



# US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

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## VETERANS HEALTH ADMINISTRATION

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# Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia

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## Executive Summary

The VA Office of Inspector General (OIG) received a hotline complaint in February 2023 alleging that the Martinsburg VA Medical Center in West Virginia was experiencing delays processing and scheduling consults for community care. VA can authorize veterans to receive care in the community in certain situations, including when their VA medical facility does not provide the requested services, they live in an area without a full-service VA medical facility, or they must drive an average of at least 30 minutes to receive primary care or 60 minutes for specialty care at a VA facility. Staff in community care departments at local VA facilities are responsible for working with veterans to schedule appointments once the veteran's healthcare provider requests a consult for the care.

Specifically, the complainant alleged the following occurred at the Martinsburg facility:

1. There were over 5,000 active and 100 urgent community care consults.<sup>1</sup>
2. Staff sometimes took more than 100 days to make the first contact attempt with veterans.
3. Staff took longer than 45 days on average to schedule veterans for care in the community.

The complainant believed these delays occurred due to staffing shortages and overwhelming workloads. The complainant also said that veterans may have passed away because of the delays in care.

The OIG conducted this review to assess the merit of the hotline complaint and to determine possible causes for any confirmed allegations.

### What the Review Found

The OIG substantiated part of the first allegation (that there were over 5,000 active consults) and the entire second and third allegations. The review team found that, as of February 28, 2023, the Martinsburg facility had over 5,000 active consults. According to the Veterans Health Administration (VHA), a consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking an opinion, advice, or expertise regarding

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<sup>1</sup> At the Martinsburg facility, local guidance allows community care nurses to identify consults they believe need to be scheduled more quickly than normal by using the "urgent" label in the Veterans Health Administration's (VHA) Consult Tracking Manager system. According to the local policy, urgent consults should be scheduled within three to five days of being placed in a pending status, compared to within seven days for normal consults, as outlined in VHA policy. VHA IVC, "Consult Timeliness" (standard operating procedure), December 1, 2022; VHA Directive 1232(5), *Consult Processes and Procedures*, December 5, 2022. Consults are in a pending status when they have been sent to the receiving service but not acted on.

evaluation or management of a specific patient problem.<sup>2</sup> A consult is in active status when the receiving service in VHA is working to fulfill it.<sup>3</sup> By September 30, 2023, the number of active consults had decreased at the Martinsburg VA medical facility from over 5,000 to about 3,300.

The team also found that for 52 veterans it took more than 100 days for schedulers to make the first contact attempt prior to scheduling.<sup>4</sup> Standards established by VHA's Office of Integrated Veteran Care (IVC) dictate that consults should be scheduled within seven calendar days of being placed in a pending status.<sup>5</sup> From October 1, 2022, to February 28, 2023, staff took longer than 45 calendar days on average to schedule a veteran's appointment for community care after being placed in pending status. This number increased to an average of 48 calendar days by September 30, 2023. The Martinsburg facility met the seven-day scheduling metric for 7,562 of 24,781 consults (31 percent) scheduled in fiscal year 2023.

In addition, while reviewing these allegations, the OIG team determined that the community care chief emailed her entire team lists of veterans who had passed away with unscheduled consults and told them this may have occurred due to scheduling delays. The facility's risk management team conducted a review of the care received by deceased veterans and determined that the deaths were not related to the delays in scheduling.<sup>6</sup> The emailed lists included personally identifiable information for multiple veterans, and the OIG referred this matter to the facility's privacy officer to determine whether this constituted a privacy violation under VA policy.<sup>7</sup> According to the privacy officer, in July 2023, the National Data Breach Response Service's review was completed, with the determination that no privacy breaches occurred. However, the chief of community care was counseled by the privacy officer that emails with personally identifiable information should no longer be sent to groups except for on a need-to-know basis.

The OIG determined that community care scheduling delays occurred because of (1) ineffective processes used to manage community care consults, (2) specialty care provider shortages, and (3) oversight challenges.

An example of the ineffective processes the OIG found was that, as of June 2023, medical support assistants received a daily list from the Consult Tracking Manager consisting of consults

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<sup>2</sup> VHA Directive 1232(5).

<sup>3</sup> VHA Directive 1232(5).

<sup>4</sup> This analysis does not include the 5,082 veterans that Martinsburg staff did not contact before scheduling consults, which could have occurred because the consult was a continuation of care, or the preferred provider's name was already included in the veteran's file. Available data for these veterans did not allow the team to determine which consults fall into each of these two categories. VHA Directive 1232(5).

<sup>5</sup> VHA IVC, "Consult Timeliness"; VHA Directive 1232(5). Consults are in a pending status when they have been sent to the receiving service but not acted on.

<sup>6</sup> The team referred the facility's review to the OIG Office of Healthcare Inspections. As of the publication of this report, that review is ongoing.

<sup>7</sup> VA Handbook 6500.2, *Management of Breaches Involving Sensitive Personal Information*, June 30, 2023.

for all categories of care, sorted by urgency and length of time in the queue, with the newest ones first. This process may have limited medical support assistants' abilities to develop expertise in any one clinical area or build relationships with the community care providers in specific specialty care practices.

The limited availability of specialty care providers at the Martinsburg medical facility and within the community also reduced consult timeliness. Interviews with Martinsburg community care staff revealed there are not sufficient providers at the facility or within the community to meet their scheduling needs in otolaryngology, gastroenterology, radiology, orthopedics, cardiology, and other services. IVC officials told the review team on September 1, 2023, that they would continue working with Martinsburg and its third-party administrator to identify additional community care providers.<sup>8</sup>

The third factor in community care delays at Martinsburg was a lack of management accountability regarding consult timeliness. For example, the community care chief's performance plan and other performance-related documents lacked timeliness standards specific to community care consults, even though she is responsible for adhering to national standards, according to VHA Directive 1232(5). The community care chief's performance plan contains only general standards that do not cover anything related to the oversight or improvement of community care metrics. This differs from the performance plans for three other Veterans Integrated Service Network (VISN) 5 community care chiefs, which all included specific elements related to the oversight and monitoring of community care.<sup>9</sup>

## What the OIG Recommended

The OIG made four recommendations to the Martinsburg VA medical facility director to improve consult timeliness and scheduling. They include ensuring that personal information of veterans who pass away is only shared on a need-to-know basis and that the medical facility director conducts a strategic business evaluation of community care workflow processes to determine alternatives to improve consult processing and scheduling, in addition to exploring ways to increase the availability of specialty care providers for veterans assigned to the Martinsburg facility. Finally, the OIG recommended that the facility director ensure that the performance plan for the chief of community care includes performance standards related to the metrics for community care.

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<sup>8</sup> Third-party administrators are contracted entities that manage a network of providers for VHA community care programs. The third-party administrators are responsible for making sure VA medical facilities have community care provider networks that are adequate in size, scope, and capacity so that veterans receive care in a timely manner.

<sup>9</sup> A VISN is one of VHA's 18 regional systems of care. VISN 5, known as VA Capitol Health Care Network, serves veterans in the District of Columbia, Maryland, West Virginia, and portions of Virginia, Ohio, Pennsylvania, and Kentucky.

## **VA Management Comments and OIG Response**

The Martinsburg VA medical facility director concurred with all four recommendations and provided an action plan for each recommendation. The Martinsburg VA medical facility director's planned corrective actions are responsive to the intent of recommendations. The facility director asked the OIG to close recommendations 1 and 4. The OIG will close recommendation 1 based on the evidence provided. The medical facility director will need to provide evidence that the steps described in the action plan were taken before the OIG will consider closing recommendation 4. The VISN director also provided comments, the full text of which can be found in appendix B. The facility director's comments appear in appendix C.



