



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Summary Report for Fiscal Year 2022

BE A
VOICE FOR
VETERANS

REPORT WRONGDOING
va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US



Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at [@VetAffairsOIG](https://twitter.com/VetAffairsOIG).

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

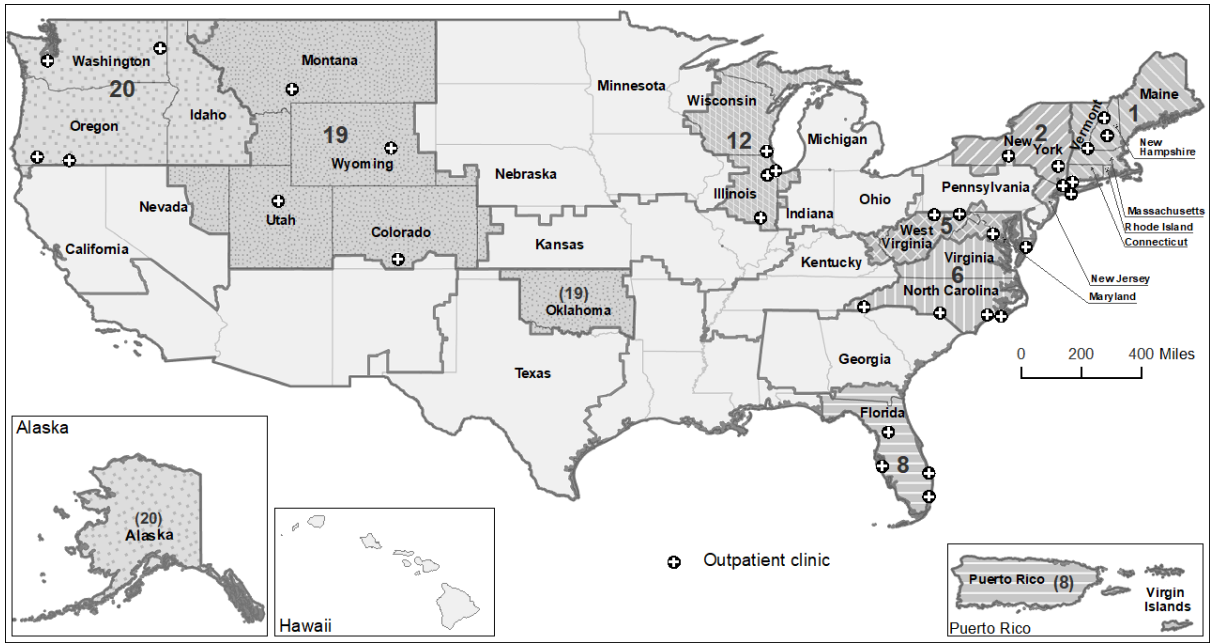


Figure 1. Fiscal year 2022 Care in the Community review locations: Veterans Integrated Service Networks 1, 2, 5, 6, 8, 12, 19, and 20.

Source: VA OIG.

Abbreviations

CBOC	community-based outpatient clinic
CCN	Community Care Network
CITC	Care in the Community
CHF	congestive heart failure
IVC	Integrated Veteran Care
OCC	Office of Community Care
OIG	Office of Inspector General
TPA	third-party administrator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This fiscal year 2022 Office of Inspector General (OIG) Care in the Community (CITC) healthcare inspection report provides summary results from the focused evaluations conducted in eight Veterans Integrated Service Networks (VISNs).¹ The OIG examined selected care processes delivered through the associated VA community-based outpatient clinics and community (non-VA) providers.

In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated “VA community care programs into one,” the Veterans Community Care Program.² This program simplified the process for veterans to receive non-VA care by expanding eligibility criteria, improving customer service, and providing a way for veterans to access in-network walk-in care without prior authorization.³ VISN leaders are responsible for ensuring “care, treatment, and services” are provided safely and effectively regardless of whether they are delivered by VA or non-VA providers.⁴

The OIG reviewed six areas of administrative and clinical operations:

1. Leadership: oversight and management of care in the community
2. Environment of care: emergency management of community-based outpatient clinics
3. Care coordination: congestive heart failure management
4. Primary and mental health care: diagnostic evaluations for depression and alcohol use disorder
5. Quality of care: home dialysis care

¹ VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). The eight VISNs covered in this report are: VISN 1: VA New England Healthcare System, VISN 2: New York/New Jersey VA Health Care Network, VISN 5: VA Capitol Health Care Network, VISN 6: VA Mid-Atlantic Health Care Network, VISN 8: VA Sunshine Healthcare Network, VISN 12: VA Great Lakes Health Care System, VISN 19: VA Rocky Mountain Network, and VISN 20: VA Northwest Health Network.

² Maintaining 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.veterans.senate.gov/services/files/E2D04FDE-4B08-4B84-988A-D5EEA907D1A7>.

³ VHA Office of Community Care, “Veteran Community Care General Information,” September 9, 2019.

⁴ The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09, July 1, 2021.

6. Women's health: mammography services by community providers⁵

The OIG conducted virtual and on-site inspections from October 2021 to September 2022. Each inspection involved interviews with key VISN staff and reviews of clinical and administrative processes used to deliver care in locations separate from the parent facility. The findings presented in this report are a snapshot of VISN oversight of the quality of care provided in VA and non-VA community-based settings within the identified focus areas at the time of the OIG review. Because gauging the quality of well-delivered and coordinated care between VA and non-VA providers is complex, this report aims to share findings that may help Veterans Health Administration leaders address vulnerabilities to improve healthcare quality for veterans.

Results Summary

The OIG noted opportunities for improvement and issued seven recommendations to the Under Secretary for Health, in conjunction with VISN directors, in the Care Coordination and Quality of Care areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided within a particular VISN, at its community-based outpatient clinics, or by non-VA providers. The intent is for leaders to use recommendations as a road map to help improve oversight of operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 26.

⁵ This was a congressionally mandated review, and the OIG will report the results of the evaluation of mammography services by community providers in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts in this area of women's healthcare services.

VA Comments

The Under Secretary for Health agreed with the Care in the Community healthcare inspection program findings and recommendations and provided acceptable improvement plans (see appendix C, page 29, and the responses within the body of the report for the full text of the Under Secretary for Health's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations	ii
Report Overview	iii
Purpose and Scope	1
Background	2
Veterans Integrated Service Networks	2
Community-Based Outpatient Clinics	2
Community Care	3
Methodology	6
Results and Recommendations	7
Leadership: Oversight and Management of Care in the Community	7
Environment of Care: Emergency Management of Community-Based Outpatient Clinics	12
Care Coordination: Congestive Heart Failure Management	15
Recommendation 1	16
Recommendation 2	17
Recommendation 3	17
Recommendation 4	18
Primary and Mental Health Care: Diagnostic Evaluations for Depression and Alcohol Use Disorder	19
Quality of Care: Home Dialysis Care	21

Recommendation 5	22
Recommendation 6	23
Recommendation 7	24
Report Conclusion.....	25
Appendix A: Care in the Community Program Recommendations.....	26
Appendix B: Community-Based Outpatient Clinics Inspected in Fiscal Year 2022.....	27
Appendix C: Office of the Under Secretary for Health Comments.....	29
OIG Contact and Staff Acknowledgments	30
Report Distribution	31



Purpose and Scope

The purpose of the Office of Inspector General (OIG) Care in the Community (CITC) healthcare inspection program is to evaluate various aspects of care delivered in Veterans Health Administration (VHA) community-based outpatient clinics (CBOCs) and through non-VA healthcare providers. In fiscal year 2022, the OIG reviewed eight Veterans Integrated Service Networks (VISNs), which are responsible for oversight of care provided by their associated medical facilities, CBOCs, and non-VA providers.¹

Effective leaders make decisions that directly or indirectly affect every aspect of operations. They “create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services.”² The OIG evaluated key processes associated with quality care and positive patient outcomes and reported its findings to VISN leaders to help guide improvements in their oversight of operations and clinical care.

