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VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers

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Executive Summary

The Office of Inspector General (OIG) Care in the Community program evaluates selected performance elements of the Veterans Health Administration (VHA) Veterans Community Care Program. The resulting report describes selected care coordination activities required to initiate and process referrals for non-VA care (community care). Using interview results and analysis of relevant data, the report also highlights opportunities and challenges for Veterans Integrated Service Network (VISN) and facility staff as they navigate current community care referral processes.[1]

Inspection Summary

The OIG reviewed community care processes in five VISN 9 medical facilities with a community care program from June 12 through July 13, 2023. The OIG evaluated the facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, and Care Coordination: Scheduling and Communication with Veterans Referred for Community Care. The OIG issued 14 recommendations across these five domains. The intent is for leaders to use recommendations as a road map to improve processes that support efficient delivery and coordination of community care going forward. The elements evaluated and OIG findings are summarized below.

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

Leadership and Administration of Community Care 	To determine how VISN and facility leaders supported community care services, the OIG evaluated the following elements: • Community care oversight councils • Resource utilization • Staffing and operations • Third-party administrator interactions • Patient safety and quality event reporting • Medical documentation scanning performance • Community care concerns expressed by facility and VISN leaders • Primary care provider survey responses The OIG issued **four recommendations** to improve staff's use of the staffing reassessment tool, reporting of patient safety events in the VHA reporting system, presentation of patient safety information at community care oversight council meetings, and timely incorporation of medical documents from community providers in patients' electronic health records.
Community Care Diagnostic Imaging Results 	To assess how VHA facility community care staff communicated results of diagnostic imaging by community providers to the ordering VHA providers, the OIG determined whether facility community care staff used the required electronic health record progress note. The OIG also evaluated whether facility community care staff used the significant findings alert to notify VHA providers when those results were abnormal. The OIG issued **two recommendations** to improve facility community care staff's use of the required note to communicate test results and the significant findings alert when results are abnormal.
Administratively Closed Community Care Consults 	To evaluate whether facility community care staff managed the administrative closure of consults, the OIG determined whether staff contacted the patient to confirm appointment attendance, documented the first attempt at obtaining medical documentation, made additional attempts after administratively closing the consult, and used the significant findings alert to notify providers. The OIG issued **two recommendations** to improve management of administratively closed consults, specifically, staff making additional attempts to obtain medical documentation, and using the significant findings alert when they administratively close consults without medical documentation.

Community Care Provider Requests for Additional Services 	To assess how facility staff coordinated the processing and notifications when community providers requested additional services not covered by the initial referral, the OIG determined whether facility staff met timeliness requirements for processing requests and notifying community providers of denials as required. The OIG issued **one recommendation** to improve timeliness in processing requests for services.
Care Coordination: Scheduling and Communication with Veterans Referred for Community Care 	To evaluate how effectively facility community care staff coordinated care for patients referred for community care, the OIG determined whether facility staff followed VHA timeliness requirements for processing referrals. The OIG issued **five recommendations** to improve care coordination and timely processing of community care referrals.

VA Comments and OIG Response

The Veterans Integrated Service Network Director concurred with recommendations 1, 3–6, and 10–14. The OIG considers these recommendations open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendations until they are completed. The Veterans Integrated Service Network Director concurred in principle with recommendations 2, 7, 9, and did not concur with recommendation 8 because of disagreements with associated VHA requirements. The OIG expects the VISN to follow the VHA requirements supporting these recommendations and considers these recommendations open until sufficient evidence demonstrates sustained improvement. See appendix D for detailed responses.

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Contents

Abbreviations

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

Introduction

The Office of Inspector General (OIG) Care in the Community program evaluates Veterans Integrated Service Network (VISN) and Veterans Health Administration (VHA) facilities' processes for coordinating community care and providing leadership and administrative oversight of VHA's Veterans Community Care Program.[1] The OIG's program also surveys facility primary care providers about their experiences with community care and assesses the feedback.

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, VHA's Veterans Community Care Program simplifies the process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[2] VHA's Office of Integrated Veteran Care (IVC) is responsible for managing the Veterans Community Care Program in a way that "is easy to understand, simple to administer, and meets the needs of Veterans, their families, community providers, and VA staff."[3] IVC's field guidebook outlines the program's requirements, processes, and tools related to eligibility, referral, and care coordination.

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101; US Senate Committee on Veterans' Affairs, "The VA MISSION Act of 2018: The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act," accessed July 8, 2021, https://www.capito.senate.gov/imo/media/doc/VAMISSIONActof202018.pdf; VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf.

[3] VHA IVC, chap. 1 in *Community Care Field Guidebook,* November 21, 2022, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This website is not publicly accessible.)

VA MidSouth Healthcare Network

The VA MidSouth Healthcare Network, also known as VISN 9, includes five medical centers located in Kentucky and Tennessee and 27 outpatient centers throughout the VISN.[4]

