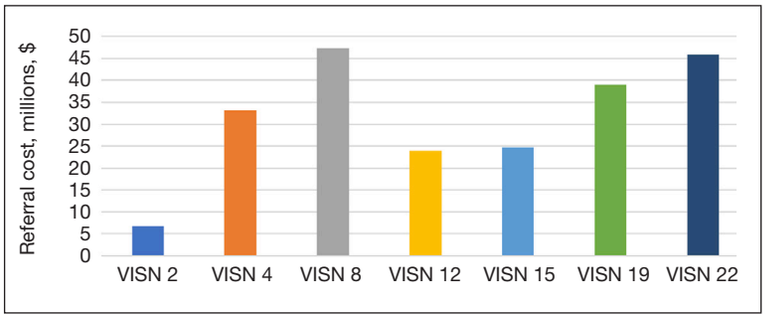

FIGURE 3. Aggregated Estimated Cost for Community Care Physical Therapy Referrals by VISN

Abbreviations: VISN, Veterans Integrated Services Network.

of referral data were missing sex information, and there was a smaller difference between male veterans living in rural communities and male veterans living in urban communities compared with female veterans. A total of 42.9% of male veterans resided in rural areas compared to 56.8% in urban areas; 32.7% of female veterans resided in rural areas compared to 66.9% in urban areas (Appendix 3).

Other Criteria

Of the 334,406 referrals, 114,983 (34.4%) had eligibility data, mostly from FY 2021 and FY 2022 (Table 3). Available eligibility data were likely affected by the MISSION Act and new regulations for reporting CC eligibility. Distance (33.4%) was the most common eligibility criteria, followed by timeliness of care (28.8%), and best medical interest (19.8%); 40.4% were rural and 59.5% were urban. Distance (55.4%) was most common for rural veterans, while timeliness of care (39.7%) was most common for urban veterans. For both groups, the second most common eligibility reason was best medical interest (Appendix 4).

Bone, joint, or soft tissue disorders were common diagnoses, with 25.2% located in the lower back, 14.7% in the shoulder, and 12.8% in the knee (Appendix 5). Amputations of the upper and lower limbs, fractures, cancer-related diagnoses, integumentary system disorders, thoracic and abdominal injuries and disorders, and other medical and mental health conditions each accounted for < 1% of the total diagnoses.

Costs

At time of analysis, the CC Dashboard had cost data available for 200,204 CC PT referrals from FY 2020 to FY 2022. The difference in referral numbers for the 2 datasets is likely attributed to several factors: CC cost data is exclusively from the HSRM, whereas Palantir includes other data sources; how VA cleans data pulled into Palantir; how the CC Dashboard algorithm populates data; and variances based on timing of reporting and/or if referrals are eventually canceled.

The total cost of PT CC referrals from FY 2020 to FY 2022 in selected VISNs was about $220,615,399 (Appendix 6). Appendix 7 details the methodology for determining the average standardized episode-of-care cost by VISN and how referral costs are calculated. Data show a continuous increase in total estimated cost from $46.8 million in FY 2020 to $92.1 million in FY 2022. From FY 2020 to FY 2022, aggregate costs ranged from $6,758,053 in VISN 2 to $47,209,162 in VISN 8 (Figure 3). The total referral cost for PT was highest at VISN 4 in FY 2020 ($10,447,140) and highest at VISN 22 in FY 2021 ($18,835,657) and FY 2022 ($22,962,438) (Figure 4). For referral costs from FY 2020 to FY 2022, distance accounted for $75,561,948 (34.3%), timeliness of care accounted for $60,413,496

TABLE 4. Estimated Referral Cost by Eligibility Type[a]

Fiscal year	1703E quality	Best medical interest	Distance to VAMC	No full service VAMC	Not defined	Presumed eligibility; HEC update[b]	Service unavailable[c]	Timeliness of care
2020, $	24,724[d]	10,724,453	15,536,878	58,557	4,517,934	NA	7,576,758	8,327,113
2021, $	113,872	18,254,997	23,500,742	478,681	4,638,153	216,916	11,478,391	23,024,410
2022, $	NA	17,311,940	36,524,328	28,751	106,820	669,302	8,439,706	29,061,973
Total, $	138,595	46,291,390	75,561,948	565,989	9,262,907	886,218	27,494,855	60,413,496