The findings presented in this report are a snapshot of the quality of care provided within selected VISNs from July 1, 2020, through June 30, 2021. To examine VISN oversight and the care provided in CBOCs and by non-VA providers, the OIG reviewed VHA requirements and Joint Commission standards and evaluated core processes in the following six areas of administrative and clinical operations:

1. Leadership: oversight and management of care in the community
2. Environment of care: emergency management of community-based outpatient clinics
3. Care coordination: congestive heart failure (CHF) management
4. Primary and mental health care: diagnostic evaluations for depression and alcohol use disorder
5. Quality of care: home dialysis care
6. Women’s health: mammography services by community providers³

¹ VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). The eight VISNs covered in this report are: VISN 1: VA New England Healthcare System, VISN 2: New York/New Jersey VA Health Care Network, VISN 5: VA Capitol Health Care Network, VISN 6: VA Mid-Atlantic Health Care Network, VISN 8: VA Sunshine Healthcare Network, VISN 12: VA Great Lakes Health Care System, VISN 19: VA Rocky Mountain Network, and VISN 20: VA Northwest Health Network.

² The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09, July 1, 2021.

³ This was a congressionally mandated review, and the OIG will report the results of the evaluation of mammography services by community providers in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts in this area of women’s healthcare services.

Background

Veterans Integrated Service Networks

A VISN is a regional system of VHA healthcare facilities. VHA established 18 VISNs to meet local healthcare needs and increase access to care.⁴ A VISN covers a geographic area defined by “patient referral patterns; numbers of beneficiaries and facilities needed to support and provide” care, as well as “boundaries such as state borders.”⁵ Under the VISN model, care is provided at VA medical facilities and CBOCs, and through contractual or sharing agreements with non-VA providers. In VA’s healthcare system, the VISN is “the basic budgetary and planning” entity.⁶ In general, a VISN director is responsible for implementing VA policies and ensuring VISN facilities have adequate staff and resources to achieve national and local performance improvement goals.⁷ Additionally, VHA has Community Care Network (CCN) contracts with community providers who provide health care for veterans when services are not available at VA facilities.⁸

Community-Based Outpatient Clinics

A CBOC is an outpatient site where veterans receive healthcare services geographically located apart from its parent VHA facility. VHA uses CBOCs to make health care more accessible to veterans and reduce their need to visit a larger medical facility for outpatient care.⁹ CBOCs provide primary, specialty, and mental health care, or any combination of these, and operate from one to seven days per week.¹⁰

⁴ “About VHA,” VHA, accessed July 23, 2020, <https://www.va.gov/health/aboutvha.asp>.

⁵ *Hearing on the Curious Case of the VISN Takeover: Assessing VA’s Governance Structure, Hearing Before the House Committee on Veterans’ Affairs*, 115th Cong. (May 22, 2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs).

⁶ Carolyn Clancy, statement before the House Committee on Veterans’ Affairs.

⁷ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

⁸ VHA Office of Community Care (OCC), “Community Care Network (CCN)—Regions 1-4, for Veterans,” May 7, 2020.

⁹ “About VHA,” VHA.

¹⁰ VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

Community Care

VHA leaders are responsible for providing oversight to ensure “care, treatment, and services provided” to veterans “are safe and effective.” Veterans should receive “the same level of care” regardless of whether it is delivered by VA or non-VA providers.¹¹

In 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act “consolidated seven VA community care programs into one,” the Veterans Community Care Program.¹² This program simplified veterans’ access to non-VA care by expanding eligibility criteria, improving customer service, and providing a way for veterans to receive walk-in care without prior authorization.¹³

The goal of VHA’s Office of Integrated Veteran Care (IVC) is to deliver a consolidated program that is easy to use and meets the needs of stakeholders.¹⁴ VHA facility providers may refer care to non-VA providers for eligible veterans who chose care in the community.¹⁵

VHA’s *Field Guidebook* outlines community care requirements, processes, and tools related to eligibility, referral, and care coordination. It also provides guidance for VA staff managing non-VA care consults, appointment scheduling, and communication between VA and non-VA providers.¹⁶ According to the guidebook, the ordering provider initiates the non-VA care referral process by placing a consult request for non-VA care. Community care staff then determines whether the care is available at VHA, or the veteran is eligible for referral to a non-VA provider.¹⁷ Depending on VHA facility operations and patient preferences, appointments may be scheduled by

- community care staff,
- the patient,
- the community provider,

¹¹ *Standards Manual*, E-dition, LD.04.03.09.

¹² Maintaining 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.veterans.senate.gov/services/files/E2D04FDE-4B08-4B84-988A-D5EEA907D1A7>.

¹³ VHA OCC, “Fact Sheet Veteran Community Care General Information,” September 9, 2019.

¹⁴ During the review timeframe, VA’s OCC and Office of Veterans Access to Care combined to form the Office of Integrated Veteran Care (IVC). For this report, the OIG used the program title IVC for the entire review. Acting Under Secretary for Health, Veterans Health Administration memo, “Notification of Program Office Reorganization,” September 23, 2021.

¹⁵ VHA OCC, *Field Guidebook*, chap. 1: “Introduction to the Community Care Network,” updated July 1, 2021; MISSION Act § 101.

¹⁶ VHA OCC, *Field Guidebook*.

¹⁷ VHA OCC, *Field Guidebook*, chap. 2: “Eligibility, Referral, and Scheduling,” updated June 1, 2022.

- third-party administrator (TPA) staff, or
- any combination of these.¹⁸

Community care staff request that patients inform them of the appointment date and time when they schedule directly with community providers. If a patient does not provide the appointment date, staff are not required to contact the patient to obtain the appointment information. In that event, community care staff wait 30 days from the date the patient elected to self-schedule and then contact the community provider to obtain and record the appointment information.¹⁹

Patients' self-scheduled appointments are excluded from certain VHA timeliness reporting requirements—for example, when consults are in an active status for longer than 30 days.²⁰

The non-VA provider is responsible for sending medical documentation to the ordering provider within 30 days of the initial appointment. Non-VA providers can submit this documentation using a variety of methods, including through the health share referral manager, TPA's portal, electronic fax, other electronic means, or on paper.²¹ Once received, VA staff then attach it to the relevant consult in the patient's electronic health record, which creates an alert notifying the ordering provider that the consult was completed.²²

VHA does not require receipt of medical documentation for consult closure.²³ Although VHA expects staff to work with community providers to ensure they submit the documentation, it requires staff to close the consults 90 days after the appointment date even if they have not received it. If community care staff have not received the documentation from the non-VA provider after 14 days of the initial scheduled appointment, they must contact the patient to confirm attendance of the appointment and then attempt to retrieve the documentation of care provided.²⁴ Community care staff record their attempts to retrieve the documentation from the community provider in the electronic health record. VHA requires staff to make three attempts to obtain medical documentation. They must close a consult after making and documenting only one attempt but make the subsequent attempts within 90 days.²⁵ If staff are unable to get the documentation, they close the consult and note it as "administratively closed without records."²⁶

¹⁸ VHA OCC, *Field Guidebook*, chap. 3: "How to Perform Care Coordination." A TPA is "a company that is contracted by VHA to create a regional network of providers that provide care to Veterans." VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, March 2021.