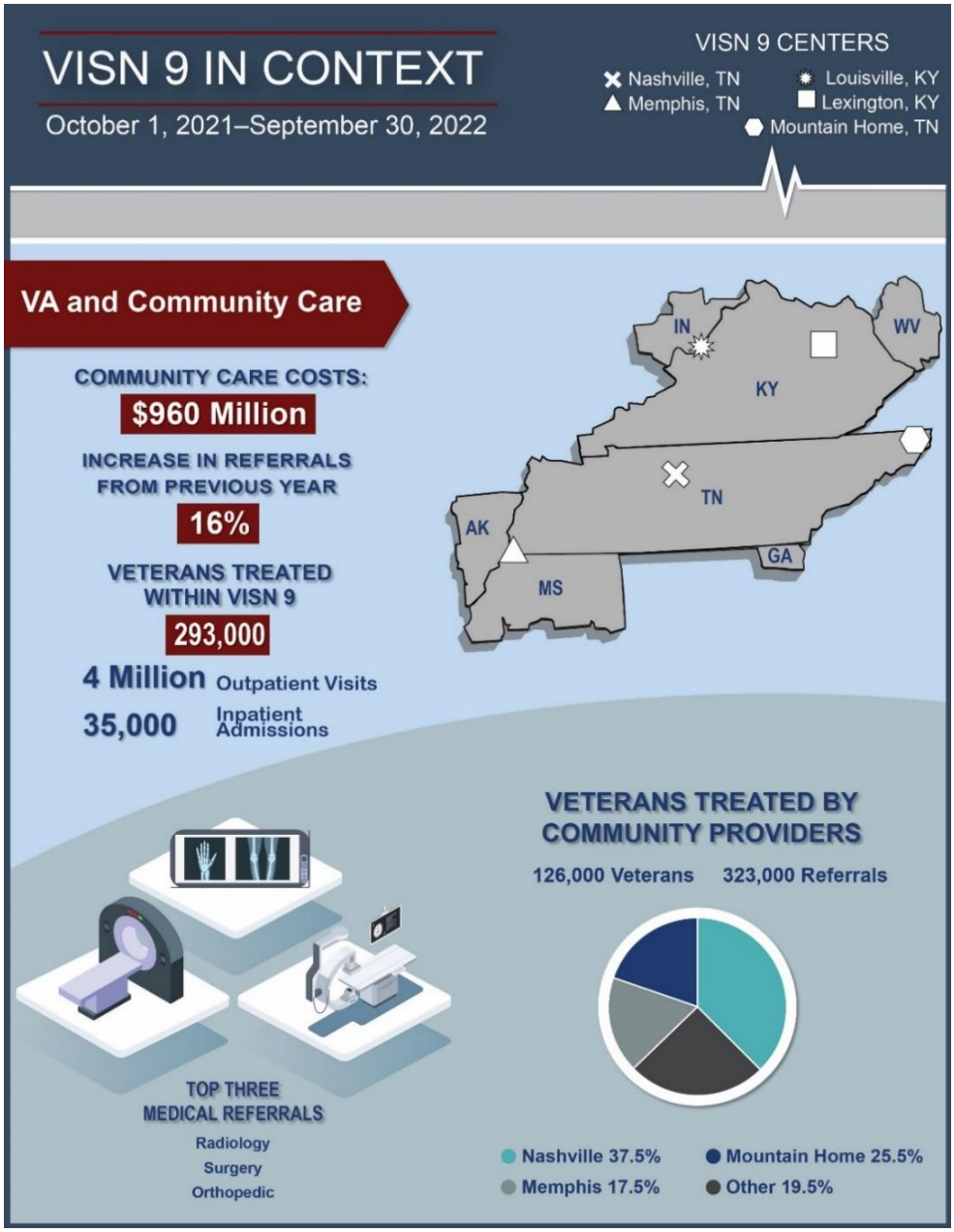

Figure 1. *Community care referral data for VISN 9: VA MidSouth Healthcare Network.*
Source: VA OIG. The OIG did not assess VHA's data for accuracy or completeness.

[4] "About VA MidSouth Healthcare Network," Department of Veterans Affairs, accessed May 24, 2023, https://www.visn9.va.gov/VISN9/about/index.asp.

Community Care Consult Management

In general, to refer a patient to a community provider for care, a VHA provider enters a consult (an order) in the patient's electronic health record. Facility community care staff receive the consult and schedule the appointment. After the appointment, staff request the community provider's medical documentation if the provider does not send it promptly. Facility community care staff complete the process by closing the consult, which may occur with or without receipt of the associated medical documentation from the community care provider. While facility community care staff work on the consult, they also coordinate care for the patient, which may include processing requests for services not preapproved in the consult or incorporating test results into the patient's electronic health record.

Inspection Elements

The OIG evaluated VISN 9 facility processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, and Care Coordination: Scheduling and Communication with Veterans Referred for Community Care. The inspection results describe the OIG's findings related to care coordination activities for patients referred for community care. The report highlights opportunities and challenges for VISN and facility staff as they navigate current community care referral processes.

Inspection Results

Leadership and Administration of Community Care

Effective leaders make decisions that directly or indirectly have an impact on every aspect of operations.[5] In health care, leaders create "policies and procedures, and secure resources or services that support patient safety and quality care, treatment, and services."[6] Leaders should ensure patients receive the same level of care whether it is delivered through the medical facility or care in the community.[7]

To determine how VISN 9 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook. The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when the OIG found noncompliance with requirements. The team also sought input from the leaders and primary care providers about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

VHA requires VISN directors to ensure that all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[8] All VISN 9 facilities had community care councils that met regularly, and the council members reviewed relevant issues. The OIG made no recommendations in this area.

Resource Utilization

When analyzing ongoing community care decisions, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[9]

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[5] The Joint Commission, *Standards Manual*, E-dition, LD.04.01.05, July 2021.

[6] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[7] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[8] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to Veterans Integrated Service Network Directors, October 17, 2017.

[9] VHA IVC, "RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document," updated January 26, 2022, https://dvagov.sharepoint.com/:w:/r/sites/ReferralCoordinationInit/_layouts/15/Doc.aspx. (This website is not publicly accessible.)

All five facilities' leadership teams reported evaluating whether to continue purchasing specific care in the community or providing the care internally and taking actions accordingly. For example, leaders at Mountain Home explained that facility radiology exam volume had declined due to difficulties in recruiting radiology technologists, resulting in increased community care referrals; leaders then used recruitment incentives to hire more technologists and rebuild their imaging capacity. At Lexington, leaders met regularly to determine what additional care could be provided at the facility after monitoring high-cost areas of community care, wait times for non-VA (community care) versus VA providers, and VA providers' availability for patient care. The OIG made no recommendations in this area.

Staffing and Operations

The OIG found that Mountain Home and Nashville personnel could not provide documentation leaders reassessed staffing at the required intervals. VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[10] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their community care programs.[11] VHA requires facility leaders to conduct an initial assessment using the tool, then reassess staffing every 90 days.[12] When facility leaders do not reassess staffing at the required intervals, they may fail to meet workload demands, which could negatively affect program operations and patient care.

Facility leaders stated that some staffing reassessments for calendar year 2022 were not saved, so the data were unavailable. Additionally, community care program leaders at every facility reviewed told the OIG that the staffing tool did not accurately assess community care staffing needs. For example, leaders at Lexington, Louisville, and Memphis stated the tool underestimated the amount of time needed for staff to complete phone calls, resolve issues, or schedule and coordinate care. Leaders at each VISN 9 facility stated they used additional information to make staffing decisions, such as their own observations of time needed for tasks.

The OIG made one recommendation for facility community care staffing reassessments.

[10] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum; VA Community Care, "VA Community Care Operating Model" (fact sheet), May 12, 2017.

[11] The tool uses average task times, workload data, types of staff (administrative or clinical), other nonclinical tasks (work that does not involve processing consults or coordinating care), and staff's projected time off to calculate program needs. VHA Office of Community Care, "Office of Community Care (OCC): Staffing Tool Training," February 2022, https://dvagov.sharepoint.com/:p:/r/sites/vacovha/DUSHCC/DC/PMO/CT/_layouts/15/Doc.aspx. (This website is not publicly available.)

[12] Assistant Under Secretary for Health for Operations (15), "National Implementation of the Community Care Operating Model Staffing Tool," memorandum to Veterans Integrated Service Network Directors, March 1, 2021.

Recommendation 1

1. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures employees complete the operating model staffing tool reassessment every 90 days.

The VISN Director concurred and provided an action plan completion date of June 24, 2024, (see appendix D).

Third-Party Administrator Interactions

VHA established contracts with third-party administrators to create regional networks of community providers able to deliver care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues (such as adverse events or close calls) to ensure that, if needed, appropriate follow-up actions are taken. However, third-party administrators are not contractually required to provide their determinations about individual investigations to VHA staff.

Facility patient safety managers communicate with third-party administrators' representatives, which enables them to evaluate the effectiveness of third-party administrators' actions and provide information to the facility community care program team regarding any issues. During interviews, facility leaders shared some concerns about third-party administrator performance. For example, Lexington leaders discussed concerns about the low number of urgent care providers available in their network. Nashville leaders explained that facility community care staff received repeated calls from patients related to actions handled by the third-party administrator. VHA community care staff could not answer patients' questions because the staff had not received the information from the third-party administrators.

Facility community care leaders suggested that changes to their contracts could improve patient care quality and access. The OIG made no recommendation in this area but provided the feedback to VHA for consideration in future third-party administrator contract negotiations.

Patient Safety and Quality Event Reporting

The OIG found that, at some facilities, staff did not enter events related to patient safety or quality of care in VHA's reporting system or brief the community care oversight councils on patient safety event trends, lessons learned, and corrective actions taken.

The OIG requested that each facility provide potential quality issues submitted by community care staff to the third-party administrator, then, compared the submitted items with those entered

in the Joint Patient Safety Reporting system and found discrepancies.[13] For example, three events that Mountain Home staff submitted to the third-party administrator were not entered in the Joint Patient Safety Reporting system. Facility staff should refer all patient safety and quality events involving a community provider to the third-party administrator for investigation.[14] In addition, VHA requires staff to report these events internally through its Joint Patient Safety Reporting system, and facility patient safety managers to review the events to determine the need for any immediate actions.[15] When events are not reported internally, patient safety managers could miss adverse events that occurred and subsequently fail to take corrective actions to address community care quality and patient safety risks.