Abbreviations: HEC, Health Eligibility Center; NA, not available; VA, US Department of Veterans Affairs; VAMC, VA medical center; VISN; Veterans Integrated Services Network.
[a]Six eligibility criteria can qualify a veteran to receive community care.[28]
[b]VA eligibility not been confirmed by the HEC but community care needed; generally limits new enrollees.
[c]Assigned as the eligibility reason in the absence of a Consult Toolbox code or Decision Support Tool code.
[d]No data exist for VISN 8, VISN 15, VISN 19, and VISN 22.

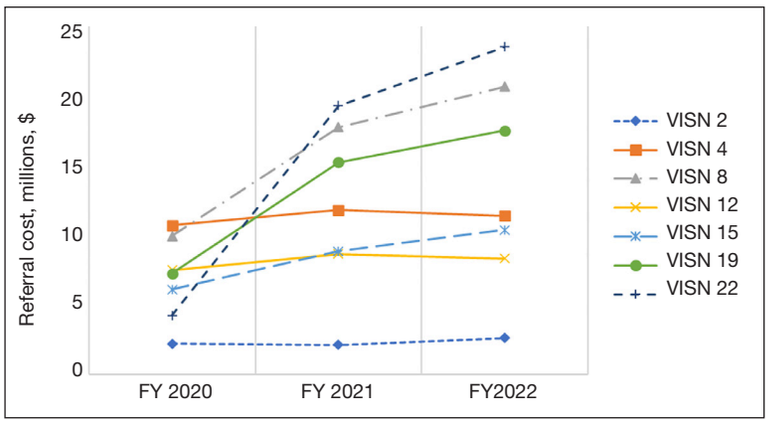

FIGURE 4. Trends in Total Estimated Referral Cost by VISN
Abbreviations: FY, fiscal year; VISN, Veterans Integrated Services Network.

(27.3%), and best medical interest accounted for $46,291,390 (21.0%) (Table 4).

Overall costs were primarily driven by specific VISNs within each eligibility type (Appendix 8; Figure 5). VISN 19, VISN 22, and VISN 15 accounted for the highest referral costs for distance; VISN 22, VISN 8, and VISN 19 accounted for the second-highest referral cost, timeliness of care; and VISN 4, VISN 8, and VISN 12 accounted for the third-highest referral cost, best medical interest (Figure 5). VISN 2, VISN 4, VISN 12, VISN 15, and VISN 22 had service unavailable as an eligibility type with 1 of the top 3 associated referral costs, which was higher in cost than timeliness of care for VISN 2, VISN 4, VISN 12, and VISN 15.

DISCUSSION

This study examines the referral of rehabilitation PT services to CC, evaluates CC costs for PT services, and analyzes utilization and cost trends among veterans within the VHA. Utilization data demonstrated a decrease in referrals from FY 2019 to FY 2020 and increases in referrals from FY 2020 to FY 2022 for most variables of interest, with cost data exhibiting similar trends. Results highlight the need for further investigation to address variations in PT referrals and costs across VISNs and eligibility reasons for CC referral.

Results demonstrated a noteworthy increase in PT CC referrals over time. The largest increase occurred from FY 2020 to FY 2021, with a smaller increase from FY 2021 to FY 2022. During this period, total enrollee numbers decreased by 3.0% across the 7 VISNs included in this analysis and by 1.6% across all VISNs, a trend that illustrates an overall decrease in enrollees as CC use increased. Results align with the implementation of the MISSION Act of 2018, which further expanded veterans' options to use CC.[1,6,7] Results also align with the onset of the COVID-19 pandemic, which disrupted care access for many veterans, placed a larger emphasis on the use of telehealth, and increased opportunities to stay within the VA for care by rapidly shifting to telehealth and leveraging telerehabilitation investments and initiatives (such as TR-EWI).[20,31]