¹⁹ VHA OCC, *Field Guidebook*, chap. 3.

²⁰ VHA OCC, *Field Guidebook*, chap. 3.

²¹ VHA OCC, *Field Guidebook*, chap. 3.

²² VHA OCC, *Field Guidebook*, chap. 3 and chap. 4: "Consult Completion and Medical Records Management."

²³ VHA OCC, *Field Guidebook*, chap. 4; MISSION Act § 111.

²⁴ VHA OCC, *Field Guidebook*, chaps. 3 and 4.

²⁵ Assistant Under Secretary for Health for Community Care memo, "Revised Administrative Closure of Community Care Consults Process," October 1, 2021.

²⁶ VHA OCC, *Field Guidebook*, chap. 4.

According to VHA, “administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation [are] expected to ensure continuity of care.”²⁷ Figure 2 is a diagram of the community care consult process from consult receipt in community care to consult closure.

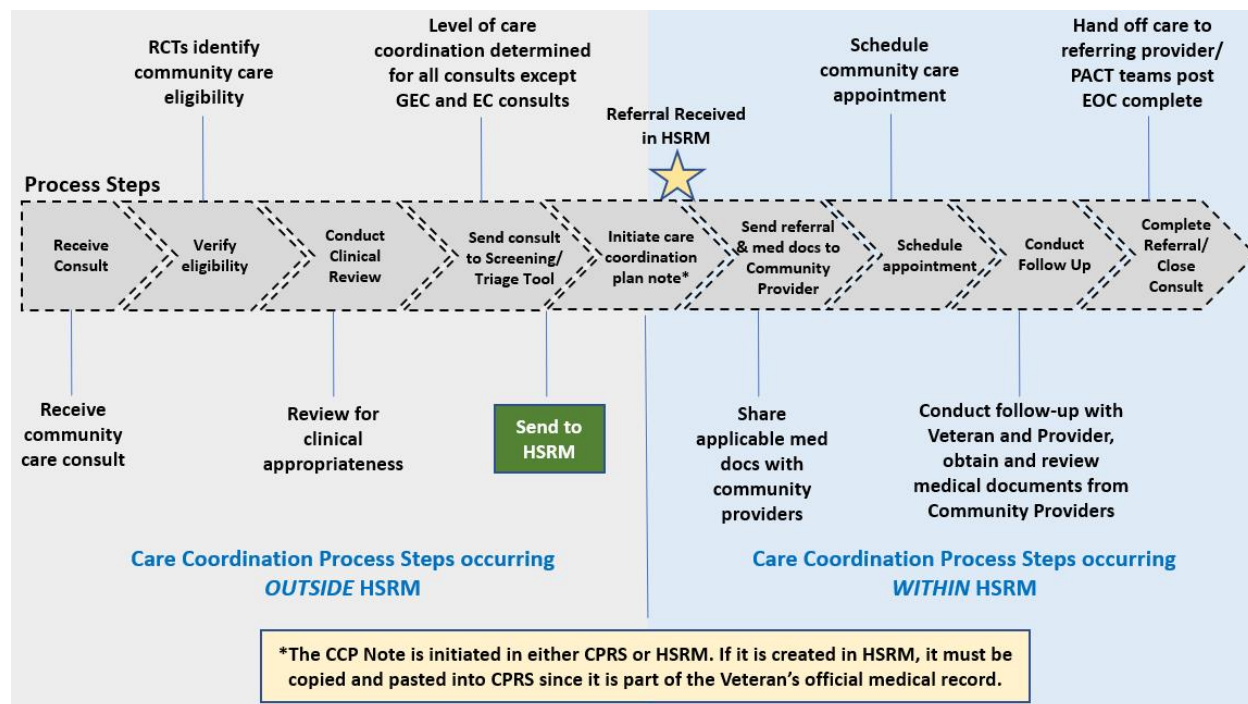


Figure 2. The community care consult process.

Source: VHA Office of Community Care (OCC) Field Guidebook.

CCP = Community Care Plan

CPRS = Computerized Patient Record System

EC = Extended Care

EOC = Episode of Care

GEC = Geriatrics and Extended Care

HSRM = Health Share Referral Manager

PACT = Patient Aligned Care Team

RCT = Referral Coordination Team

²⁷ VHA OCC, *Field Guidebook*, chap. 4.

Methodology

The OIG evaluated compliance with selected topics across eight randomly selected VISNs during fiscal year 2022 and conducted the reviews from October 2021 through September 2022.²⁸ Each involved interviews with VISN leaders and staff and reviews of clinical and administrative processes. The OIG team also reviewed the electronic health records of patients who received care by CBOC or non-VA providers from July 1, 2020, through June 30, 2021. Lastly, the team physically inspected 16 randomly selected CBOCs' environments of care (details are in appendix B).

The OIG analyzed aggregated data from the individual VISN inspections to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance. During the site visits, the OIG did not receive any complaints beyond the scope of the inspections that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.²⁹ 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.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. The Under Secretary for Health's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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.

²⁸ The OIG selected CBOCs from a statistical sample of CBOCs in each VISN.

²⁹ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership: Oversight and Management of Care in the Community

To assess VISN leaders' oversight and management of community care, the OIG reviewed the following key processes:

- Community care oversight council
- Patient safety
- TPA oversight
- Non-VA provider medical documentation scanning backlog

Community Care Oversight Council

According to VA, “an Oversight Council is comprised of clinical and business representatives who work together to ensure appropriate resources are allocated to deliver a quality experience to all community care stakeholders.”³⁰ The presence of a VISN community care oversight council is critical to the monitoring and performance improvement of a VISN's community care program and ensuring consistency in practice.

Leaders from seven of the eight VISNs reviewed reported establishing a VISN community care council to oversee administrative and clinical processes related to the program.³¹ According to VISN leaders, the councils reviewed TPA service coverage, community care consult performance, patient safety incidents, and patient complaints during meetings and shared examples of corrective actions taken. Leaders in the VISN that had not established a council reported providing oversight by reviewing facility councils' meeting minutes and talking to community care service chiefs weekly.

Patient Safety

VHA defines adverse events as “untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered

³⁰ “Community Care Oversight Council,” VA Community Care, October 11, 2017.

³¹ VHA Deputy Under Secretary for Health for Operations and Management memo, “National Implementation of the Community Care Operating Model,” October 17, 2017; “Community Care Oversight Council,” VA SharePoint website. VISN 6 leaders reported not having a community care oversight council at the time of the review. They stated the council charter had been signed but no meetings had occurred.

by VA providers.”³² Patient safety events in community care include adverse events and close calls “that occur when Veterans are receiving care on behalf of VA in the community.”³³ VHA developed the *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook* (patient safety guidebook) through collaboration with VHA program offices “to improve information sharing, reporting, and feedback to stakeholders for patient safety events.”³⁴ The patient safety guidebook promotes teamwork between VHA and community partners “to mitigate system vulnerabilities and improve patient safety by detailing processes related to identifying and reporting patient safety events,” then “analyzing and resolving [the] root causes related to the occurrence of those events.”³⁵ The guidebook states that

- facility and VISN patient safety committees should complete a quarterly review of patient safety events, trends, and severity reports,
- the VISN review process should include TPA representatives when applicable, and
- patient safety staff should provide quarterly review results to VISN leaders.³⁶

The OIG interviewed VISN leaders regarding their oversight of CITC patient safety processes. For example, leaders in VISN 12 reported implementing a weekly tracking log of new and outstanding potential quality issues, sending the list of issues to the TPA, and expecting follow-up. The VISN leaders also stated they used the tracking log to improve timeliness of follow-up (TPAs had up to six months to respond to potential quality issues, but some did not respond for as long as a year). Previously, VISN 12 leaders stopped initiating new referrals to a non-VA provider after submitting potential quality issues to the TPA for investigation; however, the TPA did not inform the VISN that the investigation had concluded so referrals could resume. Referrals resumed only after the non-VA provider contacted the VA.