The OIG reviewed community care oversight council meeting minutes and found that only those for Mountain Home included the required patient safety event information. VHA requires facility patient safety managers to brief community care oversight councils on patient safety event trends, lessons learned, and corrective actions.[16] Staff failing to analyze patient safety event trends and take corrective actions as warranted could jeopardize safe, high-quality care. Some facility leaders described communicating about these events informally through conversations or email, outside of the council meetings. The OIG made two recommendations for patient safety and quality event reporting.

[13] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[14] VHA IVC, "Veterans Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook." November 2021, https://dvagov.sharepoint.com/:w:/r/sites/vhaivcqualitypatientsafety/_layouts/15/Doc.aspx?sourcedoc=%7B2480A1BE-E5C6-42CA-824C-BC010BBB1221%7D&file=VHA%20CC%20Patient%20Safety%20Guidebook%20v6_Final.docx&action=default&mobileredirect=true (This is an internal website not publicly accessible.)

[15] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[16] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

Recommendation 2

2. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff report community care patient safety events in the Joint Patient Safety Reporting system.

The VISN Director concurred in principle and provided an action plan completion date of July 5, 2024, (see appendix D).

Recommendation 3

3. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

The VISN Director concurred and provided an action plan completion date of July 5, 2024, (*see appendix D).*

Medical Documentation Scanning Performance

VHA requires staff to import all community care documents into the patient's electronic health record within five business days of receipt.[17] The OIG found that Lexington leaders reported scanning times of 15 to 18 days. Failing to promptly scan incoming medical documentation from community care providers could negatively affect care coordination and quality of care monitoring. Therefore, it is critical that staff receive and scan these documents into patients' electronic health records in a timely manner.

Each facility's leaders stated they tracked the scanning to identify backlogs. Leaders at Lexington identified short staffing as the cause of the delay and said they took actions to resolve the backlog, including having the supervisor scan documents and offering overtime to staff, but these actions had not been enough to meet the requirement. The OIG made one recommendation related to medical documentation scanning.

[17] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements," March 2021, https://dvagov.sharepoint.com/sites/vacovha/DUSHCC/DC/DO/CI/FGB/FGB_Artifacts/Forms/AllItems.aspx. (This website is not publicly accessible).

Recommendation 4

4. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.

The VISN Director concurred and provided an action plan completion date of July 11, 2024 (see appendix D).

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns about their community care programs overall. The top concerns included care coordination, quality of care, and increased costs. Some examples are given below.

Care coordination and quality of care. Leaders throughout the VISN 9 facilities discussed difficulties caused by community care providers failing to return medical documentation, including challenges for VHA providers to determine the extent and quality of care patients received, and the additional workload placed on facility community care staff in making numerous attempts to obtain the records.

Further, leaders at each facility expressed concerns regarding VHA paying community care providers for care before they returned the medical documentation. Facility leaders explained that once community care providers received payment, they had little incentive to provide the medical documentation. VISN leaders reported feeling limited in their ability to change this process because of contractual agreements VHA made with third-party administrators. Leaders said the agreements did not facilitate VISN or facility oversight of third-party administrator actions, especially those related to quality of the community care program, which was their top priority.

Increased community care costs. Leaders at Nashville gave the example of a veteran reporting to a community emergency department who required transportation to a community hospital; in these cases, facility leaders do not have input into the method of transportation. Nashville leaders reported an increase in air ambulance charges from roughly $200,000 to $300,000 two years ago to $11 million more recently. VISN leaders stated they were aware of the related cost increases and that due to contractual agreements with the third-party administrator, they felt they had little ability to control costs. They reported sharing this issue with the IVC.

Concerns shared by VHA leaders provide insight into potential community care vulnerabilities, challenges, and areas for improvement that IVC leaders could consider for program changes at these facilities.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs, including diagnosis and management of conditions and overall coordination of care, and may initiate referrals for care by community care providers.[18] The OIG surveyed VISN 9 primary care providers anonymously for feedback about issues they encountered with the community care program, including questions about community care referrals. The survey feedback could lead to program improvements at both the local and national levels.

The OIG distributed the survey electronically from June 12 through June 21, 2023. The OIG emailed 266 surveys to VISN 9 primary care providers and received 76 replies, a 28 percent response rate. Table 1 lists selected survey results.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community provider medical documentation	93
Appointment scheduling delays	83
No call when results were urgent (or "stat") for patients referred to community care for diagnostic testing	76
Documentation receipt delays negatively affecting patient outcomes	65
Appointment delays negatively affecting patient outcomes	54
Quality-of-care concerns when referring patients to community care	48

Source: VA OIG survey of VISN 9 primary care providers' experience with community care.

**Some respondents did not answer every survey question; percentages are reported based on the number of responses for the relevant question.*

Some VHA primary care providers who reported concerns about quality of community care submitted additional comments. The OIG identified the following recurring themes:

- Lack of community provider medical documentation or images
    - Providers' comments included inability to obtain medical documentation, which contributed to inefficient patient care, with patients sometimes having to obtain results themselves.
- Concerns with the quality of community care

[18] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

  - Some providers considered evaluations by community care providers to be incomplete or inaccurate, or thought VHA specialty providers' care was more comprehensive compared to community care providers.

- Concerns with care coordination
  - Provider comments included patients being referred to specialists who lacked the ability to conduct the needed diagnostic testing, or community care providers repeating evaluations already done by VHA providers.

Community Care Diagnostic Imaging Results

Patients may receive diagnostic imaging by community providers if the imaging service is not available at a VHA facility or if access to the facility is an obstacle for the patient. VHA staff must ensure the results are entered into the electronic health record correctly, so providers are able to locate the results, especially when the results are abnormal.[19]

The OIG selected diagnostic imaging results as an inspection domain because imaging was the service most often referred to community providers during calendar year 2022. The OIG found that facility staff often did not attach medical documentation correctly in patients' electronic health records and did not use the significant findings alert to notify VHA providers of abnormal test results.

The OIG reviewed Diagnostic Imaging Results at these VISN 9 sites:

Lexington, KY
Louisville, KY
Memphis, TN
Mountain Home, TN
Nashville, TN

Although the OIG identified areas of noncompliance with VHA requirements, no adverse clinical outcomes for patients were identified.

VHA providers may refer patients to community care if a required diagnostic service is not available at a VHA facility or if the patient meets eligibility criteria, such as standards for wait time for an appointment or drive time to the facility.[20] When facility staff receive the imaging results, VHA requires them to attach the results to a progress note titled Community Care Consult Result.[21] The note title indicates to VHA providers where the results can be found. If the results are abnormal, VHA expects facility community care staff to use the significant findings alert to notify ordering providers.[22]

[19] VHA Office of Community Care, "Veteran Community Care General Information"; VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements"; VHA IVC, chap. 4 in *Community Care Field Guidebook,* November 21, 2022.

[20] "Diagnostic radiology helps health care providers see structures inside your body." "Using the diagnostic images . . . physicians can often: diagnose the cause of your symptoms . . . monitor how well your body is responding to a treatment . . . [and] screen for different illnesses." Examples of diagnostic imaging procedures are magnetic resonance imaging (MRI), ultrasound, and computed tomography (CT) scans. National Institutes of Health, National Library of Medicine, MedlinePlus, *A.D.A.M. Medical Encyclopedia*, "Imaging and radiology," accessed August 18, 2023, https://medlineplus.gov/ency/article/007451.htm; VHA Office of Community Care, "Veteran Community Care General Information."

[21] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements."