VISN 8, VISN 19, and VISN 22, accounted for more than half of PT referrals. These VISNs had higher enrollee counts compared to the other VISNs.[32] VISN 8 consistently had high levels of referrals, whereas VISN 19 and VISN 22 saw dramatic increases in FY 2021 and FY 2022. In contrast, VISN 4 and VISN 12 gradually decreased referrals during the study. VISN 2

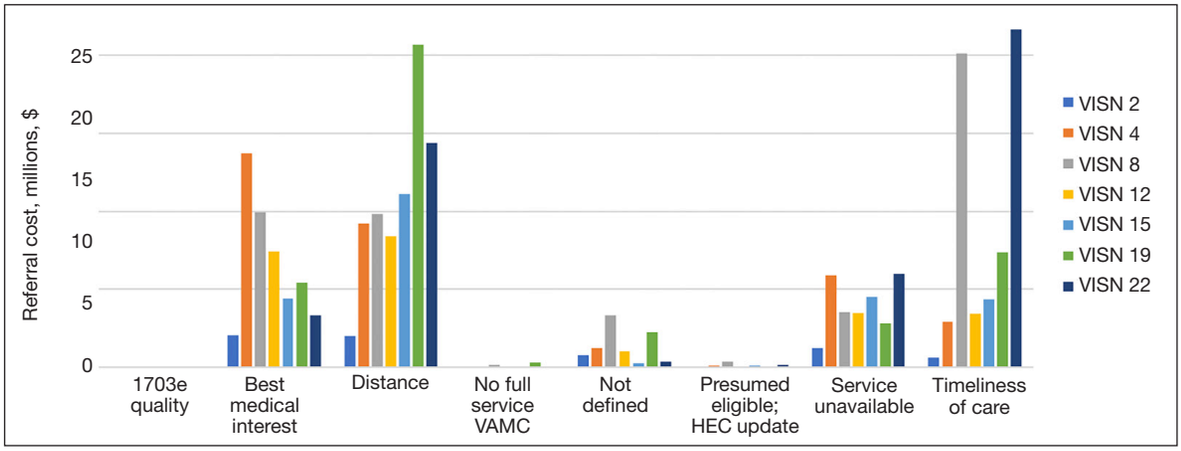

FIGURE 5. Aggregated Total Estimated Referral Cost

Abbreviations: HEC, Health Eligibility Center; VA, US Department of Veterans Affairs; VISN, Veterans Integrated Services Network.

had the lowest referral numbers during the study period, and all stations with the lowest individual referral numbers were located within VISN 2. Of the VISNs included in this study, VISN 2 had the second lowest number of enrollees (324,042).[32] Reasons for increases and decreases over time could not be determined based on data collected in this study.

There were more urban than rural PT CC referrals; however, both exhibited an increase in referrals over time. This is consistent with population trends showing that most VHA patients (62.6%) and veterans (75.9%) reside in urban areas, which could explain some of the trends in this study.[33] Some VISNs have larger urban catchment areas (eg, VISN 8 and VISN 22), and some have larger rural catchment areas (eg, VISN 15 and VISN 19), which could partially explain the rural-urban differences by VISN.[32] Rural-urban referral trends might also reflect existing health care delivery system deficits in rural areas and known challenges associated with accessing health care for veterans living in rural communities.[8,9]

This study found larger differences in rural and urban PT CC referrals for younger age groups, with more than twice as many urban referrals in veterans aged 20 to 29 years and aged 30 to 39 years, and roughly 1.8 times as many urban referrals in veterans aged 40 to 49 years. However, there were similar numbers of rural and urban referrals in those aged 70 to 79 years and aged 80 to 89 years. These trends are consistent with data showing veterans residing in rural communities are older than their urban counterparts.[23,34] Data suggest that older veteran populations might seek PT at higher rates than younger veteran populations. Moreover, data suggest there could be differences in PT-seeking rates for younger veteran populations who reside in rural vs urban areas. Additional research is needed to understand these trends.