Third-Party Administrator Oversight

VA partnered with two TPAs to manage the CCN: Optum Public Sector Solutions, Inc. (Optum), which is part of United Health Group, Inc., and TriWest Healthcare Alliance.³⁷ Figure 3 is a map

³² VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. Merriam-Webster defines iatrogenic as “induced unintentionally by a physician or surgeon or by medical treatment or diagnostic procedures.” *Merriam-Webster.com Dictionary*, “iatrogenic,” accessed February 14, 2023, <https://www.merriam-webster.com/dictionary/iatrogenic>.

³³ VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, March 2021.

³⁴ VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

³⁵ VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

³⁶ VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*. VHA staff report a community care patient safety event to the TPA as a “potential quality issue.”

³⁷ VHA OCC, “Community Care Network (CCN)—Regions 1-4, for Veterans;” VHA OCC, “Community Care Network (CCN)—Region 5 Fact Sheet for Veterans,” March 3, 2021.

of the CCN, which shows the TPAs for each of the five regions. Optum manages regions 1, 2, and 3.³⁸ TriWest manages regions 4 and 5.³⁹ VISNs 1, 2, 5, and 6 are located in region 1; VISN 12 is located in region 2; VISN 8 is located in region 3; and VISNs 19 and 20 are located in region 4.⁴⁰

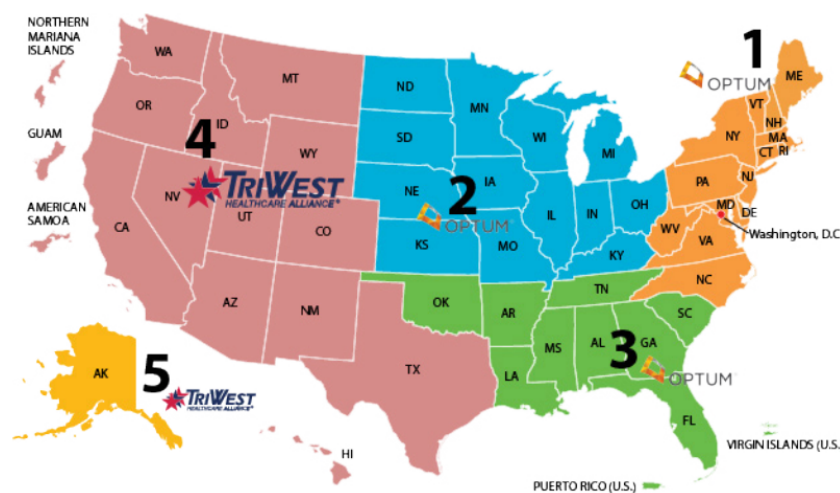


Figure 3. The five regions of the Community Care Network.

Source: VHA “Community Care Network (CCN),” January 21, 2022.

To determine how VISN leaders oversaw care provided by the CCN, the OIG evaluated if they

- assessed community providers’ patient safety or incident data, patient complaints, and network adequacy;
- ensured veterans received quality care from non-VA providers; and
- met regularly with TPA representatives.

Leaders at all eight VISNs reported holding regular meetings with their respective TPAs to discuss patient safety concerns, patient complaints, and provider coverage. Leaders reported being aware of available processes to request that specific non-VA providers be evaluated by the TPA and subsequently deactivated from receiving further referrals based on the results. Leaders at four of the eight VISNs stated they also used the meetings to discuss difficulties and delays with obtaining medical documentation from non-VA providers.⁴¹ For example, leaders at one VISN explained that VA pays the bills for services provided to veterans while community care

³⁸ VHA OCC, “Community Care Network (CCN)—Regions 1-4, for Veterans.”

³⁹ VHA OCC, “Community Care Network (CCN)—Regions 1-4, for Veterans;” VHA OCC, “Community Care Network (CCN) Region 5 Fact Sheet for Veterans.”

⁴⁰ VHA OCC, “Community Care Network (CCN) Region 5 Fact Sheet for Veterans.”

⁴¹ Leaders at VISNs 2, 5, 8, and 12 reported the information.

staff at their facilities simultaneously and repeatedly ask for the associated documentation of care provided so they can update the veterans' electronic health records. These staff members expressed their frustration because they are unable to motivate non-VA providers to provide the documentation. The leaders also reported believing that resolving this issue would positively affect continuity of care and patient safety.

VISN 12 leaders discussed a billing concern in which TPA personnel were not correctly capturing optometry medical codes nationwide, resulting in the denial of thousands of medical claims. They also reportedly identified another coding issue involving TPA staff incorrectly coding and billing specific outpatient services as urgent or emergent care. Leaders resolved these two issues through their meetings with the TPA.

When asked how VISN leaders ensured veterans received quality care from community providers, they gave a variety of responses: some VISNs delegated quality oversight to the TPA, and others reviewed TPA data in detail to identify potential quality issues. VISN leaders' responses revealed a need for VHA leaders to provide clearer guidance on the role of VA staff in ensuring veterans received quality care, sharing best practices, and actively monitoring performance.

Non-VA Provider Medical Documentation Scanning Backlog

VHA requires staff to scan medical documentation that is faxed or mailed to VHA by non-VA providers into patients' electronic health records.⁴² VHA also requires leaders in each VISN to designate a point of contact to ensure all facilities eliminate any scanning backlogs and have adequate resources and processes to prevent future backlogs.⁴³ The OIG team interviewed VISN leaders to determine if they complied with these requirements and how they prevented scanning backlogs or addressed any existing backlogs.

The leaders reported designating points of contact to monitor and oversee scanning activities. Six of eight VISN leaders reported the existence of scanning backlogs and described mitigating actions taken.⁴⁴ These actions included offering overtime to employees, using contracted staff for scanning services, having staff from other medical facilities help those with backlogs, and reassigning staff from other work areas to assist with scanning. Leaders at one VISN reported backlogs related to intermittent equipment and technology failures. Specifically, the leaders gave an example of receiving up to 6,000 faxes a day when electronic documentation transmission was interrupted, creating an immediate scanning backlog. They attributed the interruptions to limited internet bandwidth and unreliable technology.

⁴² VHA OCC, *Field Guidebook*, chap. 3.

⁴³ VHA Deputy Under Secretary for Health for Operations and Management memo, "Monitoring Health Record Scanning/Importing Backlog," August 20, 2018.

⁴⁴ Leaders in VISNs 1, 5, 6, 8, 19, and 20 reported the information.

Despite these challenges, referring providers' access to pertinent information from non-VA providers is essential for the monitoring of quality and coordination of care; therefore, it is critical that staff scan these documents into patients' electronic health records in a timely manner.

Leadership: Oversight and Management of Care in the Community Findings and Recommendations

The OIG noted that variations in how VISN leaders performed TPA oversight may indicate a need for clearer VHA program office guidance regarding their role in ensuring quality care in the community. The OIG also acknowledges that there is no contractual requirement for TPAs to provide detailed information regarding potential quality issues to the reporting VA facility. However, this does not allow VA facility leaders to ensure that TPAs appropriately reviewed the issues affecting their veterans and took robust actions to prevent reoccurrences. The OIG remains concerned that VA facility leaders and their staff cannot assure care quality and patient safety.