[22] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

Incorporating Results into the Electronic Health Record

The OIG found that Lexington and Memphis facility community care staff at times failed to attach diagnostic imaging results to the correct progress note. The OIG determined that

- for diagnostic imaging results for patients referred by Lexington providers, staff did not attach any of the results to the designated progress note, and
- for diagnostic imaging results for patients referred by Memphis providers, staff did not attach the results to the designated note in 52 percent of cases (95% CI: 37 to 67).[23]

When facility staff fail to attach diagnostic imaging results to the correct note, VHA providers may be unable to locate results efficiently, which could delay patients' diagnosis and treatment or lead to patients unnecessarily repeating procedures. During interviews, leaders acknowledged being unaware of the requirement, or said facility staff attached diagnostic imaging results to consults rather than to progress notes. The OIG made one recommendation about staff incorporating diagnostic imaging results into the electronic health record.

Recommendation 5

5. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility staff attach community diagnostic imaging results to the designated Community Care Consult Result note.

The VISN Director concurred and provided an action plan completion date of October 1, 2024 (*see appendix D).*

Provider Notification for Abnormal Imaging Results

During the review, the OIG found that staff at all five VISN 9 facilities failed to consistently use the significant findings alert to notify providers of abnormal test results as expected.

[23] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

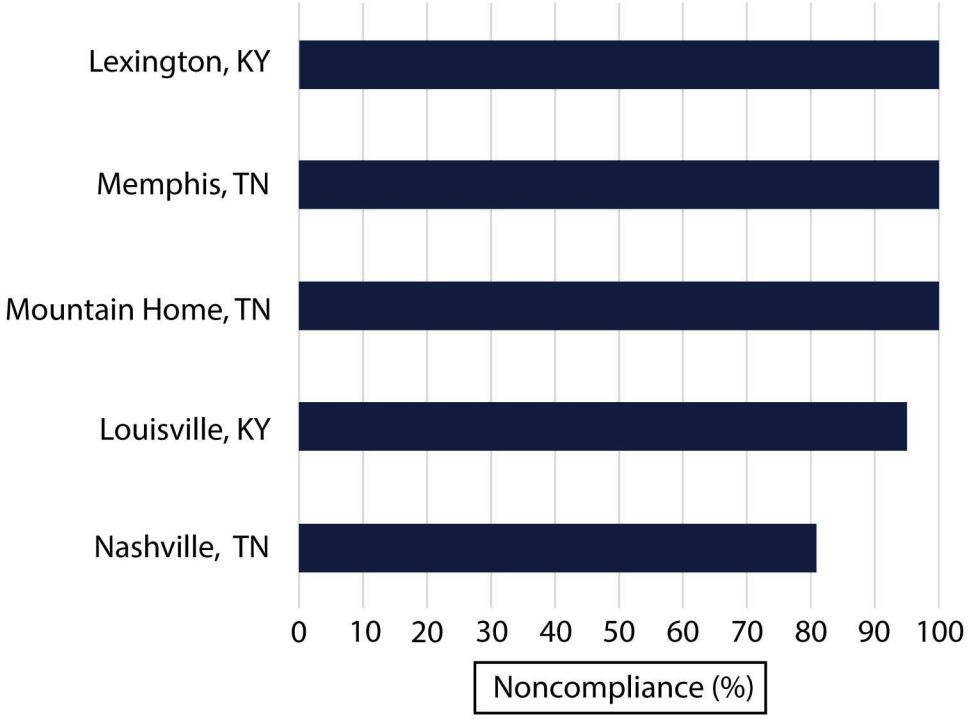

Figure 2. *Abnormal result notification via a significant findings alert.*
Source: OIG analysis of VHA data.

When staff do not use the significant findings alert, providers may be unaware of abnormal test results and patients' diagnosis and treatment may be delayed. Facility community care leaders reported many reasons staff did not use the significant findings alert, including

- being unaware of an expectation to use the alert; and
- using the standard view alert, which requires providers to acknowledge receipt of the results.

During interviews, leaders described other ways staff notified providers about abnormal results. For example, Mountain Home community care staff added the VHA referring provider as another signer on notes with attached abnormal imaging results, which, in their opinion, was a better process. The OIG made one recommendation related to provider notification of abnormal imaging results.

Recommendation 6

6. The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.

The VISN Director concurred and provided an action plan completion date of October 1, 2024, (*see appendix D).*

Administratively Closed Community Care Consults

Documentation of health care from community providers conveys treatment decisions to VHA providers and is important in the patient's care coordination. Delays in the return of medical documentation may affect continuity of patient care, and VHA staff must take steps to obtain the medical documentation and notify the referring provider if the consult is closed without it.[24]

The OIG determined that VHA community care staff did not routinely make required continuing attempts to obtain medical documentation from community providers or use the significant findings alert to notify providers when they administratively closed community care consults.[25] Within VHA, consults to other VHA providers are closed after the requested services are provided and documentation of care is readily available in the electronic health record.[26] In contrast, when community providers perform the requested services, VHA facility community care staff wait to receive medical documentation from those providers before closing the consults, and they make efforts to obtain the documentation if it is not provided soon after the appointment.[27]

The OIG reviewed Administratively Closed Consults at these VISN 9 sites:

Mountain Home, TN
Nashville, TN

Although the OIG identified areas of noncompliance with VHA requirements, no adverse clinical outcomes for patients were identified.

VHA established a process for facility community care staff to administratively close consults if they do not get the medical documentation after their first attempt. After the date of the community care appointment, staff

- contact the patient to confirm appointment attendance,
- attempt to obtain the community care provider's documentation of care provided,
- record these efforts in the electronic health records if they have not received documentation within 14 days of the scheduled appointment, and

[24] Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consult Process (VIEWS #06042227)," memorandum to Veterans Integrated Service Network Directors, October 1, 2021; VHA IVC, chap. 4 in *Community Care Field Guidebook*.

[25] The OIG assessed performance in three domains for each facility and selected the two most underperforming areas to review. The Administratively Closed Community Care Consults domain was one of the two most underperforming areas for Mountain Home and Nashville.

[26] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022.

[27] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

- use the significant findings alert to notify providers when they administratively close community care consults without medical documentation.[28]

If the community care provider does not send medical documentation after the appointment, VHA requires facility community care staff to make three attempts to obtain it. If the first attempt is unsuccessful, they must administratively close the consult without documentation and make the subsequent attempts within 90 days.[29]

Additional Attempts to Obtain Medical Documentation

The OIG found that Mountain Home and Nashville facility community care staff often failed to make two additional attempts to obtain community providers' medical documentation within 90 days of the appointments. Specifically,

- for patients referred by Mountain Home providers, the OIG estimated facility community care staff did not make the additional attempts for 73 percent of patients (95% CI: 60 to 85); and
- for patients referred by Nashville providers, the OIG estimated facility community care staff did not make the additional attempts for 57 percent of patients (95% CI: 42 to 72).

Failure to make the additional attempts to retrieve medical documentation could delay the return of patient records and negatively affect any additional care or care coordination needed. Leaders said reasons for staff not making additional attempts were related to staffing shortages. A Nashville community care leader described prioritizing facility community care staff scheduling community care appointments over making additional phone calls to retrieve medical documentation. The OIG made one recommendation regarding attempts to obtain medical documentation when consults are administratively closed without it.

[28] VHA IVC, chap. 3 in *Community Care Field Guidebook*, June 2022, and chap. 4 in *Community Care Field Guidebook*.

[29] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consult Process," memorandum; VHA IVC, chap. 4 in *Community Care Field Guidebook*.

Recommendation 7

7. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make required attempts to obtain medical documentation within 90 days of the appointment after administratively closing consults without medical documentation.

The VISN Director concurred in principle and provided an action plan completion date of October 1, 2024 (see appendix D).

