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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care

NATIONAL REVIEW | REPORT #19-00017-191 | JULY 7, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review to determine the accessibility of three types of specialty care for patients in highly rural Veterans Health Administration (VHA) community-based outpatient clinics (CBOCs). The selected areas of specialty care—dermatology, orthopedics, and urology—were among those identified as having staffing shortages by VHA facilities in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*.[1] At the time of the OIG review, VHA classified 17 clinics as highly rural CBOCs. The OIG evaluated accessibility, including barriers, and the availability and utilization of resources. The patients reviewed were established patients who needed one or more of the three specialty services during the time frame of March 1, 2018, (or from the date the CBOC became highly rural) through February 28, 2019.

In most instances, face-to-face specialty care services are not available at highly rural CBOCs. As an alternative, VHA utilizes a variety of mechanisms to provide these services, of which the OIG assessed the utilization of clinical consults, electronic consults (eConsults), telehealth, and community care.

In reviewing the use of clinical consults by highly rural CBOCs, the OIG found varying referral patterns. For most sites, the closest VA facility was their parent facility. As such, 10 of the 17 highly rural CBOCs utilized their parent facility for dermatology and orthopedic specialty care visits, and 9 of 17 for urology visits.

The use of eConsults, when appropriate, can decrease the need for in-person specialty care visits, reduce the instances of patients making long trips to the parent facility or community providers, and decrease the amount of time it takes for specialty provider consultation. During OIG site visits to the highly rural CBOCs, providers reported using eConsults. However, data indicated only five sites utilized eConsults to provide care and none of the sites sent more than two eConsults for any of the three specialty care services during the review period. Based on the positive provider response regarding eConsults and current utilization rates, an opportunity may exist to expand the usage of eConsults in highly rural settings.[2]

VHA uses telehealth to increase veteran accessibility to primary and specialty care, especially in rural areas. A review of telehealth visit data showed that only one highly rural CBOC was

[1] VA Office of Inspector General, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018,* Report No. 18-01693-196, June 14, 2018. For the 2018 staffing report, the OIG used the Office of Personnel Management's definition of 'severe shortage.' A severe shortage is defined by the Office of Personnel Management when particular occupations are difficult to fill, and a shortage exists as defined by 5 C.F.R. § 337.204 for the occupational series. https://www.govregs.com/regulations/5/337.204. (This website was accessed on January 28, 2020.)

[2] For the purpose of this report, the OIG defined utilization rate as the number of completed specialty service consults or visits divided by the total number of specialty service consults or visits, multiplied by 100.

providing telehealth specialty care services in the area of dermatology. None of the highly rural CBOCs provided urology or orthopedic care through telehealth. When asked, staff expressed various reasons as to why these specialty telehealth services were not used, including the unavailability of local community resources, specialty providers preferring to assess patients in person, a lack of telehealth equipment, and poor bandwidth adequacy. Three of the 17 highly rural CBOCs reported they did not have telehealth equipment, while five sites with telehealth equipment reported limitations due to bandwidth challenges, which compromises the quality of the telehealth experience. The OIG determined that most of the highly rural CBOCs had telehealth equipment and adequate bandwidth but were not using it for the specialty care services of dermatology, orthopedics, and urology.

One goal of community care is to provide veterans access to healthcare services when it is not similarly available at a VA facility. However, the absence of specialists in the local community eliminates, or minimizes, this option for care and can inadvertently result in delays in care. Ten highly rural CBOCs had a community care utilization rate of 50 percent or greater for at least one of the three specialty services reviewed. In addition, community care utilization rates varied within the same highly rural CBOC when comparing the three types of specialty care. This may be an indication that certain types of community care are more available in the highly rural communities.

The OIG found that highly rural CBOC resources varied in availability for community care, telehealth, and clinical consults to their parent facilities. Sites more commonly used referrals to their parent facility and community specialty providers and rarely utilized telehealth, inter-facility consults, and eConsult resources.

Following the conclusion of this review, on March 11, 2020, the World Health Organization classified the coronavirus disease 2019 (COVID-19) as a pandemic, and VHA implemented the Office of Emergency Management COVID-19 Response Plan.[3] As a result, 4 of the 17 highly rural CBOCs in this report closed and 13 maintained pre-pandemic operating hours, as indicated on the clinic websites. The OIG reviewed data from February 1, 2020, through April 20, 2020, and did not find an increase usage of telehealth or community care consults at the open sites.