Environment of Care: Emergency Management of Community-Based Outpatient Clinics

Any facility, regardless of its size or location, encounters vulnerabilities in the healthcare environment. The goal of VHA's Comprehensive Environment of Care Program is to prevent accidents and injuries and maintain safe conditions for patients, visitors, and staff.⁴⁵

VHA requires Comprehensive Environment of Care teams at each VHA medical facility to inspect the facility at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered," and track all deficiencies until they are resolved.⁴⁶

In addition to a facility-based program, VHA's Comprehensive Emergency Management Program ensures continuity of services during disasters or emergencies.⁴⁷ VHA also requires medical facility directors to establish an Emergency Management Committee and ensure CBOCs participate in their main facility's Comprehensive Emergency Management Program, which includes staff reviewing the Emergency Operations Plan and Hazards Vulnerability Analysis annually and developing training and exercises. Facility directors must also identify an emergency management lead at each clinical care site not located at the main facility.⁴⁸ Additionally, each CBOC manager is responsible for participating in the main facility's emergency plan and training clinic staff.⁴⁹

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.⁵⁰ VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related

⁴⁵ The Comprehensive Environment of Care Program "establishes the process that will be used to define, standardize, monitor, review, maintain, and improve the environment in which health care services are provided throughout VHA." Environment of care is defined as "the building or space, including how it is arranged and the special features that protect patients, visitors, and staff; equipment used to support patient care or to safely operate the building or space; and people, including those who work within the hospital, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks." VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VHA amended this directive September 7, 2023.)

⁴⁶ VHA Directive 1608.

⁴⁷ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

⁴⁸ VHA Directive 0320.01. A Hazards Vulnerability Analysis identifies hazards in the environment that can affect safety and continuity of operations. VHA Center for Engineering & Occupational Safety and Health (CEOSH), *VHA Emergency Management Program Guidebook*, March 2011.

⁴⁹ VHA Directive 0320.01.

⁵⁰ Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," November 17, 2021, accessed October 6, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.⁵¹

The OIG reviewed the following for each CBOC:

- Completion of the required number of inspections and tracking of deficiencies
- Completion of an annual review of the Hazards Vulnerability Analysis
- Inclusion of CBOCs in the facility's Emergency Operations Plan
- Appointment of an emergency management lead
- Training of CBOC staff on the Emergency Operations Plan

Additionally, the OIG physically inspected 16 of the CBOCs located in VISNs 6, 12, 19, and 20 and evaluated the following performance indicators:⁵²

- General safety
- Environmental cleanliness and infection prevention
- Privacy and camera use
- Accommodation and privacy for women veterans
- Medical equipment and supply availability
- Rapid Naloxone Initiative
- Panic alarms

⁵¹ Opioids are medications that are “effective at reducing pain” but “when taken in excess, can lead to respiratory arrest.” Naloxone “is a highly effective treatment for reversing an opioid overdose.” “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA. AEDs are devices used to treat sudden cardiac arrest. US Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed September 30, 2022, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>. “Pharmacy Benefits Management Services,” Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

⁵² The OIG inspected CBOCs in Morehead City, NC; Jacksonville, NC; Franklin, NC; Hamlet, NC; Chicago, IL; Mattoon, IL; Joliet, IL; Union Grove, WI; Bozeman, MT; Alamosa, CO; Orem, UT; Casper, WY; Klamath Falls, OR; Olympia, WA; Spokane, WA; and Grants Pass, OR.

Environment of Care Findings and Recommendations

VHA requires treatment areas with video recording devices to have notices posted announcing the area is subject to recording.⁵³ The OIG found three CBOCs with video recording in patient care areas and each lacked posted notices. This may have resulted in a lack of patient privacy. Staff reported being unaware of the requirement.

VHA also requires facilities that have implemented the Rapid Naloxone Initiative to ensure Automated External Defibrillator cabinets stocked with naloxone are clearly marked, alarmed, and secured. Additionally, staff must check the cabinets daily to ensure naloxone is unexpired.⁵⁴ Of six CBOCs that had the initiative implemented, the OIG found three clinics lacked properly secured cabinets and three lacked evidence of daily checks.⁵⁵ Unsecured cabinets and lack of daily checks increase the risk of theft, diversion, and decreased efficacy of naloxone if the medication expires. When the OIG asked about reasons for noncompliance, staff reported being unaware of the requirement, already correcting the deficiency, or checking cabinets weekly or monthly instead of daily.

The OIG made no recommendations due to the small sample of CBOCs reviewed.

⁵³ VHA Directive 1078(1), *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 4, 2014, amended November 19, 2014. (VHA rescinded and replaced this directive with VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021. Unless otherwise specified, the directive contains the same or similar language as the rescinded document.)

⁵⁴ “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA.

⁵⁵ One clinic each within VISNs 20, 12, and 6 lacked properly secured cabinets, and one clinic in VISN 12 and two in VISN 6 lacked evidence of daily checks.

Care Coordination: Congestive Heart Failure Management

Congestive Heart Failure (CHF) is a condition that results when the heart is unable to pump blood effectively to meet physiologic needs. When blood does not circulate as it should, fluid can accumulate in organs and tissue spaces such as the lungs, abdominal cavity, and lower extremities.⁵⁶ CHF is projected to affect more than 8 million people in the United States by 2030. Because CHF is a leading cause of VA hospital admissions, VA has established evidence-based guidelines for its treatment with the goal of allowing veterans to live longer with a better quality of life.⁵⁷

VHA primary care providers may refer veterans with CHF to VA or non-VA cardiologists for management of their condition.⁵⁸ Care coordination is a way to organize veterans' care and facilitate delivery of healthcare services among multiple providers or systems. It involves a comprehensive plan of care and links veterans, their families, and caregivers to services and resources.⁵⁹ VHA's IVC office staff developed a standardized Community Care Coordination Model to facilitate veterans' care transition between VA facilities and non-VA providers.⁶⁰ Community care staff assign a level of care coordination to each veteran, which indicates the "intensity, frequency, duration and care coordination services required."⁶¹ The levels range from basic, requiring coordination on an as-needed basis, to complex or chronic, requiring a higher level of coordination.⁶²

VHA established targets rather than requirements for appointment scheduling. In April 2021, prior to the OIG review period, the IVC office set 21 days after the consult entry date as the scheduling target.⁶³ For this review, the OIG evaluated electronic health records and determined whether staff scheduled community care appointments within 21 days of the consult entry date.

The OIG evaluated the electronic health records of 678 patients with at least a two-year history of CHF who had received a community care cardiology consult from a CBOC provider.

⁵⁶ "Heart Failure," National Heart, Lung, and Blood Institute, accessed September 23, 2020, <https://www.nhlbi.nih.gov/health-topics/heart-failure>.

⁵⁷ "Managing Heart Failure in Primary Care," VHA Pharmacy Benefits Management (PBM) Academic Detailing Service, accessed July 7, 2021, https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/HeartFailure_Provider_ProviderGuide_IB101161.pdf.

⁵⁸ VHA OCC, *Field Guidebook*, chap. 3.

⁵⁹ VHA Directive 1110.04(1), *Integrated Case Management Standards of Practice*, September 6, 2019, amended May 18, 2020.

⁶⁰ VHA Deputy Under Secretary for Health for Operations and Management memo, "National Deployment of the Community Care Coordination Model," September 16, 2019.