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## Abbreviations

IVC	Office of Integrated Veteran Care
MSA	medical support assistant
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

VA can authorize veterans to receive care in the community in certain instances, such as when their VA medical facility does not provide the requested services, they live in an area without a full-service VA medical facility, or they must drive an average of at least 30 minutes to receive primary care or 60 minutes for specialty care at a VA facility. Staff in community care departments at local VA facilities are responsible for working with veterans to schedule appointments once the veteran's healthcare providers have requested a consult for the care.

The VA Office of Inspector General (OIG) conducted this review to assess the merit of a February 2023 hotline complaint that the community care department at the Martinsburg VA Medical Center in West Virginia was experiencing delays processing and scheduling consults for community care. Specifically, the complainant alleged the following:

1. There were over 5,000 active and 100 urgent community care consults.<sup>10</sup>
2. Staff sometimes took more than 100 days to make the first contact attempt with veterans.
3. Staff took longer than 45 days on average to schedule veterans for care in the community.<sup>11</sup>

The complainant believed that delays occurred due to staffing shortages and overwhelming workloads. The complainant also indicated that community care staff at Martinsburg were informed by the chief of community care that veterans may have passed away because of the delays in care.

Prior OIG reports have identified issues with the management and timeliness of community care consults in general.<sup>12</sup> For example, in 2020, an OIG report on Veterans Integrated Service

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<sup>10</sup> At the Martinsburg facility, local guidance allows community care nurses to identify consults they believe need to be scheduled more quickly than normal by using the "urgent" label in the Veterans Health Administration's (VHA) Consult Tracking Manager system. According to local policy, urgent consults should be scheduled within three to five days of being placed in a pending status, compared to within seven days for normal consults, as outlined in VHA policy. VHA IVC, "Consult Timeliness" (standard operating procedure), December 1, 2022; VHA Directive 1232(5), *Consult Processes and Procedures*, December 5, 2022. Consults are in a pending status when they have been sent to the receiving service but not acted on.

<sup>11</sup> Allegation 2 relates to instances in which schedulers took more than 100 days to make a first contact attempt with veterans, while allegation 3 refers to the overall average number of days for veterans to be scheduled in the community.

<sup>12</sup> VA OIG, [Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities](#), Report No. 18-05121-36, January 16, 2020; [Audit of Community Care Consults during COVID-19](#), Report No. 21-00497-46, January 19, 2022; [Care in the Community Consult Management During the COVID-19 Pandemic at Martinsburg VA Medical Center in West Virginia](#), Report No. 21-01724-84, February 16, 2022.

Network (VISN) 8 found that veterans waited an average of 43 days to get scheduled in community care due to insufficient administrative staffing.<sup>13</sup> In 2022, the OIG issued a report reviewing community care consults during the COVID-19 pandemic. It noted that routine community care consults went unscheduled for an average of 42 days, not meeting the Veterans Health Administration's (VHA) former timeliness goal of 30 days. An additional deficiency the OIG identified within VHA's community care operations included a lack of documentation when veterans were contacted about scheduling appointments. Finally, in 2022, an OIG healthcare inspection determined that the Martinsburg VA Medical Center consistently failed to schedule 90 percent of active consults within the standard in place at the time (30 days) and did not have a plan in place to address this delay.<sup>14</sup>

## Community Care

Under the MISSION Act and related VA regulations, veterans are eligible to receive community care in multiple circumstances, including the following:<sup>15</sup>

- The veteran's local VA medical facility does not provide the requested services.
- The veteran lives in a US state or territory without a full-service VA medical facility.
- The service line at the local VA medical facility does not meet specific quality standards.
- The veteran's referring provider, with agreement from the veteran, determines community care is in the veteran's best medical interest.
- The veteran must drive an average of at least 30 minutes for primary care, mental health care, or noninstitutional services, or 60 minutes for specialty care to get to a VA medical facility.

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<sup>13</sup> VHA divides the United States into 18 regional networks, known as VISNs, which are regional systems of care working together to better meet local health care needs and provide greater access to care.

<sup>14</sup> The VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook states that an improvement action plan must be developed if targets are not met for four consecutive weeks. IVC, "How to Implement Improvement Action Plans," sec. 6.5.6.12, updated April 7, 2023, in *Community Care Field Guidebook*. (This source is not publicly accessible.)

<sup>15</sup> John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018); 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

- The veteran’s wait time for an appointment at a local VA medical facility or clinic is more than 20 days for primary care, mental health care, or noninstitutional services, or 28 days for specialty care.

## **Processing of Community Care Consults**

A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient seeking an opinion, advice, or expertise regarding evaluation or management of a specific patient problem.<sup>16</sup> Once a consult referral is made, facility staff, such as clinicians, nurses, or schedulers, determine whether the veteran is eligible for community care, based on MISSION Act eligibility criteria. If a veteran is eligible for community care, facility staff are required to explain the options of receiving care within VA or in the community by sharing key information, such as wait times, to help the veteran decide which option to pursue.<sup>17</sup> If the veteran opts for community care, facility staff ascertain the veteran’s community care preferences, such as specific care providers, days, and times, and forward the consult to the community care department for scheduling. In the community care department, medical support assistants (MSAs) are responsible for working with veterans on scheduling consults based on clinical need and veterans’ preferences. MSAs follow the steps described in figure 1.

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<sup>16</sup> VHA Directive 1232(5).

<sup>17</sup> IVC, “Eligibility,” sec. 2, updated April 19, 2023, in *Community Care Field Guidebook*.