While on-site, the OIG surveyed providers and nursing staff to identify the top three barriers experienced when referring patients for dermatology, orthopedic, and urology services. The OIG provided a list of potential barriers that staff could choose from, but also allowed individuals to write in any additional barriers they experienced. Sixteen sites responded, but not all provided three barriers. Limited access to community care providers was reported by 12 of the 16 highly rural CBOCs visited, making it the most reported barrier. The second most reported barrier was limited access to non-parent VA facilities, which are typically used when care is not available at

[3] Veterans Health Administration - Office of Emergency Management, *COVID-19 Response Plan*, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, Version 1.6, March 23, 2020.

the parent facility or in the local community. Eight highly rural CBOCs reported access at the parent facility as either their first or second barrier.

In addition, the OIG identified several discrepancies regarding hours and days of operation for the highly rural CBOCs between what was indicated in the VHA Site Tracking system, on the clinic websites, and provided by the facility points of contact.[4] Discrepancies in hours and days of operation may cause confusion for patients presenting to the clinic for care as a walk-in or when scheduling an appointment. This, in turn, could negatively influence patient perception of clinic access and patient satisfaction.

Although the majority of highly rural CBOCs visited were stand-alone, five were located in a non-VA community hospital or healthcare center that provided a variety of medical services. The highly rural CBOCs co-located with community medical services were not fully utilizing all the services available through the non-VA hospital or healthcare center. When asked, staff expressed not knowing why local resources were not being used. VHA has the opportunity to increase patient access to care and decrease appointment wait times by maximizing use of these services.

The OIG conducted site visits at 16 of the 17 highly rural CBOCs and completed a review of select aspects of the environment of care. All the visited sites generally met the standards reviewed.

The OIG made four recommendations to the Under Secretary for Health related to completing a specialty care needs assessment for highly rural CBOCs to include internet bandwidth and telehealth equipment, ensuring the VHA Site Tracking system validation process is completed as required and monitored for compliance, ensuring the maintenance of accurate and current information on websites and monitoring for compliance, and assessing whether highly rural CBOCs that are located in non-VA community hospitals or healthcare centers are fully utilizing the resources available at the non-VA facilities and taking action as necessary.[5]

[4] VHA uses various names when referring to VAST including, the Veteran Affairs Site Tracking system and VHA Site Tracking system. For the purpose of this report, OIG refers to VAST as Veterans Health Administration (VHA) Site Tracking system.

[5] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Comments

The Executive in Charge concurred with the findings and recommendations and provided acceptable action plans (see appendix A). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CBOC	community-based outpatient clinic
CDW	Corporate Data Warehouse
COVID-19	coronavirus disease 2019
eConsult	electronic consult
FY	fiscal year
IFC	inter-facility consult
IHS	Indian Health Service
OIG	Office of Inspector General
OOS	Other Outpatient Services
POC	Point of Contact
PTOC	Primary Care Telehealth Outreach Clinic
SFT	Store and Forward Telehealth
VAST	Veteran Health Administration Site Tracking system
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Office of Inspector General (OIG) conducted a review to determine the accessibility of specialty care for established patients in highly rural Veterans Health Administration (VHA) community-based outpatient clinics (CBOCs). The selected areas of specialty care—dermatology, orthopedics, and urology—were among those identified as having staffing shortages by VHA facilities in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018* (staffing report).[1]

Background

In 2018, the staffing report identified shortages in various types of care, including specialty care. Three of the most frequently designated specialty areas included dermatology, orthopedics, and urology.[2] Staffing shortages often have a more significant impact in highly rural settings due to limited community resources.[3] VHA defines highly rural as sparsely populated areas where "less than 10 percent of their working population commutes to any community larger than an urbanized cluster."[4] Often patients require care beyond the resources available in the highly rural CBOC, particularly in specialty services. VHA's shortage of specialists impacts access to care by increasing the length of time it takes to get an appointment and the distance patients may need to travel to receive care.[5]

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[1] VA Office of Inspector General, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018,* Report No. 18-01693-196, June 14, 2018. For the 2018 staffing report, the OIG used the Office of Personnel Management's definition of 'severe shortage.' A severe shortage is defined by the Office of Personnel Management when particular occupations are difficult to fill, and a shortage exists as defined by 5 C.F.R. § 337.204 for the occupational series. https://www.govregs.com/regulations/5/337.204. (This website was accessed on January 28, 2020.)

[2] VA Office of Inspector General, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, Report No. 18-01693-196, June 14, 2018. During the course of the review, the OIG published the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019,* Report No. VA OIG 19-00346-241, September 30, 2019. The 2019 report included dermatology and urology as specialty areas with staffing shortages. Orthopedics was not included in the list of shortages.

[3] Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/health-care-workforce. (The website was accessed on October 21, 2019.)

[4] VHA Support Service Center, *VAST Snapshot-VHA Station Listing Reports Data Definitions*. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=6541. (The website was access on July 10, 2019.) This is an internal VA website and not available to the general public. Urbanized Cluster is of at least 2,500 and less than 50,000 people. US Census Bureau. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html. (The website was accessed on September 26, 2019.)