Distance and timeliness of care were the predominant reasons for referral among eligibility groups, which is consistent with the MISSION Act goals.[1,6,7] The most common eligibility reason for rural referrals was distance; timeliness of care was most common for urban referrals. This finding is expected, as veterans living in rural communities are farther away from VHA facilities and have longer drive times, whereas veterans living in urban communities might live closer, yet experience longer wait times due to services and/or appointment availability. Best medical interest accounted for almost 20% of referrals, which does not provide detailed insights into why those veterans were referred to CC.

The top PT diagnoses referred to CC were related to bone, joint, or soft tissue disorders of the lower back, shoulder, and knee. This suggests that musculoskeletal-related issues are prevalent among veterans seeking PT care, which is consistent with research that found > 50% of veterans receiving VHA care have musculoskeletal disorders.[35] The probability of experiencing musculoskeletal problems increases with age, as does the need for PT services. Amputations and fractures

accounted for < 1% of CC referrals, which is consistent with the historic provision of VHA clinical specialized care to conditions prevalent among veterans. It may also represent VHA efforts to internally provide care for complex conditions requiring more extensive interdisciplinary coordination.

The total cost of referrals over time was about $221 million. VISN 8 accounted for the highest overall cost; VISN 2 had the lowest, mirroring referral utilization trends and aligning with VISN enrollee numbers. VISN 19 and VISN 22 reported large cost increases from FY 2020 to FY 2021. Total referral costs increased by $34.9 million from FY 2020 to FY 2021, which may be due to health care inflation (2.9% during FY 2019 to FY 2022), increased awareness of CC services, or increased VHA wait times.[36] Additionally, there were limitations in care provided across health care systems during the COVID-19 pandemic, including the VA.[5] The increase from FY 2020 to FY 2021 may reflect a rebound from restrictions in appointments across VA, CC, and the private sector.

While the increase in total referral cost may be partly attributed to inflation, the cost effectiveness and efficiency of referring veterans to CC vs keeping veterans within VHA care is an ongoing debate.[5] Examining and addressing cost drivers within the top eligibility types and their respective VISNs is necessary to determine resource allocation and improve quality of care. This study found that best medical interest and unavailable services accounted for 33.4% of the total cost of CC referrals, highlighting the need for policies that strengthen in-house competencies and recruit personnel to provide PT services currently unavailable within the VA.

Future Directions

The VHA should explore opportunities for in-house care, especially for services appropriate for telehealth.[18,20,37] Data indicated a smaller cost increase from FY 2021 to FY 2022 compared to the relatively large increase from FY 2020 to FY 2021. The increased telehealth usage across VHA by TR-EWI and non–TR-EWI sites within selected VISNs may have contributed to limiting the increase in CC costs. Future studies should investigate contextual factors of increased telehealth usage, which would offer guidance for implementation to optimize the integration of telehealth with PT rehabilitation provided in-house. Additionally, future studies can examine potential limitations experienced during PT telehealth visits, such as the inability to conduct hands-on assessments, challenges in viewing the quality of patient movement, ensuring patient safety in the remote environment, and the lack of PT equipment in homes for telehealth visits, and how these challenges are being addressed.[38,39] Research is also needed to understand tradeoffs of CC vs VHA care and the potential and cost benefits of keeping veterans within VHA using programs like TR-EWI.[5] Veterans living in rural communities may especially benefit from this as expanding telehealth options can provide access to PT care that may not be readily available, enabling them to stay connected and engaged in their care.[18,40]

Future studies could examine contributory factors to rising costs, such as demographic shifts, changes in PT service utilization, and policy. Researchers might also consider qualitative studies with clinicians and veterans within each VISN, which may provide insights into how local factors impact PT referral to the community.