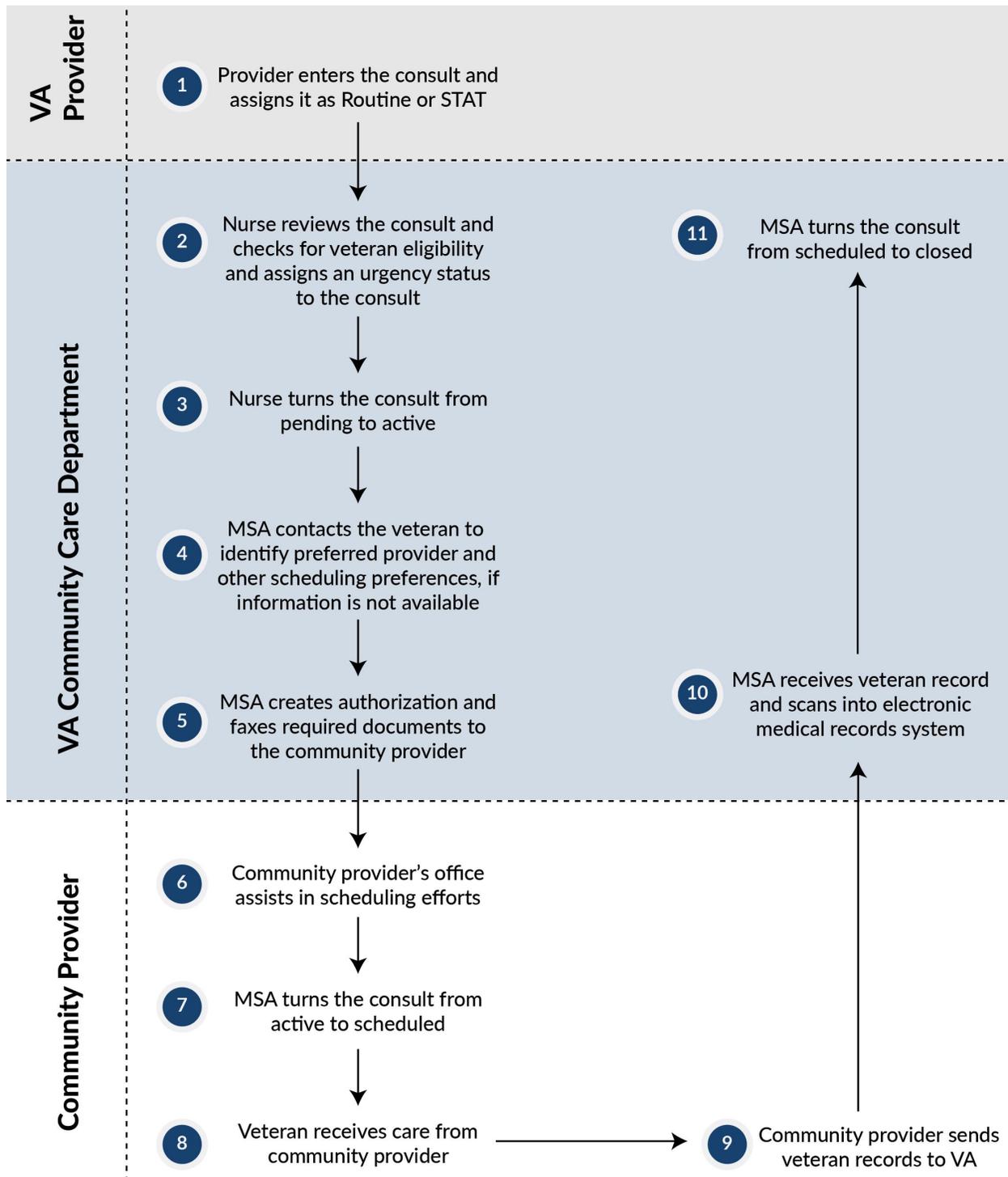
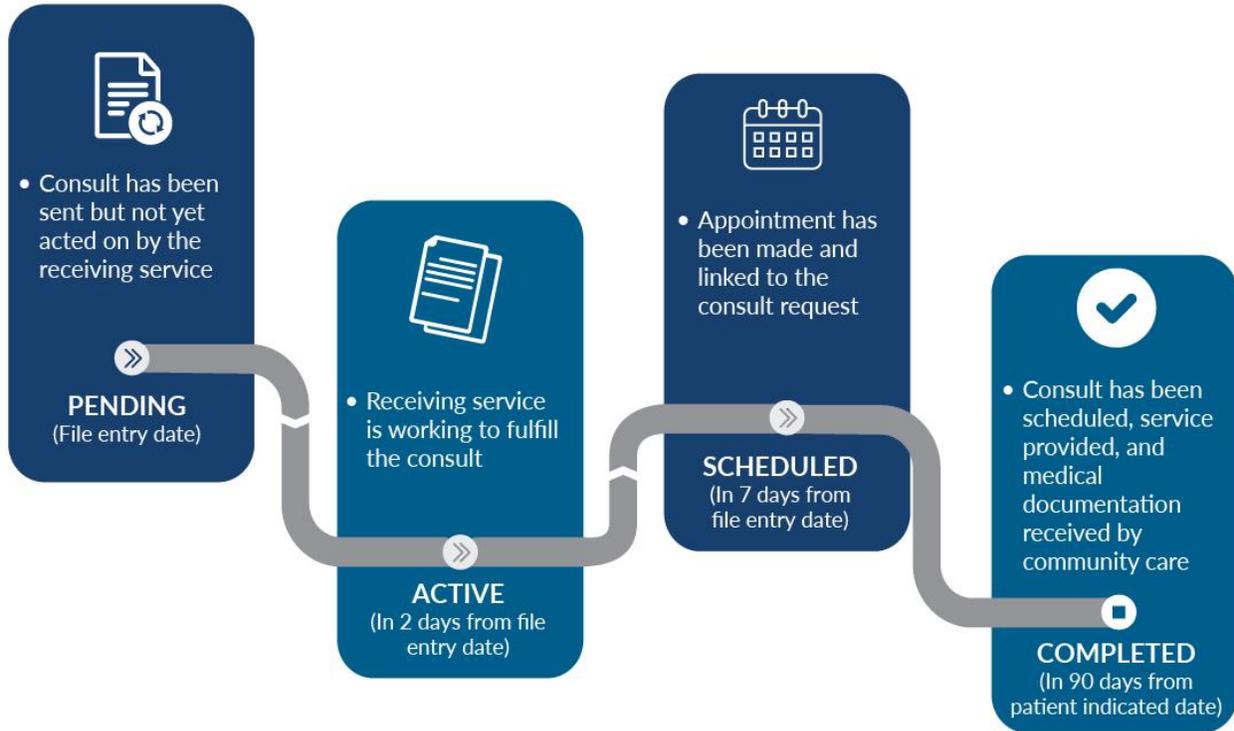


Figure 1. Community care scheduling process.

Source: OIG observation of a Martinsburg MSA scheduling community care consult; emails with Martinsburg community care MSA supervisor.

## Timeliness Standards for Consults

Once a consult is made, it can generally be in one of four statuses: pending, active, scheduled, or completed, as shown in figure 2.



**Figure 2.** Timeline for consult status.

Source: VHA Directive 1232(5), *Consults Processes and Procedures*, December 5, 2022; VHA IVC, “Consult Timeliness” (standard operating procedure), December 1, 2022.

To ensure compliance with VHA’s directive on processing consults, VHA’s Office of Integrated Veteran Care (IVC) developed standard operating procedures with timeliness standards.<sup>18</sup> This document explains that community care consult scheduling timeliness will be measured from the file entry date for those consults directly sent to community care or that are later forwarded to community care.<sup>19</sup> Table 1 describes the specific metrics for the stages of community care consults shown in figure 2, starting with the active stage.

<sup>18</sup> VHA IVC, “Consult Timeliness”.

<sup>19</sup> VHA, “Patient Eligibility [sic] and Scheduling Reference Sheet,” February 2022. The reference sheet defines the file entry date as the date the consult was created or when the patient requested an appointment.

**Table 1. Metrics for Community Care Consult Scheduling**

Consult status	Metric
Pending	Consult has been sent to the receiving service but not acted on
Active	Within two business days from the file entry date or the date the consult was last placed in a pending status
Scheduled	Within seven calendar days based on the file entry date
Completed	Within 90 calendar days from the patient indicated date

*Source: VHA IVC, “Consult Timeliness” (standard operating procedure), December 1, 2022; Patient Eligibility and Scheduling Reference Sheet, February 15, 2022; VHA Directive 1232(5), Consult Processes and Procedures, December 5, 2022.*

*Note: The reference sheet defines the patient indicated date as the appointment date requested by the provider or the date the patient requests an appointment in the absence of a provider’s request. A consult is considered complete when the requested service has been provided, according to the directive.*

When scheduling or rescheduling appointments for new or established patients, MSAs must follow minimum scheduling effort requirements:<sup>20</sup>

- **Initial contact attempt.** The first attempt to contact a veteran can be made by telephone, secure message, text message, or email.
- **Follow-up contact attempts.** If the initial contact attempt is unsuccessful, follow-up contact efforts can be conducted via letter or any contact modality previously mentioned. However, the first and second contact efforts must use different modalities—for example, if the first contact is made via telephone call, the second effort cannot be made via this method. Failed contact attempts must be recorded. There must be a minimum of two documented attempts, one by telephone call and one by letter. The letter may be mailed the same day as the call is made.
- **Dispositioning the request.** Schedulers must wait 14 calendar days after the second contact attempt to allow the veteran time to respond before they discontinue the request.

Community care staff are supposed to document their minimum contact attempts using a “Community Care Contact Attempts Report.” This report also includes information about the 14-day waiting period from the second contact attempt and on the number of consults that were discontinued because of a nonresponse.<sup>21</sup>

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<sup>20</sup> VHA “Minimum Scheduling Effort for Outpatient Appointments” (standard operating procedure), April 25, 2023.

<sup>21</sup> The scheduler must also document unsuccessful attempts to contact the veteran using the Consult Toolbox. IVC, “Contact Veteran and Fulfill Minimum Contact Requirements,” sec. 3.13, updated April 18, 2023, in *Community Care Field Guidebook*.

## Oversight Responsibilities

The following sections detail the oversight responsibilities for community care at the national, regional, and local levels, including consult scheduling.