Provider Notification for Administrative Closures

The OIG found that Mountain Home and Nashville community care staff failed to use the significant findings alert to notify providers when they administratively closed consults without medical documentation. Specifically,

- for patients referred for community care by providers at Mountain Home, the OIG found facility community care staff did not use the significant findings alert to notify providers about any of the administratively closed consults; and
- for patients referred by Nashville providers, facility community care staff failed to use the alert to notify providers for 72 percent of the administratively closed consults (95% CI: 59 to 85).

Failure to follow the process for staff notifying providers when administratively closing consults without medical documentation creates a vulnerability in the internal communication process, limiting providers' awareness that further action may be needed to obtain results of patients' care in the community. Community care leaders at both facilities reported being unaware of the expectation to use the significant findings alert to notify providers when staff administratively closed consults without medical documentation. The OIG made one recommendation regarding provider notification when staff administratively close consults without medical documentation.

Recommendation 8

8. The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert when they administratively close community care consults without medical documentation.

The VISN Director did not concur and provided a response (see appendix D).

Community Care Provider Requests for Additional Services

Community providers may submit requests for services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA clinical staff review and make timely decisions on the requests.[30]

The OIG determined that facility community care staff did not process community providers' requests for additional services in a timely manner. VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[31] The process requires

- community providers to submit the request and supporting medical documentation on a VHA-provided form; and
- facility community care staff to review the request and supporting documentation and
  - approve or deny the request within three business days of receipt,
  - incorporate the request into the electronic health record, and
  - send a letter to the community provider explaining reasons for any denied requests.[32]

The OIG reviewed Requests for Services at these VISN 9 sites:

Lexington, KY
Louisville, KY
Memphis, TN
Mountain Home, TN
Nashville, TN

Although the OIG identified areas of noncompliance with VHA requirements, no adverse clinical outcomes for patients were identified.

Requests for Additional Services Approvals or Denials

The OIG determined that facility community care staff at each VISN 9 facility did not consistently process requests for services within three business days of receipt.

[30] VHA IVC, "Requests for Services (RFS) Form 10-10172 Training," September 2023.
[31] VHA IVC, chap. 3 in *Community Care Field Guidebook*.
[32] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

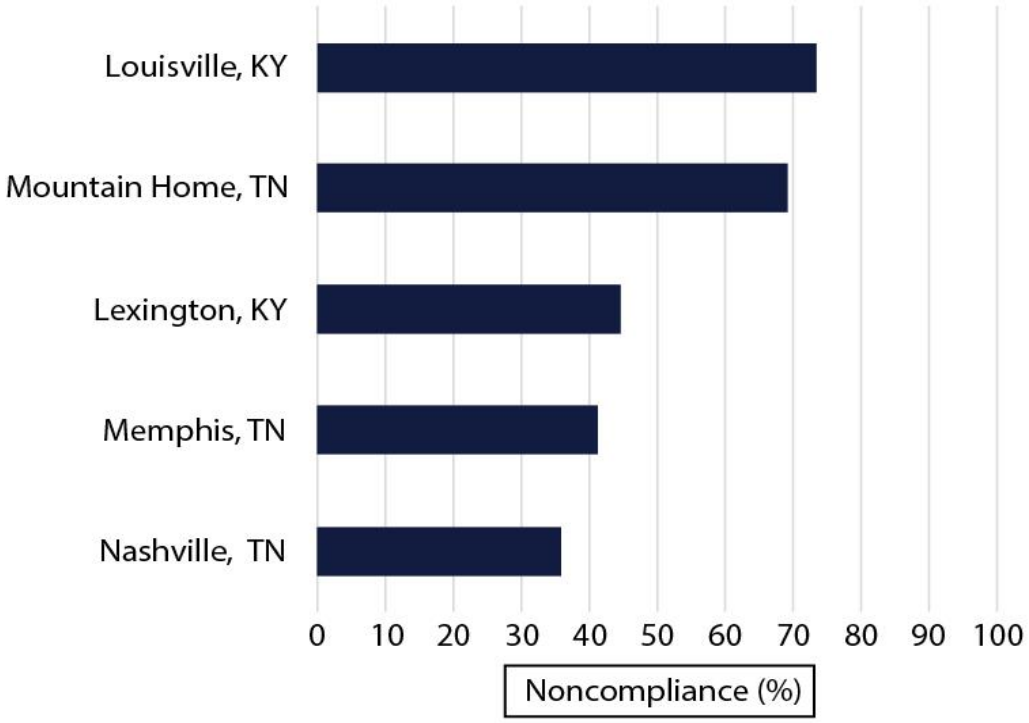

Figure 3. *Requests for service with decisions made in three business days.*
Source: OIG analysis of VHA data.

Staff's failure to process requests for services in three business days may delay needed care, which could negatively affect patient outcomes. During interviews, facility community care leaders reported many reasons for not processing requests for services in three business days, including requests received without necessary supporting medical documentation and returned to community providers for the information, and requests awaiting approval or denial from VHA providers.[33] The OIG made one recommendation about processing community providers' requests for services.

[33] Louisville leaders reported that when staff sent requests for services to VHA providers to approve or deny, the providers disagreed about whether a specialty care provider or a primary care provider should review them. Leaders at Lexington and Louisville stated that community care staff do not track the number of days it takes them to process requests for services.

Recommendation 9

9. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community care providers' requests for services within three business days of receipt.

The VISN Director concurred in principle and provided an action plan completion date of October 1, 2024 (see appendix D).

Care Coordination: Scheduling and Communication with Veterans Referred for Community Care

Care coordination based on an individual patient's needs is a way for facility community care staff to organize services and resources with patients and community care providers. A VHA care coordination plan addresses activities such as appointment scheduling, follow-up, communication with the patient and community providers, and transition back to VHA medical care.[34]

The OIG found that VHA community care staff did not consistently conduct care coordination efforts according to VHA requirements.[35] VHA has established a care coordination model as a framework for overseeing care and aligning resources based on the individual patient's needs. The model details the required activities of a facility care coordination team, defines roles and responsibilities, and describes specific ways to accomplish goals, such as improved care transitions between VHA and community providers.[36]

The OIG reviewed Care Coordination at these VISN 9 sites:

Lexington, KY
Louisville, KY
Memphis, TN

Although the OIG identified areas of noncompliance with VHA requirements, no adverse clinical outcomes for patients were identified.

Facility community care staff use an automated algorithm called the Screening Triage Tool to determine the appropriate level of care coordination for each consult.[37] Levels are based on the intensity, frequency, duration, and type of care coordination each patient needs. As care complexity increases, so does the type and frequency of care coordination services, including contact with the patient.[38] Table 2 lists the levels of care and corresponding recommended frequency of patient contact.[39]

[34] VHA IVC, "Community Care-Care Coordination Plan (CC-CCP) Note Standard Operating Procedure," June 2022.

[35] The OIG assessed performance in three domains for each facility and selected the two most underperforming areas to review. The care coordination: scheduling and communication with veterans referred for community care domain was one of the two most underperforming areas for Lexington, Louisville, and Memphis.

[36] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[37] The screening triage "tool is a component of the end-to-end care coordination process for Veterans receiving care in the community." VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure," July 2, 2019.

[38] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

[39] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

Table 2. Levels of Care and Recommended Frequency of Patient Contact

Level of Care	Frequency of Patient Contact
Basic	As needed
Moderate	Monthly to quarterly
Complex/chronic	Weekly to monthly
Urgent	Hourly to daily

Source: VHA, "Screening Triage Tool Standard Operating Procedure."