Limitations

Due to its descriptive nature, this study can only speculate about factors influencing trends. Limitations include the inability to link the Palantir and CC Dashboard datasets for cost comparisons and potential data change over time on Palantir due to platform updates. The focus on VISNs with TR-EWI sites limited generalizability and this study did not compare CC PT vs VHA PT. Finally, there may have been cost drivers not identified in this study.

CONCLUSIONS

This descriptive study provides insights into the utilization and cost of PT CC referrals for selected VISNs. Cost trends underscore the financial commitment to providing PT services to veterans. Understanding what factors are driving this cost is necessary for VHA to optimally provide and manage the rehabilitation resources needed to serve veterans through traditional in-person care, telehealth, and CC options while ensuring timely, high-quality care.

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Disclaimer
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Ethics and consent
This quality improvement project was developed in accordance with VA guidance (ORD Program Guide 1200.21, "VHA Operations Activities That May Constitute Research"). According to VA quality improvement guidelines, ethical review, approval, and written informed consent were not required.

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APPENDIX 1. Number of Physical Therapy Referrals by Location and Fiscal Year[a,b]

Health care system ID, name (VISN)[a]	FY 2019, No.	FY 2020, No.	FY 2021, No.	FY 2022, No.	Total	Change, %[c]
436 Montana (19)	880	905	3647	4459	9891	406.7
442 Cheyenne, WY (19)	271	154	643	682	1750	151.7
460 Wilmington, DE (4)	1645	1305	1431	1410	5791	-14.3
501 New Mexico (22)	1124	1253	2943	3442	8762	206.2
503 Altoona, PA (4)	1722	1404	1293	645	5064	-62.5
516 Bay Pines, FL (8)	2290	2803	3718	4091	12,902	78.6
526 Bronx, NY (2)	11	8	8	12	39	9.1
528 Western NY (2)	665	291	264	213	1433	-68.0
528A6 Finger Lakes, NY (2)	154	189	99	94	536	-39.0
528A7 Syracuse, NY (2)	845	706	572	1117	3240	32.2
528A8 Albany, NY (2)	920	644	611	576	2751	-37.4
529 Butler, PA (4)	286	634	644	384	1948	34.3
537 Chicago, IL (12)	284	331	242	217	1074	-23.6
542 Coatesville, PA (4)	299	329	374	195	1197	-34.8
546 Miami, FL (8)	279	226	485	1001	1991	258.8
548 West Palm Beach, FL (8)	1150	867	512	423	2952	-63.2
550 Danville, IL (12)	1005	720	972	1268	3965	26.2
554 Aurora, CO (19)	1967	2203	6657	5902	16729	200.1
556 North Chicago, IL (12)	965	1034	1166	1570	4735	62.7

APPENDIX 1. Number of Physical Therapy Referrals by Location and Fiscal Year[a,b] (cont)