### Office of Integrated Veteran Care

In 2022, VHA integrated its Office of Veterans Access to Care and Office of Community Care into IVC to better coordinate care at VA facilities with community care. IVC is responsible for

- allocating resources,
- developing training, and
- managing professional standards.<sup>22</sup>

In addition, VHA contracts with two third-party administrators to manage a network of providers for its community care program. The third-party administrators are responsible for making sure VA medical facilities have community care provider networks that are adequate in size, scope, and capacity so that veterans receive care in a timely manner.<sup>23</sup>

### Veterans Integrated Service Network

In addition to the oversight provided by IVC, the VISN director is responsible for the following:

- **Assisting with oversight of policy implementation.** This includes regularly reviewing and applying corrective measures to address VISN data on consult quality outcomes and implementing standardized processes for consult management and reporting across the VISN.<sup>24</sup>
- **Managing performance within the VISN.** According to the VISN 5 chief business officer, the VISN's first role is to make sure that the processes and policies that are put forth by IVC are communicated to the medical facilities for risk identification, process improvement, and sharing best practices among facilities.

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<sup>22</sup> VHA Directive 1217, *VHA Central Office Operating Units*, September 10, 2021.

<sup>23</sup> According to the contracts, third-party administrators must maintain and manage provider networks that are adequate in size, scope, and capacity based on drive- and wait-time standards. The drive-time and wait-time standards both vary by veteran location (such as urban, rural, and highly rural); drive-time standards also vary by type of care (such as primary care and general care); and wait-time standards also vary by emergency, urgent, and routine consults. For example, drive times for general care vary from 45 minutes for veterans located in an urban area to 180 minutes for veterans located in a highly rural area. Wait-time standards are 24 hours for emergent care, 48 hours for urgent care, and 30 days for routine care.

<sup>24</sup> VHA Directive 1232(5).

## Medical Facility Director

Facility directors are responsible for monitoring compliance with VHA Directive 1230, *Outpatient Scheduling Management*, and reporting noncompliance to the VISN director. They are also charged with

- providing appropriate scheduling resources (including staff) that meet the needs of veterans,
- making sure consults are scheduled appropriately,
- defining in local policy a process for managing the urgency of consults, and
- following policy and guidance from IVC and community care coordination procedures.<sup>25</sup>

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<sup>25</sup> VHA Directive 1232(5); VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

## Results and Recommendations

### **Finding: Ineffective Processes, Specialty Care Provider Shortages, and Oversight Challenges Caused Delays in Processing Community Care Consults**

Of the three allegations, the OIG substantiated part of the first (that there were over 5,000 active consults) and both the second and third allegations relating to delays in first contact attempts and scheduling veterans for community care. The confirmed delays occurred for the following reasons:

- Ineffective processes for managing and scheduling consults led to confusion for MSAs and nurses and delays in scheduling older consults in active status.
- Specialty care provider shortages at the facility and in the community left some appointments unscheduled.
- Oversight challenges with the community care department added to the delays in processing the consults.

In addition, the facility's risk management office reviewed the management of consults for veterans who had passed away while waiting for care and determined that their deaths were not related to the delays in scheduling. While assessing these allegations, the OIG review team found that the community care chief emailed her team two lists totaling 24 veterans who had passed away with unscheduled community care consults and implied that the deaths occurred due to the scheduling delays.

After determining that the emailed lists included the deceased veterans' personally identifiable information, including social security numbers and dates of birth, the OIG referred the matter to the facility's privacy officer to determine whether this constituted a privacy violation under VA policy.<sup>26</sup> In July 2023, the review was closed with no privacy breach found, but the chief of community care was counseled not to email personally identifiable information to any staff except for on a need-to-know basis.

The following elements support the OIG's finding:

- The Martinsburg VA medical facility had over 5,000 active consults, it took more than 100 days to make first contact attempt for some veterans, and it took on average longer than 45 days to schedule consults.

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<sup>26</sup> VA Handbook 6500.2, *Management of Breaches Involving Sensitive Personal Information*, June 30, 2023.

- According to the facility’s review, community care delays did not directly result in veteran deaths.
- These delays occurred because of ineffective processes for managing and scheduling consults, provider shortages at the facility and in the community, and oversight challenges.

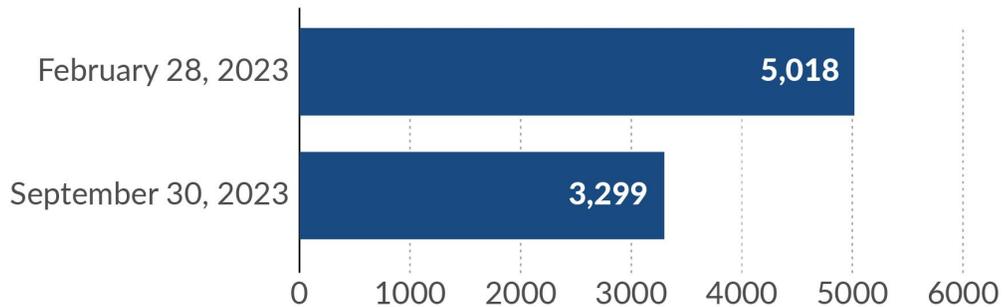
## What the OIG Did

The OIG team reviewed criteria from VA policy related to community care staffing, appointment scheduling, and consult management, as well as local facility policy. The team reviewed performance standards for community care staff and facility leaders; conducted a site visit to the Martinsburg, West Virginia, facility to interview scheduling staff; and requested information from IVC officials.

In addition, the team analyzed VA community care consult data as of February 28, 2023, and September 30, 2023, to determine whether the numbers had decreased since the February hotline submission.<sup>27</sup> See appendix A for additional details on the methodology.

## Martinsburg Had Over 5,000 Active Consults, but Did Not Have 100 Urgent Consults

The OIG substantiated that, as of February 28, 2023, the facility had over 5,000 active consults.<sup>28</sup> As of September 30, 2023, this number had decreased to about 3,300 (figure 3).



**Figure 3.** Martinsburg active community care consults that remained unscheduled.

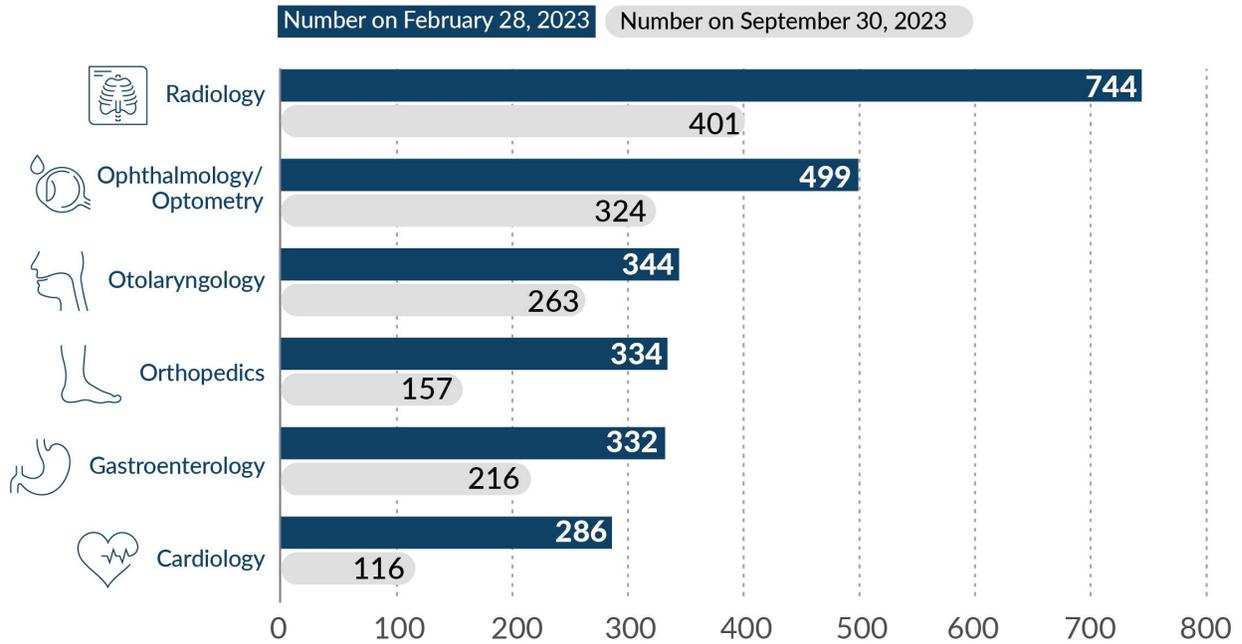
Source: VHA’s Corporate Data Warehouse and VA’s Integrated Care Workspace database.