[5] RAND Health, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans, 2015.* https://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1165z2/RAND_RR1165z2.pdf. (The website was accessed on September 12, 2019.)

At the time of the review, VHA classified 17 clinics as highly rural CBOCs. One site was identified by VHA as a Primary Care CBOC, while the other 16 were identified as Other Outpatient Services (OOS) sites. A CBOC is a VA-operated, VA-funded, or VA-reimbursed site of care, which is located separately from a VA medical facility.[6] According to VHA, "An OOS site provides services to patients but does not generate VHA encounter workload or meet minimum criteria to be classified as a CBOC."[7] Some, but not all, OOS sites are considered a Primary Care Telehealth Outreach Clinic (PTOC). A PTOC offers primary and specialty care services via telehealth to extend access in rural areas where there is not sufficient demand, or it is otherwise not feasible, to establish a CBOC.[8] However, while VHA has developed requirements related to PTOCs, it is not a classification identified in the VHA Site Tracking system (VAST).[9] The highly rural CBOCs in this review identified themselves as CBOCs, OOS sites, PTOCs, or a combination of the three.

Prior OIG Reports

Prior reports related to this topic include, *Consult Delays and Management Concerns, VA Montana Healthcare System*, published in 2017.[10] The OIG reported that system leadership in 2016 provided an institutional disclosure for one of the patients. The review was conducted at the

[6] VHA Handbook 1006.2, *VHA Sites Classification and Definitions*, December 30, 2013.

[7] VHA Handbook 1006.2, *VHA Sites Classification and Definitions*, December 30, 2013. This handbook was scheduled for recertification on or before the last working date of December 2018 but has not been recertified. Some of the minimum criteria include registering more than 500 primary care encounters within the primary care stop class within a given fiscal year AND more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year, VAST Report Data Definitions. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=6541. (The website was accessed on July 10, 2019.) This is an internal VA website and not available to the general public. An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting, VHA Handbook 1006.2, *VHA Sites Classification and Definitions*, December 30, 2013.

[8] VHA Office of Telehealth Services, *Primary Care Telehealth Outreach Manual*, updated March 2020.

[9] VHA uses various names when referring to VAST including, the Veterans Affairs Site Tracking system and VHA Site Tracking system. For the purpose of this report, OIG refers to VAST as Veterans Health Administration (VHA) Site Tracking system; VAST is VHA's authoritative source on sites of care and is critically important to the operations of VHA. It is a web-based system that maintains details about each VHA site delivering clinical care to patients, including address and operating hours. Ensuring the accuracy of the information in VAST is critical to VHA's mission to serve veterans and their families. VAST Facility Validation Instructions. http://planning.vssc.med.va.gov/VAST/Documents/VAST%20Facility%20Validation%20Instructions.pdf. (The website was accessed on July 10, 2019.) This is an internal VA website and not available to the general public.

[10] VA Office of Inspector General, *Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana*, Report No. 16-00621-175, March 10, 2017.

request of Senators Jon Tester and Steve Daines to assess the extent that patients experienced delays in obtaining consults and the impact of any delays on patient outcomes.[11]

Beginning in July 2015, system leaders focused on identifying and resolving factors that contributed to consult delays and outstanding consults when referring patients to the community failed to reduce a backlog. Despite the effort, the OIG found evidence of persistent issues with completing consults timely in fiscal year (FY) 2016 (through late August 2016). Consistent with federal standards for internal control for information and communication, the OIG also found that the system had several mechanisms in place for staff to communicate concerns about consult delays to system leaders. However, despite available mechanisms, staff expressed concerns about communication with system leaders.[12]

The OIG made three recommendations to the System Director. As of March 19, 2018, all three recommendations were closed.

Scope and Methodology

The OIG evaluated three specialty care areas—dermatology, orthopedics, and urology—in highly rural CBOCs. These three areas were selected due to the high need identified in the OIG staffing report and because access to the three specialty care areas had not been recently reviewed. The OIG assessed accessibility, including barriers, and the availability and utilization of resources. The review was conducted from January 2019 through November 2019.

The highly rural sites were identified using reports generated from VAST, which were compiled based on data from the first day of each quarter of FY 2018 and the date the OIG extracted the information in FY 2019. The 17 sites that were designated as highly rural in FY 2018 (and remained as such into FY 2019) were included in this review.[13] The OIG verified the highly rural status of the 17 sites with VHA, facility, and CBOC leadership. Between March 1, 2018, through February 28, 2019, the sites provided care to over 6,000 veterans. They were aligned under 11 different parent facilities within seven Veterans Integrated Service Networks (VISNs).