561 New Jersey (2)	863	562	561	459	2445	-46.8
562 Erie, PA (4)	936	802	967	813	3518	-13.1
573 Gainesville, FL (8)	4083	2338	3586	5129	15136	25.6
575 Grand Junction, CO (19)	295	333	1151	1022	2801	246.4
578 Hines, IL (12)	2133	1725	2059	1397	7314	-34.5
585 Iron Mountain, MI (12)	1857	1517	1332	1588	6294	-14.5
589 Kansas City, MO (15)	1340	1126	1046	1326	4838	-1.0
589A4 Columbia, MO (15)	3871	2383	1734	1305	9293	-66.3
589A5 Eastern Kansas (15)	2331	1473	739	862	5405	-63.0
589A7 Wichita, KS (15)	2913	2567	2669	3076	11,225	5.6
595 Lebanon, PA (04)	1223	1042	1398	1501	5164	22.7
600 Long Beach, CA (22)	141	71	687	790	1689	460.3
605 Loma Linda, CA (22)	950	838	2218	3459	7465	264.1
607 Madison, WI (12)	2160	1816	1562	1067	6605	-50.6
620 Hudson Valley, NY (2)	131	154	73	98	456	-25.2
623 Muskogee, OK (19)	301	307	1131	1421	3160	372.1
630 New York Harbor (2)	34	33	30	25	122	-26.5
632 Northport, NY (2)	362	547	419	472	1800	30.4
635 Oklahoma City, OK (19)	823	549	1263	2087	4722	153.6
642 Philadelphia, PA (4)	5225	3835	4512	4417	17,989	-15.5
644 Phoenix, AZ (22)	1312	1513	3189	2477	8491	88.8
646 Pittsburgh, PA (04)	2317	2227	1231	1055	6830	-54.5
649 Northern Arizona (22)	407	661	1981	2363	5412	480.6
657 St. Louis, MO (15)	829	544	503	1345	3221	62.2
657A4 Poplar Bluff, MO (15)	1592	1459	1392	1271	5714	-20.2
657A5 Marion, IL (15)	1972	1751	1843	1911	7477	-3.1
660 Salt Lake City, UT (19)	991	1141	3938	3979	10,049	301.5
664 San Diego, CA (22)	676	1330	3713	4719	10,438	598.1
666 Sheridan, WY (19)	344	342	1495	1630	3811	373.8
672 San Juan, PR (8)	2486	1029	1341	1332	6188	-46.4
673 Tampa, FL (8)	3928	3788	4410	4633	16759	17.9
675 Orlando, FL (8)	6428	4201	5111	4808	20,548	-25.2
676 Tomah, WI (12)	1292	1008	925	756	3981	-41.5
678 Southern Arizona (22)	751	922	3096	3418	8187	355.1
691 Greater Los Angeles (22)	289	862	5025	5742	11,918	1886.9
693 Wilkes-Barre, PA (04)	2001	1469	1641	1925	7036	-3.8
695 Milwaukee, WI (12)	1099	1345	905	806	4155	-26.7
Total	77,448	65,616	97,157	104,185	344,406	34.5

Abbreviations: FY; fiscal year; ID, identification; VISN, Veterans Integrated Service Network.

[a]Health care system (service station) defined as a collection of all the points of service that a leadership group manages; the points of service can include any institution where health care is delivered; all data that originate from points of service roll up to a single station number representing the administrative parent for management and programmatic activities.

[b]US Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Veterans Health Administration: Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care. July 7, 2020. Accessed January 28, 2025. https://www.va.gov/oig/pubs/VAOIG-19-00017-191.pdf

[c]The percentage change from FY 2019 to FY 2022 was calculated for each heath care system (service station). A positive number indicates a percentage change increase whereas a negative number indicates a percentage change decrease.

APPENDIX 2. Physical Therapy Community Care Referral Trends by VISN and Rurality

Rurality	Rural	Urban	Insular Isle	Unknown	Missing	Total
FY 2019	1396	1698	1	3	887	3985
VISN 2	5152	9398	0	77	1027	15,654
VISN 4	3702	15,569	187	127	1059	20,644
VISN 8	5647	4468	0	15	665	10,795
VISN 12	8987	2596	0	65	3200	14,848
VISN 15	3003	2845	0	24	0	5872
VISN 19	1920	3704	2	24	0	5650
VISN 22	29,807	40,278	190	335	6838	77,448
Total						
FY 2020	1308	1543	0	2	281	3134
VISN 2	4720	8104	1	13	209	13,047
VISN 4	2451	10,777	149	22	1853	15,252
VISN 8	5036	4190	1	5	264	9496
VISN 12	8776	2290	0	8	229	11,303
VISN 15	3034	2898	1	1	0	5934
VISN 19	2408	5032	1	9	0	7450
VISN 22	27,733	34,834	153	60	2836	65,616
Total						
FY 2021	1242	1233	0	0	162	2637
VISN 2	4734	8484	0	1	272	13,491
VISN 4	3413	15,449	148	6	147	19,163
VISN 8	4644	4317	0	0	202	9163
VISN 12	7851	1939	0	0	136	9926
VISN 15	10,575	9172	1	2	175	19,925
VISN 19	6361	16,063	2	0	426	22,852
VISN 22	38,820	56,657	151	9	1520	97,157
Total						
FY 2022	1471	1446	0	0	149	3066
VISN 2	4302	7839	0	1	203	12,345
VISN 4	3548	17,423	128	25	293	21,417
VISN 8	4476	4028	0	1	164	8669
VISN 12	8045	2965	1	0	85	11,096
VISN 15	12,015	9057	3	3	104	21,182
VISN 19	6987	19,049	1	7	366	26,410
VISN 22	40,844	61,807	133	37	1364	104,185
Total						
Total	137,204	193,576	627	441	12,558	344,406