<sup>27</sup> VA Integrated Care Workspace consult report and VHA Corporate Date Warehouse.

<sup>28</sup> According to an IVC official, active consults include those that have not been acted on by schedulers, those that are in the process of being scheduled with a community care provider, and in some instances, those that had been scheduled or had an appointment but were not updated by the scheduler in the Consult Toolbox. At the Martinsburg facility, all active consults remain part of the consult workload for schedulers until they are updated to “scheduled” in the Consult Toolbox.

The IVC standard operating procedure states that consults should be placed in an active status within two business days of being placed in a pending status. In addition, consults should be scheduled within seven calendar days based on the file entry date of the consult.<sup>29</sup>

Figure 4 illustrates the categories of care that had the most unscheduled—pending or active—community care consults as of February 28, 2023, and the progress made as of September 30, 2023.

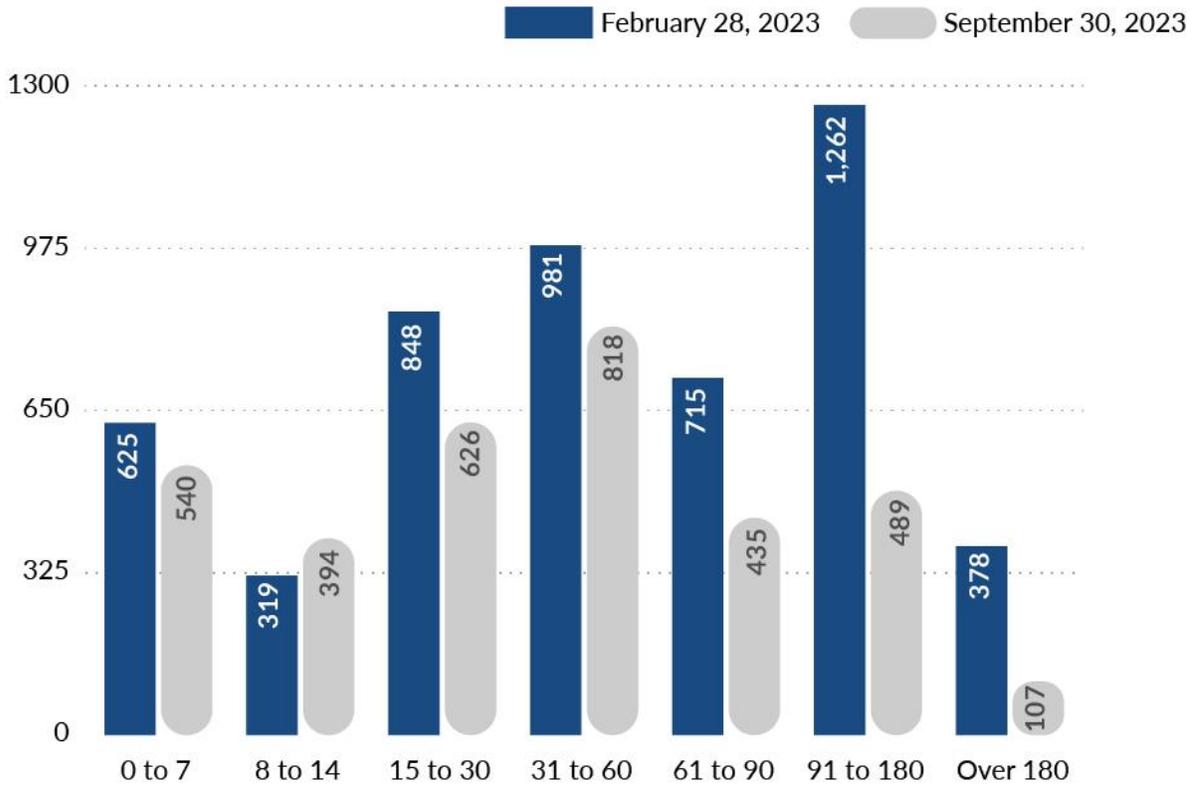


**Figure 4.** Martinsburg’s categories of care with the most unscheduled community care consults on February 28, 2023 and September 30, 2023.

Source: VHA’s Corporate Data Warehouse and VA’s Integrated Care Workspace database. These data include both pending and active status consults.

<sup>29</sup> VHA IVC, “Consult Timeliness.”

In addition, as of February 28, 2023, 4,503 of the 5,128 unscheduled consults (pending and active) (88 percent) were more than seven days old despite the requirement to be scheduled within seven days of the file entry date. This number had decreased to 2,869 of 3,409 unscheduled consults (84 percent) as of September 30, 2023. See figure 5 for details.



**Figure 5.** Number of unscheduled community care consults by days aged, including pending and active consult, on February 28, 2023 and September 30, 2023.

Source: VHA’s Corporate Data Warehouse and VA’s Integrated Care Workspace database.

The OIG did not substantiate that there were over 100 urgent consults as of February 28, 2023, as shown in table 2. The table divides consults into “stat” and “urgent,” the former used VHA-wide and the latter used by community care nurses at Martinsburg. According to VHA policy, providers are to select a scheduling urgency (routine or stat), with “stat” consults requiring expedited scheduling action where the appointment occurs within two business days of the file entry date.<sup>30</sup> At the Martinsburg facility, local guidance allows community care nurses to select “urgent” as an additional scheduling priority. An urgent consult is a consult that should be scheduled within three to five days, according to the local policy. IVC officials did not prohibit the use of the “urgent” label in the Consult Tracking Manager but told the team it is also important for sites to follow the appropriate national guidance.

<sup>30</sup> VHA Directive 1232(5).

The team identified 46 consults with an urgent or stat designation as of February 28, 2023. However, 32 of the 43 urgent consults were over five days old and should have been scheduled within three to five days to comply with local guidance, and all three of the stat consults were over two days old. By September 30, 2023, the number of urgent or stat consults that remained open was down to eight.

**Table 2. Number of Urgent and Stat Community Care Consults, by Days Open**

Days open	Number on February 28, 2023	Number on September 30, 2023
Referring provider—Stat		
0–2	0	3
3–10	3	2
Community care nurse—Urgent		
0–5	11	2
6–14	18	0
15–30	10	1
31–60	1	0
61–90	1	0
91–148	2	0
<b>Total</b>	<b>46</b>	<b>8</b>

*Source: VHA’s Corporate Data Warehouse and VA’s Integrated Care Workspace database.*

*Note: The table groups open consults by days open according to file entry date.*

*All of the 46 urgent and stat consults from February 2023, had been scheduled (20), completed (23), or discontinued (3) as of September 2023.*

## **Staff Generally Contacted Veterans on Time, but Took More Than 100 Days to Initiate Contact with Some Veterans**

As shown in table 3, Martinsburg staff contacted veterans within seven days nearly 66 percent of the time. When reviewing unscheduled consults, the team found that in the most egregious cases staff took more than 100 days to make the first contact attempt for 55 consults, affecting 52 veterans.