[11] VA Office of Inspector General, *Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana*, Report No. 16-00621-175, March 10, 2017.

[12] VA Office of Inspector General, *Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana*, Report No. 16-00621-175, March 10, 2017.

[13] Two of the 17 highly rural CBOCs (Pine Ridge and McLaughlin) were classified as highly rural on April 1, 2018, and July 1, 2018, respectively, and therefore contain less than 12 months of data for FY 2018.

The sites are located 60 miles to 507.3 miles from their parent facilities.[14] Table 1 provides a list of highly rural CBOCs and includes clinic location and classification. Figure 1 displays the location of each site by the number listed in table 1.

Table 1. Highly Rural CBOCs Included in this Review

Sites Numbered	VISN	Official Station Name	State	VAST Classification[15]
1	**1**	Fort Kent VA Clinic	ME	Other Outpatient Services
2	**2**	Coudersport VA Clinic	PA	Other Outpatient Services
3	**2**	Wellsboro VA Clinic	PA	Other Outpatient Services
4	**9**	Jonesville VA Clinic	VA	Other Outpatient Services
5	**9**	Vansant VA Clinic	VA	Other Outpatient Services
6	**9**	Tullahoma VA Clinic	TN	Primary Care CBOC
7	**19**	Plentywood VA Clinic	MT	Other Outpatient Services
8	**19**	Afton VA Clinic	WY	Other Outpatient Services
9	**20**	Homer VA Clinic	AK	Other Outpatient Services
10	**20**	Wallowa County VA Clinic	OR	Other Outpatient Services
11	**22**	Polacca VA Clinic	AZ	Other Outpatient Services
12	**22**	Kayenta VA Clinic	AZ	Other Outpatient Services
13	**23**	Wagner VA Clinic	SD	Other Outpatient Services
14	**23**	Gordon VA Clinic	NE	Other Outpatient Services
15	**23**	Pine Ridge VA Clinic	SD	Other Outpatient Services
16	**23**	Mission VA Clinic	SD	Other Outpatient Services
17	**23**	McLaughlin VA Clinic	SD	Other Outpatient Services

Source: VAST

[14] VAST Database Fields and Definitions. Parent Station Name: Also called Administrative Parent site. Defined as a collection of all the points of service that a leadership group manages. The points of service can include any institution where health care is delivered. All of the data that originate from these points of service roll up to a single station number representing the administrative parent for management and programmatic activities. http://fcdm.vssc.med.va.gov/Definitions/Document%20Library/VAST%20Fields%20with%20Definitions.xlsx?web=1. (The website was accessed on February 27, 2020.) This is an internal VA website and not available to the general public.

[15] VA Clinics that reported classification of PTOC; Plentywood, Wallowa County, Polacca, Kayenta, Wagner.