Abbreviations: FY, fiscal year; VISN, Veterans Integrated Service Network.

APPENDIX 3. Community Care Physical Therapy Referrals by Rurality

Criteria	Rural, No.	Urban, No.	Insular isle, No.	Unknown, No.	Missing, No.	Total, No.
Age group						
20-29 y	2372	6038	7	11	0	8428
30-39 y	10,527	22,438	49	17	0	32,941
40-49 y	13,793	25,464	59	16	0	39,332
50-59 y	21,695	34,594	138	30	0	56,457
60-69 y	29,308	41,820	179	99	0	71,406
70-79 y	44,907	47,476	130	135	0	92,648
80-89 y	12,001	12,646	55	87	0	24,789
≥ 90 y	2601	3190	10	46	0	5847
Gender						
Male	120,036	158,677	442	416	0	279,571
Female	16,676	34,109	184	23	0	50,992
Nonbinary	10	18	0	0	0	28
Transgender female	11	33	0	0	0	44
Transgender male	0	24	0	0	0	24
Other	9	23	0	0	0	32
Total	137,204	193,576	627	441	12,558	334,406

APPENDIX 4. Community Care Physical Therapy Referrals by Eligibility Group and Rurality[a]

Eligibility group	Rural, No.	Urban, No.	Insular isle, No.	Unknown, No.	Missing, No.	Total, No.
Distance to VAMC	25,730	12,658	6	9	1	38,404
Best medical interest	7231	15,555	0	18	0	22,804
Timeliness of care	5992	27,142	1	8	1	33,144
Service unavailable	3070	7671	1	1	0	10,743
Presumed eligibility; HEC update[b]	372	545	0	1	1	919
No full-service VAMC	23	42	128	0	0	193
Not defined[c]	4000	4770	1	5	0	8776
Total	46,418	68,383	137	42	3	114,983

Abbreviations: HEC, Health Eligibility Center; VA, US Department of Veterans Affairs; VAMC, VA medical center.
[a]Six eligibility criteria can qualify a veteran to receive community care.[28]
[b]Utilized for veterans whose eligibility for VA services has not been confirmed by the HEC but need to receive CC; generally limits new enrollees.
[c]Assigned as the eligibility reason in the absence of a Consult Toolbox code or Decision Support Tool code.

APPENDIX 5. Diagnoses Classifications for Community Care Physical Therapy Referrals (N = 344,406)

Classification	No. (%)
Amputations	
Lower	1236 (0.4)
Upper	13 (0.01)
Bone, joint, soft tissue disorder	
Ankle, foot	11,010 (3.2)
Hand, wrist, elbow	4287 (1.2)
Head, neck	23,399 (6.8)
Hip	16,648 (4.8)
Knee	44,184 (12.8)
Lower back	86,936 (25.2)
Pelvis (pelvic floor and lower abdominal)	8905 (2.6)
Shoulder	50,518 (14.7)
Thoracic cage/upper abdominal	1563 (0.5)
Unspecified	41,687 (12.1)
Cancer-related diagnosis	1352 (0.4)
Cardiovascular and pulmonary dysfunction	3972 (1.2)
Falls, gait, and mobility issues	12,169 (3.5)
Fractures	
Axial skeleton	351 (0.1)
Lower extremity	1352 (0.4)
Upper extremity	802 (0.2)
Integumentary disorders	167 (0.05)
Neurological insults and nervous system disorders	13,603 (4.0)
Other medical conditions and mental health diagnosis	1987 (0.6)
Vestibular disorders	5630 (1.6)
Conditions with no indicated or missing diagnoses	12,635 (3.7)