**Table 3. Days to First Contact Attempt,  
October 1, 2022, to February 28, 2023**

Days to first contact attempt	Total number of veterans	Percentage of total
0–7	1,029	66%
8–14	99	6%
15–30	83	5%
31–60	160	10%
61–90	128	8%
91–99	16	1%
100 or more	52	3%
<b>Total</b>	<b>1,567</b>	<b>100%</b>

*Source: VHA’s Corporate Data Warehouse and VA’s Integrated Care Workspace database showing results as of February 28, 2023.*

*Note: This table does not include any consults with no contact attempts made prior to scheduling. The percentages shown are rounded and do not equal 100 percent.*

Not shown in the table are the 5,082 veterans that Martinsburg staff did not contact before scheduling, something that could have occurred because the consult was a continuation of care, or the preferred provider’s name was already included in the veteran’s file.<sup>31</sup> The facility director indicated that this also may have occurred because MSAs were not always documenting their contact attempts in the Consult Toolbox, as required.<sup>32</sup>

### **Staff Took Longer Than 45 Days on Average to Schedule Veterans in the Community**

The OIG substantiated that Martinsburg has not been able to schedule community care consults within the guidelines provided by IVC. From October 1, 2022, to February 28, 2023, the Martinsburg VA medical facility was taking longer than 45 calendar days on average to make veterans an appointment for community care after being placed in pending status. IVC’s standard operating procedure states that consults are to be scheduled within seven days. This continues to be a challenge for the facility. As of September 30, 2023, staff met this scheduling metric for

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<sup>31</sup> Available data did not allow the team to determine which consults fell into each of these two categories.

<sup>32</sup> The Consult Toolbox is a web-based tool integrated into the Consult Tracking Manager to ensure that consult factors are appropriately updated and action is taken on a consult. It states that throughout the process of managing community care consults, users may use the Consult Toolbox to access options such as consult review, community care eligibility, contact attempts, and patient preferences.

7,562 of 24,781 consults (30 percent), and the average number of days to schedule an appointment increased to 48.

## **Facility Review Determined That Community Care Delays Did Not Result in Veteran Deaths**

In addition to general concerns about consult timeliness, the complainant alleged that patients may have passed away because of the delay in care. The complainant provided the OIG review team with two lists totaling 24 veterans who had passed away between 2022 and 2023 while waiting for a consult with a community care provider. The facility’s risk management office conducted a review of the consult management for these veterans. The internal review determined that the deaths were not related to the delays in scheduling.<sup>33</sup> In addition, according to the complainant, the community care chief emailed the entire department lists of 24 veterans with unscheduled consults who had passed away. The OIG confirmed these two lists included personally identifiable information. These emails noted that the chief “need[ed] assistance with the review of these consults to determine if our delay in scheduling hastened the Veterans [sic] death.” Multiple MSAs told the team that these lists of deceased veterans with unscheduled consults made them feel responsible for patients’ deaths, and they had not been told the outcomes of any patient harm reviews completed by the facility.

The review team provided these instances of possible improper disclosure of veterans’ personally identifiable information to the Martinsburg privacy officer for further review. According to the privacy officer, in July 2023, the National Data Breach Response Service review was completed, with the determination that no privacy breaches occurred. However, the chief of community care was counseled by the privacy officer that emails with personally identifiable information should no longer be sent to groups except for on a need-to-know basis.

## **Delays Occurred Because of Ineffective Processes for Managing Consults, Specialty Care Provider Shortages, and Oversight Challenges**

In addressing consult delays, the OIG found that processes used by staff to manage and schedule community care consults were ineffective, VA and community care providers were in short supply, and the facility lacked sufficient clinical oversight and management accountability.

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<sup>33</sup> The team referred the facility’s review to the OIG Office of Healthcare Inspections. As of the publication of this report, that review is ongoing.

## Ineffective Processes for Managing and Scheduling of Consults

MSAs at the Martinsburg facility told the review team that the process for managing consults was ineffective to address the high number of unscheduled consults.<sup>34</sup> For example, as of June 2023, the MSAs received a daily list from the Consult Tracking Manager, which included consults for all categories of care based on urgency and length of time in the queue, with the newest ones first. Therefore, newer consults were continually processed before older ones, and MSAs never got to the older unscheduled consults. The community care MSA supervisor told the team that on Mondays and Tuesdays the MSAs worked on active consults, and Wednesdays through Fridays they worked on getting the necessary referral documentation. This may have limited MSAs' ability to develop expertise in any one clinical area or build relationships with the community care providers in specific specialty care practices.

However, according to the community care chief, the process changed shortly after the review team's site visit, and staff no longer received a list of consults to work on each day. Instead, they were responsible for pulling their own consult list from the Consult Toolbox by specialty service. One MSA said that when they work on consults from a specific service line, they learn about the providers and where to successfully send the referral document packages for scheduling. Since this change, active consults decreased from over 5,000 to about 3,300.

### *Schedulers' Workload Allocation Was Inefficient*

Another reason consults were not processed on time was because of an inefficient division of workload among the community care staff, reducing staff's time to schedule and complete consults. In fiscal year 2023, the Martinsburg community care service had more than the recommended number of administrative staff based on IVC's staffing tool, with 22 MSAs compared to the recommended 18.<sup>35</sup> However, eight of the nine MSAs interviewed by the review team noted that community care did not actually have enough resources to address the active consults because of workload allocation, which included rotating to the automatic call distribution center.<sup>36</sup> An MSA supervisor said that in April 2023, four of the 22 MSAs were assigned by the community care chief to work on a backlog team to process consults. An MSA

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<sup>34</sup> Federal internal control standards require managers to create control activities to achieve objectives and respond to risks through information systems, policies, and activities. The team determined that the Martinsburg VA medical facility had not created an effective process for managing its consults, which was a deficiency in control activities. Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014, p. 44 "control activities."

<sup>35</sup> The staffing tool is designed to enable each site with a method for quantifying resource needs to successfully operate and execute the operating model for community care. "OCC Staffing Tool," chap. 6, section 6.14, updated April 7, 2023, in *Community Care Field Guidebook*. In January 2024, IVC officials told the review team that facilities should use the tool as a guide, but should not rely solely on it for staffing needs.

<sup>36</sup> A community care MSA at Martinsburg VAMC explained that the call center receives calls from veterans and providers related to the scheduling and approval of community care services.

confirmed the team worked on consults from December 2022 or prior. Martinsburg community care staff stated that the remaining 18 MSAs were split into four teams to work on new consults, and each week four MSAs were rotated to the call center.

According to the facility director, he developed the community care call center to pull phone traffic away from MSAs and consolidate calls. The community care MSAs rotate two to three times a week to work the call center. The community care chief noted that MSAs did not like working the phone lines because it takes them away from their consult work. MSAs agreed that while working on the phone lines, the consults they are assigned to work on that day are not completed. Similarly for the backlog team, MSAs said that when they are pulled to the call center, they are not able to make progress on the unscheduled consults. Seven of the nine MSAs the team interviewed noted that rotating to the call line slows the processing of community care consults. One told the team that if the full staff could focus on scheduling, there would be fewer calls coming in.

In addition, interviews with staff revealed that the inconsistency in the consult processing and scheduling workflow have led to staff attrition at the facility. The chief of staff told the team that staff are demoralized with the huge backlog. He stated that it is common for MSAs to apply for other jobs because no one wants to be held accountable for the backlog. The community care social work supervisor told the review team that there were not enough staff to handle the consult workload, and there is high turnover. Similarly, the community care MSA supervisor said MSAs leave because they get frustrated with the work. She said they get overwhelmed and feel like they are never going to catch up. One of the MSAs the review team spoke with said that when she first started, seven other employees quit. For that reason, the MSA always felt care in the community was understaffed.

### *VISN Was Aware of Challenges Managing Consults*

The VISN 5 community care program manager told the review team that the VISN was aware that one of the challenges at the Martinsburg facility is the inconsistency in how consults are managed and scheduled at the facility.<sup>37</sup> In 2021, VISN 5 invited a Community Care Assist Team from VISN 4 to review the community care processes at Martinsburg because of the facility's consult scheduling challenges. Findings from VISN 4's review revealed (1) constant changes in daily staff assignments that rendered staff unable to adhere to the consult process, (2) lack of alignment between clinical and administrative staff that prevented them from working as a team, and (3) unequal distribution of workload.