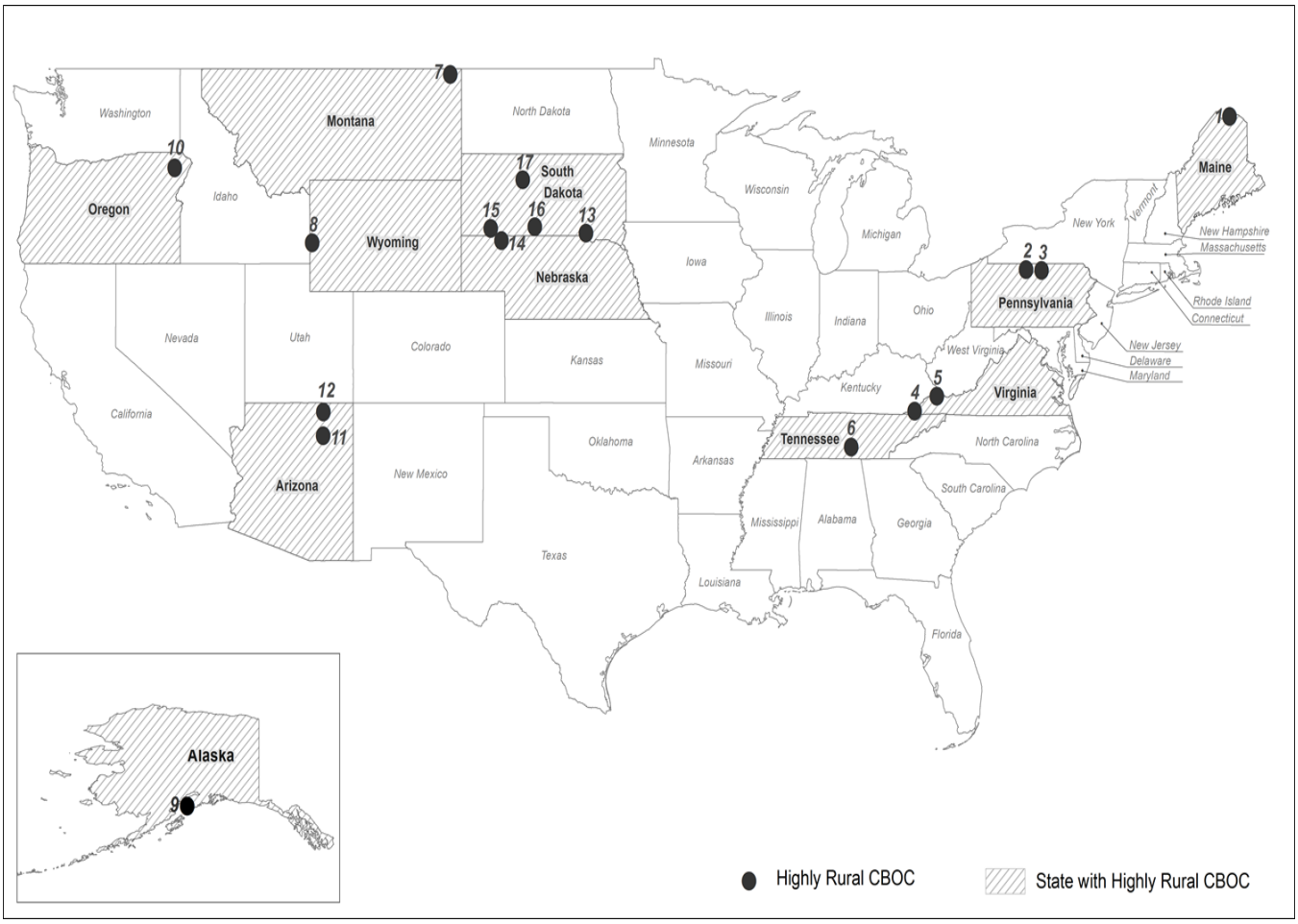

Figure 1. Map of highly rural CBOCs
Source: VAST

Of the 17 highly rural CBOCs, three were staffed with non-VA staff, 10 had less than one full-time medical doctor assigned, and five had no assigned medical doctor but did have a nurse practitioner or physician assistant.[16]

In order to determine the number of patients served by highly rural CBOCs from March 1, 2018, (or from date CBOC became highly rural) through February 28, 2019, the OIG extracted outpatient visit data from the VHA Corporate Data Warehouse (CDW).[17] Patients were included

[16] Non-VA staff at highly rural CBOCs could be a registered nurse working for a community hospital where VHA leases rooms, but the registered nurse serves the veteran patient population. Sites with non-VA staff include Plentywood, Montana, Gordon, Nevada, and Mission, South Dakota. Two sites did not respond when queried after the site visit about the non-MD staffing.

[17] VHA's Corporate Data Warehouse (CDW) is a national repository comprising data from several VHA clinical and administrative systems. The objective of CDW is to facilitate reporting and data analysis at the enterprise level by incorporating data from multiple data sets throughout the VHA into one standard database structure. CDW provides data and tools to support management decision making, performance measurement, and research objectives. http://vaww.vhadataportal.med.va.gov/DataSources/CDW.aspx. (The website was accessed on January 13, 2020.)

if they had at least one visit during the time period for any service other than the processing of laboratory specimens. From the resulting patient population, the OIG obtained the details of dermatology, orthopedic, and urology consults that were requested by the highly rural sites during the same period. Visit location information was matched to completed consults and used for subsequent analyses. These visits could have been completed by a telehealth, parent facility, non-parent facility, or community provider.

From June 3 through June 28, 2019, the OIG conducted site visits at 16 of the 17 highly rural CBOCs. The OIG confirmed the days and hours of operation as reported from the facilities to ensure staff would be available during the visit. The McLaughlin VA Clinic in Eagle Butte, South Dakota, was not included in the site visits as it reported no regular days or hours of operation for patient visits and only used telehealth for sporadic mental health visits. The remaining 16 highly rural CBOCs were located in 11 different states with varying distances from their parent facilities. The site visits included staff interviews and an environment of care review focused on patient privacy during medical and telehealth sessions, protection of patient information, clear access to exits, monitoring of equipment maintenance, and overall cleanliness. In addition, provider and nursing staff were asked to complete a survey identifying the specialty care resources available at the clinic, and the top three barriers experienced when referring patients for dermatology, orthopedic, and urology services. Respondents could select from a list of potential barriers provided by the OIG, or they could provide additional barriers not included on the list. Not all sites provided three barriers.