⁶¹ VHA OCC, *Field Guidebook*, chap. 3.

⁶² VHA OCC, *Field Guidebook*, chap. 3.

⁶³ The 21-day target applied to all consults except future care consults with a requested date for care greater than 90 days from consult initiation.

Care Coordination Findings and Recommendations

VHA requires that staff document veterans' care coordination needs within the templated Community Care Coordination Plan note for consults assigned a level of care coordination above basic.⁶⁴ The OIG did not find evidence staff used the note to document veterans' care coordination plans for an estimated 70.6 (95% CI: 60.0 to 81.9) percent of community care cardiology consults, which is statistically significantly above the OIG's 10 percent deficiency benchmark.⁶⁵ Failure to use the templated note may result in uncoordinated and delayed care. Staff-reported reasons for noncompliance included lack of leadership involvement, inadequate attention to detail, and managers' belief that staff's documentation of care coordination activities in other areas of the electronic health record met requirements.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures staff document veterans' care coordination needs within the Community Care Coordination Plan note for consults assigned a level of care coordination above basic.

VHA concurred.

Target date for completion: September 2024

VHA response: The Veterans Health Administration (VHA) Office of the Assistant Under Secretary for Health (AUSH) for Integrated Veteran Care (IVC), in collaboration with the Office of AUSH for Operations (OPS), will develop an integrated project team (IPT) to reassess applicable policies, analyze compliance data, and develop a strategy to address the areas of non-compliance related to documenting care coordination needs within the Community Care Coordination Plan for consults assigned a level of care greater than basic.

VHA requires staff to act on consults within two business days after receiving the referral request and document this step by changing the consult status.⁶⁶ The OIG estimated that staff did not act on 28.7 (95% CI: 19.4 to 38.2) percent of community care cardiology consults within two business days. Inaction on the consult within the required time frame delays the scheduling of

⁶⁴ VHA Deputy Under Secretary for Health for Operations and Management memo, "National Deployment of the Community Care Coordination Model;" VHA OCC, *Field Guidebook*, chap. 3.

⁶⁵ 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 study design, the true value would have been covered by the confidence intervals 95 percent of the time.

⁶⁶ VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021. (VHA made more updates following this publication, most recently with 1232(5) on December 5, 2022.)

community care appointments.⁶⁷ Reasons given for overall noncompliance included staffing challenges that caused consult backlogs and clinical staff evaluating consults prior to community care staff initiating scheduling, which led to delays.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures staff act on consults no later than two business days after receipt and document accordingly.

VHA concurred.

Target date for completion: September 2024

VHA response: The VHA Office of the AUSH for IVC in collaboration with the Office of the AUSH for OPS will develop an IPT to reassess applicable policies, analyze compliance data, and develop a strategy to address the areas of non-compliance regarding consults that have no action in two business days after receipt.

VHA also requires staff to schedule community care appointments in a timely manner.⁶⁸ The OIG evaluated scheduled appointments against the 21-day target. The OIG estimated that for 31.3 (95% CI: 23.2 to 39.8) percent of consults, staff did not schedule the appointments within 21 days. Failure to schedule appointments in a timely manner may lead to delays in care. Several staff members attributed noncompliance to staffing issues affecting their ability to meet the requirement.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures staff schedule community care appointments in a timely manner.

⁶⁷ VHA Directive 1232(3).

⁶⁸ VHA Directive 1232(3).

VHA concurred.

Target date for completion: September 2024

VHA response: The VHA Office of the AUSH for IVC, in collaboration with the Office of AUSH for OPS, will develop an IPT to reassess applicable policies, analyze compliance data, and develop a strategy to address the areas of non-compliance regarding community care appointments that are not scheduled in a timely manner.

VHA allows staff to administratively close community care consults after confirming the initial appointment attendance and documenting one attempt to retrieve the related medical documentation. However, VHA also requires staff to make and document two additional attempts to retrieve the documentation after the consults' administrative closure.⁶⁹ The OIG estimated that staff did not make three attempts to obtain medical documentation for 64.3 (95% CI: 47.5 to 81.0) percent of community care cardiology consults that were administratively closed. If VA providers do not receive the medical documentation from non-VA providers, it may hinder them from providing adequate follow-up care.⁷⁰ Community care leaders and staff acknowledged a lack of follow-through in making the additional contact attempts.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures staff make three attempts to retrieve medical documentation from non-VA providers.

VHA concurred.

Target date for completion: September 2024

VHA response: The VHA Office of the AUSH for IVC, in collaboration with the Office of the AUSH for OPS, will develop an IPT to reassess applicable policies, analyze compliance data, and develop a strategy to address the areas of non-compliance with attempts to retrieve medical documentation from non-VA providers.

⁶⁹ VHA OCC, *Field Guidebook*, chap. 4.

⁷⁰ VHA OCC, *Field Guidebook*, chap. 4.

Primary and Mental Health Care: Diagnostic Evaluations for Depression and Alcohol Use Disorder

Comprehensive primary care ensures patients have access to the care and services needed to improve their health and maintain their quality of life.⁷¹ Clinical preventive services—such as screenings, immunizations, health education, and preventive medications—are part of primary care. These services may help prevent or detect disease early in patients who do not have symptoms and improve health outcomes.⁷² Primary care staff screen patients for conditions like depression and alcohol use disorder.⁷³ They also educate and refer patients to specialty care when clinically indicated.⁷⁴

“Major depression is one of the most common mental disorders in the United States” and can cause sadness, loss of energy or interest in activities, withdrawal from interactions with other people, feelings of hopelessness, and thoughts of suicide.⁷⁵ VHA requires diagnostic evaluations for patients who screen positive for depression.⁷⁶

Additionally, excessive alcohol use is associated with health problems including chronic diseases and unintentional injuries, as well as homicide and suicide.⁷⁷ At the time of the inspection, VHA required clinicians to complete a diagnostic evaluation of patients who screen positive for alcohol misuse and educate and counsel them on drinking limits and negative effects of heavy drinking.⁷⁸

To determine whether clinicians complied with the requirement for a diagnostic evaluation, the OIG team reviewed the electronic health records of 677 patients who had a positive depression screen. The team also reviewed the electronic health records of 759 patients to assess CBOC clinicians’ compliance with diagnostic evaluations of patients with positive alcohol use disorder screens and provision of education and counseling.

⁷¹ VHA Handbook 1101.10(1).

⁷² VHA Handbook 1101.10(1).

⁷³ VHA Handbook 1101.10(1).

⁷⁴ VHA Handbook 1101.10(1).

⁷⁵ “VA Research on Depression,” VA Office of Research & Development, accessed September 1, 2021, https://www.research.va.gov/pubs/docs/va_factsheets/Depression.pdf.

⁷⁶ *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 4.0, February 2022; “Veterans Health Information Systems and Technology Architecture (VistA) Clinical Reminders, MH Reminder Updates, Installation and Setup Guide, February 2017,” VA Product Development website.

⁷⁷ “Alcohol and Public Health Frequently Asked Questions,” Centers for Disease Control and Prevention, accessed August 26, 2020, <https://www.cdc.gov/alcohol/faqs.htm>.

⁷⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Primary and Mental Health Care Findings and Recommendations

VHA required providers to complete diagnostic evaluations for patients identified as at risk for alcohol misuse through a positive screen.⁷⁹ The OIG estimated that 22.0 (95% CI: 19.0 and 25.2) percent of patients did not receive a diagnostic evaluation following a positive alcohol screen. Failure to conduct diagnostic evaluations after positive alcohol screens could result in missed opportunities for providers and patients to discuss treatment options. Reasons provided for noncompliance included lack of oversight and inadequate reporting systems that would allow staff to monitor compliance.