The recommendations VISN 4 provided to Martinsburg from this visit included the following:

1. Follow uniform day-to-day processes to ensure performance can be met.

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<sup>37</sup> VISN 5, known as VA Capitol Health Care Network, serves veterans in the District of Columbia, Maryland, West Virginia, and portions of Virginia, Pennsylvania, Ohio, and Kentucky.

2. Prioritize consults by specialties, age, and last action date.
3. Split teams into specialties.

While Martinsburg facility officials stated they took corrective actions related to how they process consults, they could not provide the team with any documentation of changes made or how corrective actions have been monitored. The community care chief told the team that facility officials did not ignore any of the recommendations but talked about what they could implement. The facility director told the review team that he was aware of the recommendations provided by VISN 4, but that there were no data to support the findings, which were already known by the facility.

Even though VISN 5 provides reviews of medical facility performance reports and helps implement guidance at the facility level, it is limited in its enforcement abilities. The VISN 5 community care chief business officer told the review team the VISN does not have the authority to enforce changes at the Martinsburg facility. In light of that, the VISN 5 community care program manager told the team she is not sure if Martinsburg is trying the recommendations provided by the VISN 4 Community Care Assist Team. She stated that during conversations about changes, Martinsburg community care leaders gave reasons about why different processes would not work and were generally opposed to trying the changes recommended by VISN 4.

### **Provider Shortages at the Facility and in the Community**

The Martinsburg VA medical facility took longer than 45 days on average to schedule appointments in the community, in part because of a lack of providers for specialty services both at the facility and in the community. Facility staff told the review team that there are not enough providers at the facility or in the community to meet their needs. As a result, there were no available appointments for some services, and consults remained in active status without being scheduled. The chief of staff stated that, due to the MISSION Act and the pandemic, many veterans went out to the community, but there was pressure to bring them back into VA. However, the facility had a hard time getting quality providers, and the rate at which it is losing providers, physician assistants, and nurses is high.

For example, facility staff noted that the facility had three part-time gastroenterology providers, and none of the community gastroenterology providers were seeing new veteran patients. As another example, the director and the chief of staff indicated the facility has no otolaryngology providers at the facility, despite working to hire one for the past two years using recruitment incentives.

For community care providers, the third-party administrator that oversees the network of providers is required to have monthly meetings with Martinsburg facility staff concerning network adequacy. In those monthly meetings, as of March 2023, otolaryngology, gastroenterology, radiology, and orthopedics were identified as categories of care needing more

providers. In addition, the Martinsburg facility director identified cardiology as needing additional providers. The director stated that providers are leaving the network because they are upset about the process of getting referrals and payments from the third-party administrator. He also told the team that providers in the community care network often have many non-VA patients to treat, resulting in a lack of availability of clinicians for veterans in community care. VA also reported to the third-party administrator that MSA staff attempting to schedule veterans continue to experience providers denying in-network participation.

The facility director has reached out to IVC on several occasions to discuss the lack of providers in Martinsburg. IVC officials acknowledged to the OIG that the population increase in Martinsburg has limited the availability of healthcare services and has encountered challenges in recruiting providers for internal vacancies, including positions in behavioral health, social work, gastroenterology, dermatology, and otolaryngology. According to IVC, Martinsburg's third-party administrator is actively pursuing additional providers in these areas. As of September 2023, IVC officials told the team that work will continue with VA medical facilities and the third-party administrator to identify additional providers, but they continue to recruit from the same limited pool of providers.

## **Community Care Oversight Challenges**

The performance standards for the community care chief at Martinsburg lacked timeliness requirements for community care consults, even though she is responsible for following consult-related national program office guidance, according to VHA Directive 1232(5). The community care chief said that her performance plan is general and covers a broad scope because her standards are “cascaded down” from the facility director's performance plan, which covers other aspects of the medical facility unrelated to community care (for example, flu shots and enhanced access to telehealth). While the plan permits the supervisor and the employee to insert designated goals and standards unique to the employee, the community care chief and facility director elected not to include standards for community care consults.

The facility director indicated other methods were used to monitor performance on community care. For example, he stated that he monitors how the community care chief addresses employee performance and vacancies. However, he could not provide the review team with any evidence or examples of performance monitoring specific to community care. The team reviewed performance plans for three other facilities in VISN 5—Baltimore, Maryland; Beckley, West Virginia; and Clarksburg, West Virginia.<sup>38</sup> All three plans included standards specific to the oversight and monitoring of community care. For example, one plan had standards to demonstrate timely review, scheduling, and closeout of consults.

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<sup>38</sup> These were the three performance plans the VISN community care program manager provided to the team for review.

In addition, Martinsburg VA medical facility leaders did not follow the suggestions outlined in the IVC operating model or practices used at other facilities in the VISN to have the community care department aligned with clinical leaders. This may have contributed to the Martinsburg facility having over 5,000 active consults and staff taking more than 100 days to make the first contact attempt to schedule some veterans in the community. VHA's Community Care Operating Model—a nationally standardized model of care—outlines that the community care leaders should be aligned with the medical facility clinical leaders or chief of staff because community care operates as a clinical department. In addition, the chief of staff is responsible for regularly reviewing and improving consult performance and outcomes.<sup>39</sup>

However, at Martinsburg the community care chief reports directly to the facility director. The Martinsburg director told the team it was important for him to be responsible, due to the significant increase in medical administration and financial operation tasks and the expanded role for nurses in community care. Other facilities in the VISN have the community care chief aligned under the chief of staff or clinical leaders, and the VISN 5 chief business officer told the team that facilities in the VISN that are structured differently have not experienced the same timeliness challenges.

The Martinsburg deputy chief of staff said he acts as a liaison between the services and community care. As such, he is aware of the issues with community care at this facility and has helped address the backlog and trained providers on using the Consult Toolbox but does not have any formal oversight of community care. The VISN 5 chief business officer told the team that the VISN highly recommends that community care reports to the chief of staff because community care consults include clinical functions.

## Conclusion

The OIG substantiated that the care in the community service at Martinsburg had over 5,000 active consults, that staff took more than 100 days to make the first contact attempt for 52 veterans, and that staff took longer than 45 days on average to schedule veterans in the community. However, the OIG did not substantiate that there were 100 urgent consults. The noted delays occurred because the workflow and processes used by community care staff to manage and schedule community care consults were ineffective, the limited availability of specialty care providers at Martinsburg and in the community diminished consult timeliness, and the lack of clinical oversight reduced management accountability for the community care program. The recommendations that follow are meant to help the facility take corrective actions to address the deficiencies outlined in this report.

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<sup>39</sup> VHA Directive 1232(5).

## Recommendations 1–4

The OIG made the following recommendations to the Martinsburg VA medical facility director:

1. Ensure that personal information of veterans who have passed away while waiting for community care consults to be scheduled is only shared with staff who need to know for specific work assignments.
2. Conduct a strategic business evaluation of the community care department's workflow processes to determine if there are alternatives that could improve consult processing and scheduling efficiency and timeliness.
3. Continue to increase specialty provider availability in VA and the community for veterans assigned to the Martinsburg VA medical facility.
4. Ensure that the performance plan of the chief of community care has standards related to the metrics for community care.

## VA Management Comments

The Martinsburg VA medical facility director concurred with the recommendations and provided an action plan for each. The facility director asked the OIG to close recommendations 1 and 4. The VISN director also provided comments, the full text of which can be found in appendix B. Appendix C includes the full text of the facility director's comments, which are summarized below.

To address recommendation 1, the facility stated that the sharing of personal information of veterans who had passed away was an isolated incident that involved a specific staff member. The incident was addressed and education was provided. The facility requested to close this recommendation.