The OIG also reviewed VHA directives, handbooks, manuals, and memorandums related to the operation of CBOCs, telehealth, community care, and electronic consult (eConsult) requests.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Results

The OIG assessed the following three areas related to the provision of care by highly rural CBOCs: (1) access to specialty care (dermatology, orthopedics, and urology), (2) barriers to providing specialty care, and (3) highly rural CBOC operations.

Issue 1. Access to Specialty Care

In most instances, face-to-face specialty care services are not available at highly rural CBOCs. As an alternative, VHA utilizes a variety of mechanisms to provide these services:

- Clinical Consults—sending patients to their parent facility or a non-parent facility, known as an inter-facility consult (IFC), for a face-to-face appointment. In these cases, the patient would travel to the facility for the care needed.[18]
- eConsults—requesting a record review by a specialist to provide clinical advice without a face-to-face visit.[19]
- Telehealth—utilizing telehealth, which is defined as technologies used to provide clinical care in circumstances where distance separates those receiving services from those providing services through telecommunication technologies. The three types of telehealth care are synchronous, asynchronous, and remote monitoring through home telehealth.[20]
- Community Care—utilizing health care provided in the local community through non-VA providers. This care is paid for by VHA through the parent facility's community care service.

Data reviewed by the OIG revealed 15 highly rural CBOCs had patients that needed dermatology, orthopedic, or urology specialty services.

[18] VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

[19] eConsult is a "chart only consult" or "virtual consult," *eConsult Implementation Guide*, version 1.2, December 2014.

[20] Synchronous telehealth encompasses real-time care delivered to patients through interactive video such as Clinical Video Telehealth, *VHA Connected Care/Telehealth Manual*, November 2018. Asynchronous or Store-and-Forward Telehealth (SFT) within VHA is defined as the use of Telehealth Advisory Board approved technologies and processes to acquire and store clinical information (e.g., data, image, sound, and video) that is then forwarded to or retrieved by a provider at a different time for clinical evaluation, *VHA Connected Care/Telehealth Manual*, November 2018. Home Telehealth provides non-urgent/non-emergent care and case management that also includes tracking and trending vital signs and other biometric data and symptoms, *VHA Connected Care/Telehealth Manual*, November 2018.

Clinical Consult (Face-to-Face Consult)

For most sites, the closest VA facility was their parent facility. As such, 10 of the 17 highly rural CBOCs utilized their parent facility for dermatology and orthopedic specialty care visits, and 9 of 17 for urology visits. Only the Afton VA Clinic utilized IFCs to request specialty care visits at a non-parent facility. Twelve of the 17 highly rural CBOCs are greater than 100 miles from the closest VA facility, which could be a barrier to patients going to VA for care (see table 2).[21]

Table 2. Distance Between Highly Rural CBOCs and Closest VA Facility

Station Number	Official Station Name	Distance Between Highly Rural CBOCs and Closest VA Parent or Non-Parent Facility (miles)
402QA	Fort Kent VA Clinic	271.6
528QE	Coudersport VA Clinic	95.5
528QF	Wellsboro VA Clinic	60
621QA	Jonesville VA Clinic	68.1
621QC	Vansant VA Clinic	110.1
626GG	Tullahoma VA Clinic	74
436QB	Plentywood VA Clinic*	390.3
666QA	Afton VA Clinic*	199
463GD	Homer VA Clinic	230.3
687QC	Wallowa County VA Clinic	103.8
649QG	Polacca VA Clinic	228.7
649QH	Kayenta VA Clinic	243.6
438GE	Wagner VA Clinic	110.4
568HB	Gordon VA Clinic*	102.8
5c68HF	Pine Ridge VA Clinic*	61
568HJ	Mission VA Clinic*	168.8
568HK	McLaughlin VA Clinic	170.8

Source: VAST
**Non-Parent VA Facility was closer for specialty care visits.*

[21] Rural Health Information Hub, *Healthcare Access in Rural Communities.* https://www.ruralhealthinfo.org/topics/healthcare-access#barriers. (The website was accessed on October 2, 2019.)

eConsult

According to VHA Office of Specialty Care Services, the use of eConsults, when appropriate, can decrease the need for in-person specialty care visits, reduce the instances of patients making long trips to a parent facility or community providers, and decrease the amount of time it takes for specialty provider consultation.[22] Highly rural CBOC providers communicated they used eConsults to obtain quick clinical consultations from specialists, expressed the value in this practice, and stated that it saved veterans from driving to the parent VA facility or non-VA facility. However, data indicated only five sites utilized eConsults to provide care and none had sent more than two eConsults for any of the three specialty care services. The rate of eConsult utilization compared to total consults for specialty care ranged from 0–8 percent. Orthopedics had the highest eConsult utilization rate, followed by dermatology.[23] Based on the positive provider response regarding eConsults and current utilization rates, an opportunity may exist to expand the usage of eConsults in highly rural settings.