APPENDIX 6. Estimated Referral Cost by FY and VISN

VISN	FY 2020, $	FY 2021, $	FY 2022, $	Aggregated estimated cost FYs 2020-2022, $
2	2,138,211	2,068,822	2,551,021	6,758,053
4	10,447,140	11,526,811	11,130,847	33,104,798
8	9,709,455	17,331,311	20,168,396	47,209,162
12	7,317,292	8,451,724	8,117,819	23,886,835
15	5,958,791	8,631,486	10,118,184	24,708,461
19	7,065,675	14,860,351	17,094,117	39,020,143
22	4,129,853	18,835,657	22,962,438	45,927,948
Total	46,766,417	81,706,162	92,142,821	220,615,399

Abbreviations: FY, fiscal year; VISN, Veterans Integrated Services Network.

APPENDIX 7. Cost Data Used to Determine Referral Cost for Physical Therapy[a]

VISN	SEOC	Estimated Cost per SEOC, $	Cost methodology
2	Physical therapy	1,102.74	VISN SEOC
4	Physical therapy	1,203.45	VISN SEOC
8	Physical therapy	1,130.72	VISN SEOC
12	Physical therapy	1,168.71	VISN SEOC
15	Physical therapy	1,086.18	VISN SEOC
19	Physical therapy	984.08	VISN SEOC
22	Physical therapy	1,087.09	VISN SEOC
Mean	Physical therapy focused intervention	1,113.15	National Average

Abbreviations: SEOC, standardized episode of care; VISN, Veterans Integrated Service Network
[a]Referral cost established using referral payments completed in the payment system only. The referral payments were balanced by the Financial Service Center. The SEOC estimate is a VISN average unless the volume of paid referrals is < 20, in this scenario, a national average is used. If there are no payments associated with a given SEOC, a national average is established based on the HealthShare Referral Manager category of care and applied to the referral. The estimated cost per SEOC is then multiplied by the volume of referrals for that SEOC to display the referral cost. The referral cost does not include any estimation for inpatient reimbursement for SEOCs that include inpatient care.

APPENDIX 8. Aggregated Total Estimated Referral Cost[a]

VISN	1703E quality	Best medical interest	Distance	No full service VA	Not defined	Presumed eligibility; HEC update[b]	Service unavailable[c]	Timeliness of care
2	$8822	$2,076,551	$2,007,162	$2205	$779,636	$23,158	$1,219,827	$640,691
4	$70,823	$13,703,047	$9,191,862	$9537	$1,231,970	$104,429	$5,882,653	$2,910,475
8	$2261	$9,907,074	$9,805,004	$186,568	$3,317,520	$359,568	$3,549,815	$20,081,352
12	$29,218	$7,447,308	$8,407,591	$4675	$1,010,934	$60,717	$3,507,358	$3,419,034
15	$1086	$4,388,717	$11,109,120	$7603	$259,678	$96,670	$4,509,391	$4,336,195
19	$22,037	$5,430,437	$20,677,280	$343,443	$2,270,363	$73,613	$2,838,549	$7,364,421
22	$4348	$3,338,255	$14,363,929	$11,958	$392,804	$168,063	$5,987,263	$21,661,328
Total	$138,595	$46,291,390	$75,561,948	$565,989	$9,262,907	$886,218	$27,494,855	$60,413,496

Abbreviations: CC, community care; HEC, Health Eligibility Center; VA, US Department of Veterans Affairs; VISN; Veterans Integrated Services Network.
[a]Six eligibility criteria can qualify a veteran to receive CC.[28]
[b]Utilized for veterans whose eligibility for VA services has not been confirmed by the HEC but need to receive CC; generally limits new enrollees.
[c]Assigned as the eligibility reason in the absence of a Consult Toolbox code or Decision Support Tool code.