To address recommendation 2, the facility has changed workflow processes for MSAs who now pull their own consult list from the Consult Toolbox by specialty service. The facility's response also indicated that active consults decreased from 5,018 to 1,996 because of additional improvements that have been made. The facility also plans to complete a strategic business evaluation of a prior study to determine its applicability to community care workflow processes.

In response to recommendation 3, the Martinsburg VA medical facility continues to recruit VA specialty providers. The facility will also continue to hold regular network adequacy meetings with the third-party administrator to identify and monitor network adequacy issues. Adequacy gaps will be tracked by the facility Care in the Community Oversight Committee, and compliance will be monitored until 90 percent compliance is met for six months.

For recommendation 4, the facility will add metrics on staff productivity and reporting network adequacy issues to the community care chief's performance plan. Additionally, community care scheduling timeliness is a performance standard that will be issued to facility leaders in the

2024 executive career field performance plan. The facility requested to close this recommendation.

## **OIG Response**

The Martinsburg VA medical facility director's planned corrective actions are responsive to the intent of recommendations.

The OIG will close recommendation 1. For recommendation 4, the medical facility director will need to provide the OIG with the community care chief's performance plan and the standards in the 2024 executive career field performance plan before the OIG will consider closing the recommendation.

The OIG will monitor the facility's implementation of the recommendations until all proposed actions are completed.

## Appendix A: Scope and Methodology

### Scope

The VA Office of Inspector General (OIG) review team conducted its work from June 2023 through January 2024. The team conducted this review to assess the merits of a February 2023 hotline allegation that the community care department at the Martinsburg VA Medical Center was experiencing delays processing and scheduling consults for community care. Specifically, the complainant alleged the following:

- There were over 5,000 active community care consults, 100 of them urgent.
- Staff sometimes took over 100 days to make the first contact attempt with veterans.
- Staff took over 45 days on average to schedule veterans for care in the community.

The team also determined reasons for such delays and reviewed the current status of community care consults as of September 2023.

### Methodology

The team identified and reviewed relevant Veterans Health Administration (VHA) and Martinsburg VA medical facility documents, including training materials, applicable laws and regulations, and VA policies, procedures, and guidebooks related to community care consult scheduling. The team also conducted a site visit including 20 interviews with Martinsburg VA medical facility executive leaders and staff from the local community care department, as well as an observation of how Martinsburg VA medical facility community care staff scheduled appointments. Also, the team interviewed Veterans Integrated Service Network (VISN) 5 and Office of Integrated Veteran Care (IVC) employees with knowledge of community care processes. The site visit and other interviews provided the team with an understanding of the processes, challenges, and general governance structure used to schedule community care consults. The team obtained and analyzed community care consult scheduling data from VA's Integrated Care Workspace consult reports and VHA's Corporate Data Warehouse to determine the nature and extent of the community care unscheduled consults at the facility.

## Internal Controls

The team determined that the Martinsburg VA medical facility had not created an effective process for managing its consults, which was a deficiency in control activities.<sup>40</sup> The finding in this report addresses the deficiency found during the review.

## Fraud Assessment

The review team did not assess the risk of fraud as it was not required for this review. However, the team exercised due diligence in staying alert to any fraud indicators during the course and scope of this review. The OIG did not identify any instances of fraud or potential fraud during this review.

## Data Reliability

The review team relied on computer-processed data to support the finding, conclusion, and recommendations of this review. Electronic data retrieved from VA's Integrated Care Workspace data dashboard and VHA's Corporate Data Warehouse were used to determine community care appointment scheduling timeliness and the extent of unscheduled consults awaiting scheduling actions. The review team checked for the completeness and accuracy of the data from both electronic data systems by checking for missing or duplicate entries, text and number format accuracy, and testing of consult records' data entries against source consult documentation in Veterans Health Information System Technology Architecture electronic medical records. The review team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the review objective and results. The team did not conduct statistical sampling reviews and projections of results, as it reviewed the entire population of community care consults at the Martinsburg VA medical facility during fiscal year 2023.

## Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

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<sup>40</sup> Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014, p. 44 "control activities."

## **Appendix B: VA Management Comments, Director, VA Capitol Health Care Network**

### **Department of Veterans Affairs Memorandum**

Date: March 12, 2024

From: Director, VA Capitol Health Care Network (10N5)

Subj: Draft Report – Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia

To: Director, Office of Audits and Evaluations (52A02),  
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. I have reviewed and concur with the Office of Inspector General's (OIG's) draft report entitled - Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia.
2. Furthermore, I have reviewed and concur with the request to close recommendations # 1 and 4. Recommendations # 2 and 3 will remain open and in progress.
3. Should you require any additional information please contact the VISN 5 network office.

(Original signed by)

Robert M. Walton, FACHE

## **Appendix C: VA Management Comments, Martinsburg VA Medical Facility Director**

### **Department of Veterans Affairs Memorandum**

Date: March 12, 2024

From: Director, Martinsburg VA Medical Center (613/00)

Subj: Draft Report – Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia

To: Director, VA Capitol Health Care Network (10N5)

Thank you for the opportunity to review the final report on Community Care Delays at the Martinsburg VA Medical Center in West Virginia. I have reviewed the document and concur with the findings and recommendations.

We are requesting closure of recommendations 1 and 4.

The facility Chief of Quality Management will be available for additional information or assistance.

I thank you for the opportunity to continue strengthening our high-quality health care activities.

(Original signed by)

Kenneth W. Allensworth, FACHE

Medical Center Director

**Recommendation 1**

1. Ensure that personal information of veterans who have passed away while waiting for community care consults to be scheduled is only shared with staff who need to know for specific work assignments.

Medical Center: Concur

Completion Date: February 7, 2024

Medical Center response: This was found to be an isolated incident involving a specific staff member sending an email to all service staff. This was addressed and education was provided. The facility requests this item to be closed.

**Recommendation 2**

2. Conduct a strategic business evaluation of the community care department's workflow processes to determine if there are alternatives that could improve consult processing and scheduling efficiency and timeliness.

Medical Center: Concur

Target date for completion: July 31, 2024

Medical Center response: As mentioned in the report, processes were changed soon after the site visit that now have Medical Support Assistants (MSA) pull their own consult list from the Consult Toolbox, by specialty service. Additional process improvement initiatives have been also implemented resulting in significant improvement of scheduling timeliness and the number of active consults. As a result, the number of active consults decreasing from 5,018 to 1,996. A strategic business evaluation of the previously completed Kaizen study will be done, to determine currently applicability and efficacy. This review will be completed by July 31, 2024.

**Recommendation 3**

3. Continue to increase specialty provider availability in VA and the community for veterans assigned to the Martinsburg VA medical facility.

Medical Center: Concur

Target date for completion: December 31, 2024

Medical Center response: The Martinsburg VAMC continues recruitment efforts for VA specialty care providers. The facility will continue to hold regular network adequacy meetings with the third-party administrator to identify and monitor network adequacy issues. Communicated adequacy gaps will be tracked in the facility Care in the Community (CITC) Oversight Committee. Compliance will be monitored until 90% compliance is met for 6 consecutive months. The measure reported will be the number of monthly CITC Oversight meeting minutes with documented network adequacy updates divided by total number of monthly CITC Oversight minutes.

**Recommendation 4**

4. Ensure that the performance plan of the chief of community care has standards related to the metrics for community care.

Medical Center: Concur

Completion Date: February 7, 2024

Medical Center response: Additional metrics regarding staff productivity and reporting network adequacy issues will be included in the Community Care Chief's performance plan, when hired. Additionally, Community Care scheduling timeliness is among the performance standards being issued to facility leaders in the 2024 Executive Career Field performance plan. The facility requests this item to be closed.

*For accessibility, the original format of this appendix has been modified  
to comply with Section 508 of the Rehabilitation Act of 1973, as amended.*

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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