Telehealth

VHA utilizes telehealth to increase veterans' access to primary and specialty care, especially in rural areas.[24] As previously stated, the three types of telehealth care are synchronous, asynchronous, and remote monitoring through home telehealth.[25]

VHA instituted teledermatology in 2012, making this one of the most utilized telehealth technologies at VHA facilities.[26] The two modes of teledermatology used are store and forward telehealth (SFT) and clinical video telehealth.[27] While SFT and clinical video telehealth each have distinct advantages, SFT is now the predominant form used for teledermatology.[28] SFT

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[22] VHA Office of Specialty Care Services, Specialty Care Transformation, eConsult implementation guide, pg. 3. December 2014.

[23] For the purpose of this report, the OIG defined utilization rate as the number of completed specialty service consult or visit divided by the total number of specialty service consults or visits, multiplied by 100.

[24] Jessica Young et al. Telehealth: Essential to Access, Enduring Barriers, January 2019.

[25] *VHA Connected Care/Telehealth Manual*, November 2018. Synchronous telehealth encompasses real-time care delivered to patients through interactive video such as clinical video telehealth. Asynchronous (store and forward telehealth) within VA is defined as the use of Telehealth Advisory Board approved technologies and processes to acquire and store clinical information (e.g., data, image, sound, and video) that is then forwarded to or retrieved by a provider at a different time for clinical evaluation. Home Telehealth provides non-urgent/non-emergent care and case management that also includes tracking and trending vital signs and other biometric data and symptoms.

[26] Shoshana M. Landow et al, *Teledermatology Within the Veterans Health Administration, 2002–2014,* Telemedicine Journal and eHealth, 2015 Oct;21(10):769-773.

[27] VHA Telehealth Services, *Teledermatology Specialty Operations Manual Supplement*, pg.7 of 40. August 2016. Clinical video telehealth uses the transmission of live video from the imaging site to the reader's location for formulation of diagnostic impressions and treatment/management plans.

[28] VHA Telehealth Services, Teledermatology Specialty Operations Manual Supplement, August 2016.

teledermatology involves transmitting images (photographs) of a patient's skin, along with medical history, to a remote dermatologist who reviews the information and provides a diagnostic impression with recommendations for treatment.[29]

Teleorthopedics is utilized to provide evaluations for conditions such as checking of incisions, monitoring progress after a joint replacement, interpreting images, and providing consultation services for joint pain.[30] Staff in highly rural CBOCs may help perform the physical exam and provide information to the orthopedist at the main site. In many circumstances, pre-operative assessments can be performed via telehealth technologies so that veterans do not need to travel for repeated visits prior to surgery.[31]

Teleurology provides pre-operative, post-operative, and triage care for patients in remote areas. Teleurology also provides consult services for disorders such as lower urinary tract complaints, guidance of elevated prostate specific antigen levels, erectile dysfunction, and prostate cancer follow-up. For example, the VA Greater Los Angeles Healthcare System has successfully implemented teleurology services to patients in remote clinics that have resulted in reduced travel time for patients, lower costs, and higher satisfaction scores from both patients and providers.[32]

Telehealth Utilization

Telehealth visit data from March 1, 2018, (or the date a CBOC was designated highly rural) through February 28, 2019, indicated that six highly rural CBOCs provided telehealth specialty care services for the three specialties reviewed in this report (see table 3). However, when the visits were reviewed, the OIG found that only one highly rural CBOC (Tullahoma, Tennessee) was in fact providing telehealth specialty care services. The Tullahoma VA Clinic performed teledermatology services using SFT for 60 percent of its dermatology visits.

Other sites that had data indicating the provision of telehealth specialty care visits were either not telehealth visits or not performed at that site. Fort Kent, Jonesville, and Vansant CBOCs patients with specialty care needs who could benefit from telehealth services were apparently sent to the nearest CBOC that provided those services. Although the Fort Kent CBOC had telehealth equipment, there were bandwidth challenges preventing its use. The telehealth visits for Fort

[29] VHA Telehealth Services, Teledermatology Specialty Operations Manual Supplement, August 2016.

[30] Jacquelyn Marsh et al, *Are Patients Satisfied With a Web-based Follow up after Total Joint Arthroplasty?* Clin Orthop Relat Res 472, February 2014, (1972–1981), pg.1972.

[31] Telesurgery Operations Manual, 2015. Margaret Mullen-Fortino, et al, Presurgical Assessment Using Telemedicine Technology: Impact on Efficiency, Effectiveness, and Patient Experience of Care, TELEMEDICINE and e-HEALTH, 25 (2), February 2019.