VHA also developed a standardized progress note called Community Care–Care Coordination Plan that facility community care staff use to document aspects of care coordination, such as clinically indicated services and a patient's psychosocial needs, preferences, and goals. Staff are required to document all care coordination activities for each consult in the note, except for consults with a basic level of care coordination or those for Geriatrics and Extended Care, direct scheduling, and dialysis.[40]

Assignment of Care Coordination Levels

The OIG found that of the three reviewed facilities, Louisville community care staff did not use the Screening Triage Tool to assign a level of care coordination for 23 percent of consults (95% CI: 11 to 37). The absence of a care coordination level may result in multiple errors in subsequent care processes, including misidentification of the severity of diagnoses and lack of appropriate follow-up, which could negatively affect patient outcomes. A leader from Louisville reported that managers had already identified failures in staff's use of the tool to assign levels of care coordination and had taken corrective action by having community care nurses review consults for the levels, resulting in improvement. The OIG made one recommendation regarding care coordination levels.

[40] Deputy Under Secretary for Health for Operations and Management (10N), "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum to Veterans Integrated Service Network Directors, September 16, 2019; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

Recommendation 10

10. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff assign a level of care coordination to all community care consults as required.

The VISN Director concurred and provided an action plan completion date of October 1, 2024 (see appendix D).

Care Coordination Documentation

Some facility staff did not document care coordination as VHA directed. The OIG found that for the three facilities reviewed, Lexington and Louisville community care staff failed to consistently create and use the care coordination note as required.[41] Specifically,

- for all consults with a level of care coordination above basic, Lexington community care staff did not create the note and use it to document care coordination; and
- for consults with a level of care coordination above basic, Louisville community care staff did not create the note and use it to document care coordination for 60 percent of them (95% CI: 38 to 81).

VHA requires staff to create and use the Community Care–Care Coordination Plan note in the electronic health record to document patients' care, including developing, monitoring, and tracking care coordination efforts for all consults with an assigned level of care other than basic.[42] When facility community care staff fail to create the Community Care–Care Coordination Plan note and use it as required, patients may experience delays in care or diagnosis or miss appointments. VHA community care leaders reported issues including staff not knowing how to use the note, which they addressed through training, and staffing shortages and competing priorities that diminished time for staff to complete the note. The OIG made one recommendation for care coordination documentation.

[41] Deputy Under Secretary for Health for Operations and Management, "National Deployment of the Community Care Coordination Model," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[42] Deputy Under Secretary for Health for Operations and Management, "National Deployment of the Community Care Coordination Model," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

Recommendation 11

11. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create and use the Community Care–Care Coordination Plan note for documenting all care coordination activities for consults with an assigned level of care other than basic.

The VISN Director concurred and provided an action plan completion date of October 1, 2024 (see appendix D).

Contacting Patients according to Recommended Care Coordination Frequencies

The OIG found that facility community care staff did not consistently contact patients according to the recommended frequency for consults requiring more than a basic level of care coordination. Of 49 patients referred for community care by Lexington providers, 32 consults had a level of care coordination above basic, and community care staff did not communicate with 72 percent of the patients as recommended (95% CI: 56 to 87). Although VHA requires facility community care staff to assign a level of care coordination to each consult, they are not required to follow up with patients according to recommended frequencies.[43]

The OIG is concerned that because VHA requires staff to assign a level of care coordination but only recommends associated communication, patients may not receive adequate care coordination and follow-up, which could compromise patient safety. The Lexington community care Nurse Manager said a shortage of nurses resulted in staff conducting care coordination activities only for very high-risk patients, such as those with cancer. Because the guidebook recommends but does not require contacts based on assigned levels of care, the OIG made no recommendation.

Timely Activation of Community Care Consults

The OIG found that Memphis and Louisville facility community care staff did not consistently change the consult status within timeliness requirements.[44] To ensure timely care, VHA requires facility community care staff to change the status of consults from pending (staff have not yet started work on the consult) to active (staff are actively working on the consult) within two business days of the consult's initial entry or the date the consult was forwarded to community care staff.[45]

[43] VHA IVC, chap. 2 in *Community Care Field Guidebook*, November 29, 2022, and chap. 3 in *Community Care Field Guidebook*.

[44] VHA IVC, "Consult Timeliness Standard Operating Procedure," December 1, 2022; VHA Directive 1232(5).

[45] VHA IVC, "Consult Timeliness Standard Operating Procedure"; VHA Directive 1232(5).

- For patients referred to community care by Memphis providers, community care staff did not change the consult status within the required time frame for 32 percent of the consults (95% CI: 19 to 46); the time for changing consults to an active status took up to 9 days.
- For patients referred by Louisville providers, community care staff did not meet the requirement for 23 percent of the consults (95% CI: 11 to 37), taking up to 28 days to change consults to an active status.

Staff failing to update consult status may delay other care coordination activities, such as scheduling appointments. VHA community care leaders attributed delays in changing the consult status to staff waiting for clarification from the referring provider or misunderstanding the requirement, interpreting it to mean they had 48 hours instead of 2 business days to change the status. The OIG made one recommendation regarding timely activation of consults.

Recommendation 12

12. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff change the status of community care consults to active within two business days of the consult's initial entry or date forwarded to community care staff.

The VISN Director concurred and provided an action plan completion date of October 1, 2024 (see appendix D).

Timely Scheduling of Community Care Consults

The OIG found facility community care staff did not consistently meet timeliness requirements for scheduling appointments. VHA requires facility community care staff to schedule community care appointments for patients according to timeliness standards, which have changed over time.[46] Community care consults entered between January 1 and March 31, 2022, had to be scheduled within 14 days of entry, while those entered between April 1 and December 31, 2022, had to be scheduled within 7 days of entry.[47] Memphis, Lexington, and Louisville community care staff failed to consistently meet this requirement. Specifically,

- for patients referred to community care by Memphis providers, community care staff did not meet the scheduling requirement for 72 percent of consults (95% CI: 59 to 85), and scheduling appointments with community care providers took up to 225 days;

[46] VHA IVC, "Consult Timeliness Standard Operating Procedure."
[47] VHA IVC, "Consult Timeliness Standard Operating Procedure."

- for patients referred to community care by Lexington providers, staff did not meet the scheduling requirement for 47 percent of consults (95% CI: 33 to 61), and the time for scheduling the appointments took up to 63 days; and
- for patients referred to community care by Louisville providers, staff did not meet the scheduling requirement for 51 percent of consults (95% CI: 37 to 66), and scheduling the appointments took up to 98 days.

When staff do not schedule patients' community care appointments in a timely manner, it may delay the provision of needed care. A Memphis community care leader attributed scheduling delays to limited staffing and heavy workloads, adding that after hiring additional community care staff, the delays had decreased significantly. A Lexington community care leader said staffing shortages, as well as having to allocate time for community care administrative staff to answer patients' questions at a call center, contributed to the inability to meet scheduling requirements. The Nurse Manager also said the process of sending clinical documentation to community providers and waiting for them to review it before scheduling the appointments contributed to delays.

The Louisville Chief of Staff for Community Care mentioned several additional factors contributing to the scheduling delays, primarily the large number of consults overall. This leader also said that when community providers used centralized scheduling services, facility community care staff encountered difficulty contacting the third-party's staff to schedule an appointment. The OIG made one recommendation about scheduling community care appointments.

Recommendation 13

13. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff schedule patients for community care appointments within the required time frames.

The VISN Director concurred and provided an action plan completion date of October 1, 2024 (see appendix D).

Confirming Patients Attended Community Care Appointments

The OIG found that facility community care staff at Lexington and Louisville did not consistently confirm that patients attended their scheduled appointments. Before searching for medical documentation from the visit, facility community care staff need to confirm patients attended their scheduled appointments. To do this, facility community care staff contact the patient, and if the patient cannot be reached, staff then contact the community provider to determine if the patient kept the appointment.[48] The OIG estimated that

- for patients referred to community care by Lexington providers, community care staff did not confirm 69 percent of them attended their appointment (95% CI: 56 to 82), and
- for patients referred to community care by Louisville providers, community care staff did not confirm 33 percent of them attended their appointment (95% CI: 19 to 47).