VHA also required clinicians to educate and counsel patients who are identified as at risk for alcohol use disorder following a positive screen.⁸⁰ The OIG estimated that 19.9 (95% CI: 16.8 and 22.9) percent of patients did not receive education and counseling following a positive alcohol screen, which could result in missed opportunities for clinicians to inform them about the effects of alcohol. Staff attributed noncompliance to lack of oversight.

VHA rescinded the guidance in effect during fiscal year 2022, and the current guidance no longer requires clinicians to conduct a diagnostic evaluation after a positive alcohol screen or educate and counsel patients following a positive screen.⁸¹ The OIG did not issue recommendations but without these requirements, clinicians could miss opportunities to offer treatment options or educate at-risk patients on drinking limits and negative effects of excessive alcohol use.

⁷⁹ VHA Handbook 1160.01.

⁸⁰ VHA Handbook 1160.01.

⁸¹ VHA Directive 1160.01.

Quality of Care: Home Dialysis Care

Home dialysis provided by VHA may offer advantages over in-center (VA and non-VA) dialysis, including increased access to care for veterans with end-stage renal disease, especially when patients live far from VA medical centers.⁸² In addition, patients may experience improved quality of life with “greater survival and fewer hospitalizations,” and costs may be lower than contracted dialysis service.⁸³ All VHA dialysis programs must offer home dialysis to medically qualified patients with end-stage renal disease.⁸⁴ Additionally, VHA requires

VISN directors [to] convene a VISN Dialysis Council...with Dialysis Program representation from each VA medical facility in the VISN for the purpose of promoting efficient, high quality dialysis care within the VISN, coordinating the VISN operations of dialysis initiatives, harmonizing dialysis care within VISNs, and enhancing communication related to dialysis to/from VA facilities, non-VA dialysis facilities, VISN leadership, and the VHA National Kidney Program.⁸⁵

VHA also requires all dialysis outpatients to be seen at least monthly by a clinician who provides end-stage renal disease care, evidenced by a monthly progress note “endorsed by the responsible independent renal practitioner.”⁸⁶ A VHA home dialysis program must provide the following services:

- Patient training performed by a dialysis registered nurse
- Patient monitoring (patients’ self-monitored data and a clinical exam) at least every two months
- “Ongoing medical, nursing, nutritional, and social work support services,” as needed
- “Initial and periodic (at least annual) home visits”⁸⁷

⁸² Dialysis or Hemodialysis is “the process of removing blood from an artery (as of a patient affected with kidney failure), purifying it by dialysis, adding vital substances, and returning it to a vein.” *Merriam-Webster.com Dictionary*, “dialysis,” accessed August 22, 2023, <https://www.merriam-webster.com/dictionary/dialysis>. End stage renal disease “is a condition of permanent advanced CKD [chronic kidney disease].” VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

⁸³ Areef Ishani et al., “Comparative Effectiveness of Home-based Kidney Dialysis versus In-center or Other Outpatient Kidney Dialysis Locations - A Systematic Review, Department of Veterans Affairs Health Services Research & Development Service,” *Evidence Based Synthesis Program*, April 2015.

⁸⁴ VHA Handbook 1042.01.

⁸⁵ VHA Handbook 1042.01.

⁸⁶ VHA Handbook 1042.01. The clinician should be “a physician, nurse practitioner, clinical nurse specialist, or physician’s assistant.”

⁸⁷ VHA Handbook 1042.01. VHA requires home visits prior to a patient’s acceptance into the home dialysis program (initial) and then at least annually to assess the environmental safety in patients’ homes and their adjustment to home dialysis.

- “Provision of all necessary disposable supplies and” dialysis devices approved by the US Food and Drug Administration
- “Regular monitoring of water quality in the case of home hemodialysis”⁸⁸

VHA facilities lacking a home dialysis program must offer veterans access to home dialysis through non-VA providers. These non-VA providers are contractually responsible for patient training and monitoring and support services when providing home dialysis. VA staff, however, are still responsible for monitoring and overseeing the contracted clinical services. VHA does not require non-VA dialysis providers to submit documentation of ongoing care. The VHA National Program Director for Kidney Disease explained that the Centers for Medicare & Medicaid Services established the requirements for non-VA dialysis care, and VHA does not require non-VA dialysis providers to send their medical documentation to VA. However, the National Program Director also stated that VHA providers can request it, for example, in response to patients’ complaints about their care.

Quality of Care Findings and Recommendations

VHA requires initial and annual home visits as components of support services in a home dialysis program. Home visits are a means to assess environmental safety in the patient’s residence and may include water quality testing.⁸⁹ The OIG reviewed the records of 119 VA-managed dialysis patients. Of these, 29 patients started home dialysis during the study period and required an initial visit. Of the 29 patients, 21 did not receive an initial visit prior to entry into the program. Similarly, 75 of the 119 patients had been in the home dialysis program for twenty-seven months or more and needed at least two annual home visits. The OIG found that 56 of the 75 patients’ records lacked evidence that annual home visits had occurred.⁹⁰ Failure to conduct initial and annual home visits leads to a lack of assurance that patients’ home settings are safe and adequately maintained for dialysis treatments. Reasons provided for noncompliance included lack of oversight.

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures patients in the home dialysis program receive initial and annual home visits.

⁸⁸ VHA Handbook 1042.01.

⁸⁹ VHA Handbook 1042.01.

⁹⁰ The OIG only included patients who had periodic home visits within the past 27 months from the date of the last home dialysis treatment in the study period. Patients who had not been in the home dialysis program long enough to have two annual home visits were excluded. The OIG was unable to evaluate 16 patients because they had not been in the program long enough to require annual visits.

VHA concurred.

Target date for completion: September 2024

VHA response: The VHA Office of the AUSH for Clinical Services and the Kidney Medicine Program have augmented the intramural Dialysis Dashboard to capture home peritoneal dialysis patients and are training VA Home Dialysis Programs to attest to completion of [the] initial home safety check, as well as the date performed, on the dashboard. Home safety checks will be included in the annual Veterans Integrated Service Network (VISN) Director memo reporting on the status of kidney quality metrics for corrective action. VA Dialysis Directive 1042.01 (pending publication) clarifies that subsequent home safety checks are for-cause and that the initial and periodic for-cause home visits to assess adaptation to self-dialysis modality may be conducted virtually.

The OIG reviewed the records of 415 home dialysis patients managed by non-VA providers during the study period. Since VHA does not require medical documentation from non-VA dialysis providers, the OIG was unable to determine the quality of care. Instead, the OIG interviewed 199 of the 415 patients and asked about various aspects of their care, including the accessibility of the physician managing their dialysis when questions or issues arose, as well as the availability of supplies and nursing and social work support, if needed.⁹¹ The majority of patients reported satisfaction with these aspects of their care.

VHA is responsible for monitoring contracted clinical services (home dialysis, in this case) when patients receive care through a non-VA provider.⁹² The OIG determined that lack of non-VA providers' medical documentation hindered VISN and facility staff from monitoring the quality of care delivered, and they had not established other internal processes to comply with this requirement. Without the ability to monitor contracted home dialysis services, VA staff could not effectively coordinate care needs or assess the continued appropriateness of home dialysis. VISN leaders attributed this to contractual agreements that do not require non-VA providers to submit medical documentation to the VA.

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures staff implement and sustain processes to monitor the delivery of non-VA home dialysis.