If facility community care staff do not confirm patients attended their appointments, they may not be able to determine the need for obtaining necessary medical documentation. A community care leader at Lexington reported believing receipt of medical documentation was equivalent to confirmation of appointment attendance and described a facility process for community care staff to contact community providers five days after the appointment date if medical documentation had not been received. The facility community care staff did not usually verify that the patient went to the appointment because they had received records from the appointment, even though the records may have been delayed.

A Louisville community care leader identified the main challenge as the large number of appointment confirmations facility community care staff were responsible for, explaining that staff had taken on the responsibility for other service lines. The OIG made one recommendation regarding appointment confirmation.

[48] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

Recommendation 14

14. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended scheduled community care appointments and received care.

The VISN Director concurred and provided an action plan completion date of May 28, 2024 (see appendix D).

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at selected facilities within VISN 9, the OIG conducted a detailed inspection from June 12 through July 13, 2023, across five community care domains. The inspection resulted in 14 recommendations on systemic issues that may adversely affect patient outcomes. The total number of recommendations does not necessarily reflect the overall quality of all services delivered by facility community care staff within this VISN. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Summary of Recommendations

Domain	Recommendations
 **Leadership and Administration of Community Care**	1. Employees complete the operating model staffing tool reassessment every 90 days. 2. Facility community care staff report community care patient safety events in the Joint Patient Safety Reporting system. 3. Patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings. 4. VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.
 **Community Care Diagnostic Imaging Results**	5. Facility staff attach community diagnostic imaging results to the designated Community Care Consult Result note. 6. Facility community care staff use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.
 **Administratively Closed Community Care Consults**	7. Facility community care staff make required attempts to obtain medical documentation within 90 days of the appointment after administratively closing consults without medical documentation. 8. Facility community care staff use the significant findings alert when they administratively close community care consults without medical documentation.
 **Community Care Provider Requests for Additional Services**	9. Facility community care staff process community care providers' requests for services within three business days of receipt.
 **Care Coordination: Scheduling and Communication with Veterans Referred for Community Care**	10. Facility community care staff assign a level of care coordination to all community care consults as required. 11. Facility community care staff create and use the Community Care–Care Coordination Plan note for documenting all care coordination activities for consults with an assigned level of care other than basic. 12. Facility community care staff change the status of community care consults to active within two business days of the consult's initial entry or date forwarded to community care staff. 13. Facility community care staff schedule patients for community care appointments within the required time frames. 14. Facility community care staff confirm patients attended scheduled community care appointments and received care.

Appendix B: Methodology

The OIG reviewed community care processes in five VISN 9 medical facilities with a community care program from June 12 through July 13, 2023. The facilities were the Lexington VA Health Care System (Lexington); Robley Rex VA Medical Center (Louisville); Lt. Col. Luke Weathers, Jr. VA Medical Center (Memphis); Tennessee Valley Healthcare System (Nashville); and James H. Quillen VA Medical Center (Mountain Home). The team reviewed facilities' policies and standard operating procedures, in addition to the results from electronic health record reviews and the OIG's survey distributed to VHA facility primary care physicians.[1] The OIG also interviewed leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. The OIG's analysis relied on inspectors identifying information from surveys, interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*[2]

The inspection team examined operations and electronic health records from January 1 through December 31, 2022. The OIG inspected each facility for performance in the Leadership and Administration of Community Care and Community Care Diagnostic Imaging Results domains. The OIG selected two other domains, for a total of four per facility, after reviewing facility performance data relevant to each respective domain; OIG leaders approved selections based on content and professional judgment. The OIG conducted statistical analysis of results from Community Care Diagnostic Imaging Results and the two other domains selected for the inspection. The domains selected for each VISN 9 facility are shown in figure 4.

[1] Facility liaisons identified primary care physicians. The OIG contacted them using their VA email addresses, and staff from the OIG Office of Data Analytics analyzed the responses. Participation in the survey was voluntary.

[2] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

	Lexington KY	Louisville KY	Memphis TN	Mountain Home TN	Nashville TN
Leadership and Administration	✓	✓	✓	✓	✓
Diagnostic Imaging Results	✓	✓	✓	✓	✓
Administratively Closed Consults				✓	✓
Requests for Service	✓	✓	✓	✓	✓
Care Coordination	✓	✓	✓		

Figure 4. *Domain review selections for VISN 9 facilities.*
Source: OIG analysis of VHA data.

For the Leadership and Administration of Community Care domain, the OIG interviewed VISN and facility executive and community care leaders, identified participants according to their roles or titles, and used standardized interview questions to maintain consistency.

For the Community Care Diagnostic Imaging Results domain, the OIG identified community care diagnostic imaging referrals for computed tomography, ultrasound, or magnetic resonance imaging entered from January 1 through December 31, 2022, and selected a random sample of 50 records from each VISN 9 facility for review.[3]

For the Administratively Closed Community Care Consults domain, the OIG identified community care consults administratively closed without medical documentation from January 1 through December 31, 2022, and excluded referrals for low-risk, Dental, and Geriatrics and Extended Care services. The OIG randomly selected a sample of 50 records each from the Mountain Home and Nashville facilities for review.

For the Community Care Provider Requests for Additional Services domain, the OIG identified patients with requests for services submitted by community care providers from January 1 through December 31, 2022, and excluded requests for Dental or Geriatrics and Extended Care services. If a patient had more than one request for service, the OIG evaluated the earliest request during the study period. The OIG randomly selected a sample of 50 records from each VISN 9 facility for review.

For the Care Coordination: Scheduling and Communication with Veterans Referred for Community Care domain, the OIG identified community care referrals entered from

[3] For all reviews, the sample size was 50 records; during the review process, some records may have been excluded, resulting in a final number of records less than 50.

January 1 through December 31, 2022, and reviewed those for which VHA community care staff scheduled the community care appointment for the patient and did not complete the consult within 90 calendar days. The OIG excluded referrals for services on VHA's low-risk list, Optometry, Audiology, Dental, or for future care. The OIG randomly selected a sample of 50 records from each of the Lexington, Louisville, and Memphis facilities for review.

This report is a review of VISN 9 and selected facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Findings cannot be generalized across VHA.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability. The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[4] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 26, 2024

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Care in the Community Healthcare Inspection of VA MidSouth Healthcare Network (VISN 9)

To: Director, Office of Healthcare Inspections (54CC02)

Director, GAO/OIG Accountability Liaison Office (VHA 100ICGOAL Action)

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Care in the Community Healthcare Inspection of VISN 9: VA MidSouth Healthcare Network and Selected VA Medical Centers. I concur with the action plans submitted.
2. We thank the OIG for the opportunity to review and respond to the Draft Report: Care in the Community Healthcare Inspection of VISN 9: VA MidSouth Healthcare Network and Selected VA Medical Centers.

(*Original signed by:*)

Gregory Goins, FACHE
Network Director, VISN 9

Appendix D: Action Plans

Recommendation 1

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures employees complete the operating model staffing tool reassessment every 90 days.

VISN concurs.

Target date for completion: June 24, 2024.

VISN response: Last completed in FY24Q3. This is a re-occurring VISN suspense that is completed every quarter. The data is now nationally accessible, both current and historical.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 2

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff report community care patient safety events in the Joint Patient Safety Reporting system.

VISN concurs in principle.

Target date for completion: July 5, 2024.