⁹¹ The OIG made two attempts to contact each non-VA managed patient by phone.

⁹² VHA Handbook 1042.01.

VHA concurred.

Target date for completion: September 2024

VHA response: The VHA Office of the AUSH for IVC, in collaboration with the Office of the AUSH for OPS and the Office of the AUSH for Clinical Services, will develop an IPT to reassess applicable policies, analyze compliance data, and develop a strategy to monitor the delivery of non-VA dialysis.

VHA requires VISN directors to establish a VISN dialysis council with members from each medical facility to promote quality care, coordinate dialysis initiatives, and enhance communication.⁹³ The OIG found that two of eight VISNs did not have a dialysis council. Lack of a VISN-level dialysis council may hinder VISN directors' ability to coordinate dialysis initiatives, synchronize dialysis care among facilities, and improve communication between VA and non-VA facilities. Leaders of one of the two VISNs reported believing they met the requirement, saying the VISN council met every two months; however, they did not provide evidence to the OIG. A leader at the other VISN had chartered a council and planned to have its members meet, but they had not met by the time of the inspection.⁹⁴

Recommendation 7

7. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, ensures each Veterans Integrated Service Network establishes a dialysis council.

VHA concurred.

Target date for completion: September 2024

VHA response: The Office of the AUSH for OPS and the Office of the AUSH for Clinical Services will ensure each VISN has a dialysis council in place in accordance with VHA Handbook 1042.01. As a note, VHA Handbook 1042.01 is currently being transitioned to a VHA Directive (Directive 1042.01 Veteran Dialysis Care) and is currently under review for concurrence prior to publication. The future VHA Directive 1042.01, like the handbook, requires VISN Dialysis Councils.

⁹³ VHA Handbook 1042.01.

⁹⁴ VISNs 1 and 19 did not have a dialysis council.

Report Conclusion

The OIG reviewed six areas of VHA administrative and clinical operations affecting community care at eight VISNs inspected from October 1, 2021, through September 30, 2022. To examine VISN oversight of the community care program, CBOCs' environments, and the care provided by non-VA providers, the OIG reviewed VHA requirements and Joint Commission standards and evaluated core processes.

The OIG acknowledges the challenges with oversight of community care, especially considering the continued stress of the COVID-19 pandemic on the US healthcare system during the time of the review. To assist VISN leaders in prioritizing improvements, the OIG made seven recommendations on systemic issues that may adversely affect veterans' care outcomes in the community. The number of recommendations does not necessarily reflect the quality of community care in the VISNs reviewed. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide quality improvement efforts. A summary of the recommendations is presented in appendix A.

Appendix A: Care in the Community Program Recommendations

The table below outlines seven OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The intent is for VHA leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership: Oversight and Management of Care in the Community	<ul style="list-style-type: none"> • None
Environment of Care: Emergency Management of Community-Based Outpatient Clinics	<ul style="list-style-type: none"> • None
Care Coordination: Congestive Heart Failure Management	<ul style="list-style-type: none"> • Staff document veterans' care coordination needs within the Community Care Coordination Plan note for consults assigned a level of care coordination above basic. • Staff act on consults no later than two business days after receipt and document accordingly. • Staff schedule community care appointments in a timely manner. • Staff make three attempts to retrieve medical documentation from non-VA providers.
Primary and Mental Health Care: Diagnostic Evaluations for Depression and Alcohol Use Disorder	<ul style="list-style-type: none"> • None
Quality of Care: Home Dialysis Care	<ul style="list-style-type: none"> • Patients in the home dialysis program receive initial and annual home visits. • Staff implement and sustain processes to monitor the delivery of non-VA home dialysis. • Each Veterans Integrated Service Network establishes a dialysis council.

Appendix B: Community-Based Outpatient Clinics Inspected in Fiscal Year 2022

VA outpatient clinics provide primary care integrated with women’s health, mental health, and telehealth services. Multi-specialty care includes these services in addition to providing two or more specialty services. The term “other outpatient services” refers to clinics that provide services but do not meet the criteria to be classified as a CBOC. The clinics are classified as either urban, rural, or highly rural depending on their location.

Table B.1. CBOCs Inspected in Fiscal Year 2022

Location	CBOC Classification	Rural Classification (Urban/Rural/Highly Rural)
VISN 1*		
Brattleboro, VT	Primary Care	Rural
Littleton, NH	Multi-Specialty	Rural
Stamford, CT	Other Outpatient Services	Urban
Tilton, NH	Primary Care	Rural
VISN 2*		
East Meadow, NY	Multi-Specialty	Urban
Freeville, NY	Primary Care	Urban
Kingston, NY	Primary Care	Urban
White Plains, NY	Primary Care	Urban
VISN 5*		
Cumberland, MD	Multi-Specialty	Urban
Fort Belvoir, VA	Multi-Specialty	Urban
Pocomoke City, MD	Primary Care	Rural
Westover, WV	Primary Care	Urban
VISN 6		
Franklin, NC	Primary Care	Rural
Hamlet, NC	Primary Care	Rural
Jacksonville, NC	Primary Care	Urban
Morehead City, NC	Multi-Specialty	Rural
VISN 8*		
Bradenton, FL	Multi-Specialty	Urban
Hollywood, FL	Primary Care	Urban
Ocala, FL	Multi-Specialty	Urban
Stuart, FL	Multi-Specialty	Urban

Location	CBOC Classification	Rural Classification (Urban/Rural/Highly Rural)
VISN 12		
Chicago, IL	Primary Care	Urban
Joliet, IL	Multi-Specialty	Urban
Mattoon, IL	Primary Care	Rural
Union Grove, WI	Primary Care	Rural
VISN 19		
Alamosa, CO	Primary Care	Rural
Bozeman, MT	Primary Care	Rural
Casper, WY	Primary Care	Rural
Orem, UT	Primary Care	Urban
VISN 20		
Grants Pass, OR	Other Outpatient Services	Urban
Klamath Falls, OR	Primary Care	Rural
Olympia, WA	Other Outpatient Services	Urban
Spokane, WA	Other Outpatient Services	Urban

Source: VHA Support Service Center.

*The OIG reviewed these VISNs virtually and their CBOCs administratively (no physical inspections).

Note: The OIG did not assess VA's data for accuracy or completeness.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: October 5, 2023

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Care in the Community Summary Report for Fiscal Year 2022

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the OIG draft report, Care in the Community Summary Report for Fiscal Year 2022. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

Shereef Elnahal, M.D., MBA

OIG Contact and Staff Acknowledgments

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

Inspection Team	Katharine Foster, RN, Director Joseph Giries, MHA, Director Shelia Farrington-Sherrod, MSN, RN Carol (Shannon) Foote, MSN, RN Lisa Fredrickson, MHS Marlo Gallegos, MHA, RN Nancy Krzanik, MSN, RN Cynthia LeMoine, LSCSW Nancy Mikulin, MSN, RN Renay Montalbano, MSN, RN-BC Noel Morris II, MBA Shedale Tindall, MSN, RN Constantine Voyevodka Nancy Winchester, MSN, RN
------------------------	---

Other Contributors	Debra Baskin, RN, DNP Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Courtney Harold, BA LaFonda Henry, MSN, RN Cynthia Hickel, MS, CRNA Ping Luo, PhD Amy McCarthy, JD Ryan McGovern, MS Joan Redding, MA Yurong Tan, PhD Dawn M. Woltemath, MSN, RN Jarvis Yu, MS
---------------------------	--

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Directors, VISNs 1, 2, 5, 6, 8, 12, 19, and 20

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.va.gov/oig.