VISN response: Since the review, national guidance has been revised and training has been provided within VISN 9 on the use of Joint Patient Safety Reporting (JPSR) system to submit a JPSR when a PQI [Prevention Quality Indicator] report is submitted to the Third-Party Administrator (TPA). The PQI reports will not be a 1:1 match to the JPSRs since the PQI can be filed by anyone (employees, stakeholders, and Veterans) directly with the TPA, thus bypassing Community Care.

By July 5th, JPSRs will be submitted for those PQIs submitted through or by Community Care locally, the VISN will strengthen the guidance on tracking of JPSRs and PQIs and VISN 9 will re-educate staff.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 3

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

VISN concurs.

Target date for completion: July 5, 2024.

VISN response: Patient safety events have been incorporated into the facility Community Care Oversight Committee meetings. The events are briefed by the Patient Safety Officer or their representative. By July 5th, VISN 9 will strengthen the guidance on Community Care tracking of JPSRs and PQIs to ensure a consistent frequency of reporting, and the elements tracked, through the facility Community Care Oversight Boards across VISN 9. The VISN will encourage that PQIs should be reported to or through Community Care for awareness and tracking, regardless of origin in the facility.

VISN 9, in collaboration with Integrated Veteran Care (IVC) and TPA partners will continue to work on obtaining information on open and completed PQI submissions with consideration to protected information.

The VISN 9 Community Care Manager attends all VISN facility Oversight Committee meetings.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 4

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.

VISN concurs.

Target date for completion: July 11, 2024.

VISN response: VISN 9, Community Care currently has no backlog in scanning medical records and is tracking the five-day standard within Healthcare Information Management (HIM). VISN 9 reports Community Care backlogs (>5 days) to the National HIM Program Office through a quarterly suspense. Action plans are provided, as required, through the national process. As of the FY24Q3 reporting, due July 11, 2024, we were showing no backlogs for Community Care scanning.

The Enterprise Precision Scanning and Indexing (EPSI) program will allow VISN 9 to consistently track the progress of the scanning. EPSI is being implemented, by July 5, 2024, at all sites to track receipt of Community Care documentation. We have an additional active follow-up VISN suspenses verifying site compliance. EPSI significantly speeds up the scanning process allowing records to be indexed into VISTA [Veterans Health Information Systems and Technology Architecture] Imaging in a timely manner. Care Coordination can be done concurrently on the incoming clinical documents.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 5

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility staff attach community diagnostic imaging results to the designated Community Care Consult Result note.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: VISN 9 has previously worked on Mammogram oversight and reporting and developed an SOP [Standard Operating Procedure]. VISN 9 will establish a workgroup to broaden and create a VISN SOP that covers all community care imaging to clarify specific processes, staff roles, documentation requirements, significant findings alert assignment, and use of VISN tools such as Medicom. The oversight reporting structure through governance will also be addressed. The VISN SOP draft was completed by the end of July 2024. Process testing and leadership concurrence will be completed and implementation is expected for the beginning of FY25.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 6

The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: VISN 9 has previously worked on Mammogram oversight and reporting and developed an SOP. VISN 9 will establish a workgroup to broaden and create a VISN SOP that covers all community care imaging to clarify specific processes, staff roles, documentation requirements, significant findings alert assignment, and use of VISN tools such as Medicom. The oversight reporting structure through governance will also be addressed. The VISN SOP was completed by the end of July 2024. Process testing and leadership concurrence will be completed and implementation is expected for the beginning of FY25.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 7

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make required attempts to obtain medical documentation within 90 days of the appointment after administratively closing consults without medical documentation.

VISN concurs in principle.

Target date for completion: October 1, 2024.

VISN response: VISN 9 performs all nationally required steps within 90 days, but we order them differently (contact attempts are all prior to administrative closure).

We will retrain all Community Care staff in VISN 9 to do administrative closures after the first contact attempt, and then make second and third contact attempts.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 8

The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert when they administratively close community care consults without medical documentation.

VISN does not concur.

VISN response: Significant finding alerts should not be used for all administrative closures. Significant finding alerts should only be used for abnormal test, study or procedure results or for no records returned on screening/testing referrals per the Field Guidebook Chapter 4: 05.04.02 and the memo from the Assistant Under Secretary Sub: Revised Administrative Closure of Community Care Consults Process 10N Memo dated 10/01/2021 as instructed.

The OIG notes that the VISN response contradicts current IVC requirements for administrative closure as described in the field guidebook and clarified through OIGs interview with IVC leaders. The OIG expects the VISN to follow the current IVC process for administrative closure of community care consults, which includes use of the significant findings alert. The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 9

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community care providers' requests for services within three business days of receipt.

VISN concurs in principle.

Target date for completion: October 1, 2024.

VISN response: VISN 9 re-educated Community Care leadership on RFS [Requests for Services] timeliness and process expectations on May 28th.

We are in the process of publishing a VISN Directive that will include consistent reporting on RFS timeliness through Governance (Facility and VISN Community Care Oversight Boards).

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 10

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff assign a level of care coordination to all community care consults as required.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: Per FGB [Field Guidebook] Chapter 2:05.02.21 Community Care staff will use the Screening/Triage process tool to determine the appropriate levels of care of basic, moderate, complex, urgent. This level lays the foundation for the Veteran's care coordination plan. The overall VISN 9 performance has improved based on system upgrades within the CTM [Consult Tracking Manager] that force staff to use the triage tools. VISN 9 re-educated Community Care leadership on Triage Tool use on May 28th We are in the process of publishing a VISN Directive that will include Triage Tool utilization through Governance (Facility and VISN Community Care Oversight Boards).

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 11

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create and use the Community Care–Care Coordination Plan note for documenting all care coordination activities for consults with an assigned level of care other than basic.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: As of May 28th, VISN 9 has fully implemented and trained staff on the clinical screening triage tool for proper Veteran level of care recommendations. In the Consult Tracking Manager (CTM), VISN 9 facilities have developed labels/flags for Moderate and Complex cases, to identify, through consult workflow, Veterans with assigned levels of care other than basic to ensure documentation of care coordination activities for consults on the Community Care Coordination Plan note.

By October 1, 2024, VISN 9 will verify use of CTM labels/flags are consistent with the FGB, at all VISN 9 facilities.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 12

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff change the status of community care consults to active within two business days of the consult's initial entry or date forwarded to community care staff.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: While we have been tracking this data for some time in a variety of venues, we are in the process of publishing a VISN Directive that will include consistent tracking of this access data via standing reports through Governance (Facility and VISN Community Care Oversight Boards).

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 13

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff schedule patients for community care appointments within the required time frames.

VISN concurs.

Target date for completion: October 1, 2024.

VISN response: Currently, VISN 9 is the 2nd best performing network on Community Care appointing timeliness. While we have been tracking this data for some time in a variety of venues, we are in the process of publishing a VISN Directive that will include consistent tracking of this access data via standing reports through Governance (Facility and VISN Community Care Oversight Boards).

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

Recommendation 14

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended scheduled community care appointments and received care.

VISN concurs.

Target date for completion: May 28, 2024.

VISN response: FGB Chapter 4:05.04.00 states community care staff will verify the Veteran attended the appointment by calling the Community Provider, calling the Veteran or using other tasks including the Health Share Referral Manager (HSRM) Task List (including obtaining Medical Records).

On May 28th, the VISN 9 BIM [Business Implementation Manager] and Community Care Chief confirmed that the VISN 9 facilities currently use the HSRM Task List and VEText to verify care. A text message is sent the day following a scheduled appointment. The Veteran can reply with Attended, Not Attended, Cancelled or Rescheduled (and enter the new appointment information).

Consults are not closed, administratively or clinically, without verifying that care took place.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions for the recommendation until they are completed.

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