[32] Stephanie Chur et al, Veterans Affairs Telemedicine: Bringing Urologic Care to Remote Clinics, Urology 86(2), April 8, 2015.

Kent patients were actually performed at the Caribou CBOC (approximately 40 miles away). The Jonesville and Vansant CBOCs had telehealth equipment and appeared to have provided telehealth visits, but the OIG found that telehealth services were actually performed at the Norton CBOC (more than 40 miles away). Telehealth visits shown in table 3 for Wallowa and Plentywood were not actually telehealth visits. Although they were recorded as such, the care was in fact completed via an IFC or a transfer of images in VistA.[33] During the OIG site visits, staff from the Wallowa and Plentywood CBOCs confirmed that teledermatology services had not been provided.

None of the highly rural CBOCs provided urology or orthopedic care through telehealth. When asked, staff expressed various reasons as to why these specialty telehealth services were not used, including local community resources were unavailable, some specialty providers preferred to see the patient, a lack of telehealth equipment, and issues with bandwidth adequacy.

Table 3: Highly Rural CBOC Telehealth Utilization by Specialty

	Dermatology			Orthopedics			Urology		
Official Station Name	Total Visits	Tele-Visits	% of Tele-Utilization	Total Visits	Tele-Visits	% of Tele-Utilization	Total Visits	Tele-Visits	% of Tele-Utilization
Fort Kent VA Clinic	10	8	80	7	0	0	8	0	0
Coudersport VA Clinic	10	0	0	21	0	0	6	0	0
Wellsboro VA Clinic	39	0	0	76	0	0	17	0	0
Jonesville VA Clinic	12	2	17	10	0	0	13	0	0
Vansant VA Clinic	9	7	78	12	0	0	6	0	0
Tullahoma VA Clinic	131	79	60	44	0	0	30	0	0
Plentywood VA Clinic	3	1	33	2	0	0	1	0	0
Afton VA Clinic	22	0	0	79	0	0	38	0	0
Homer VA Clinic	8	0	0	29	0	0	7	0	0
Wallowa County VA Clinic	2	1	50	4	0	0	1	0	0
Polacca VA Clinic	0	0	0	0	0	0	0	0	0
Kayenta VA Clinic	0	0	0	0	0	0	2	0	0
Wagner VA Clinic	19	0	0	41	0	0	19	0	0
Gordon VA Clinic	7	0	0	6	0	0	4	0	0
Pine Ridge VA Clinic	1	0	0	6	0	0	0	0	0
Mission VA Clinic	4	0	0	14	0	0	4	0	0

[33] A transfer of images in VistA does not fall within the parameters of what constitutes a telehealth visit. According to VHA, "Images of the patient are captured by an Imager (e.g., a TCT or nurse) at the originating site on the same day or at a separately scheduled time. Image selection is guided by PCP instructions. The Imager closes the consult request from the PCP and attaches the images to a new consult request which is sent to the Teledermatologist Reader." Telehealth Services, Teledermatology Specialty Operations Manual Supplements. https://vaww.infoshare.va.gov/sites/telehealth/docs/tderm-spp.pdf (The website was accessed on February 11, 2019.) This is an internal VA website and not available to the general public.

Official Station Name	Dermatology			Orthopedics			Urology		
	Total Visits	Tele-Visits	% of Tele-Utilization	Total Visits	Tele-Visits	% of Tele-Utilization	Total Visits	Tele-Visits	% of Tele-Utilization
McLaughlin VA Clinic	0	0	0	0	0	0	0	0	0

Source: CDW

Telehealth Equipment

While telehealth has the potential to expand access to care, it relies on the availability and use of telehealth equipment. If the telehealth equipment is not user-friendly, image quality is poor, or additional time is required for care for patients via telehealth, providers are less inclined to incorporate this advanced technology into their daily practice.

Three of the 17 highly rural CBOCs reported they did not have telehealth equipment.[34] Although the Wellsboro CBOC had recently received the equipment, it had not been set up and as a result, was not operational yet. Five sites with telehealth equipment had bandwidth challenges, which could compromise the quality of certain types of telehealth care (see table 4). Only one of the highly rural CBOCs with telehealth equipment actually used it for teledermatology between March 1, 2018, (or the date the CBOC was designated highly rural) through February 28, 2019.

Telehealth equipment requires adequate bandwidth, the speed of communication across cable or telephone lines. The VHA Office of Telehealth Services developed a map that indicates bandwidth adequacy at each location. It was created to assist in prioritizing locations for synchronous VA Video Connect expansion and increase awareness of bandwidth adequacy for non-VA Video Connect telehealth.[35] A color is assigned to each site of care that indicates its ability to provide VA Video Connect sessions transmitting live video from the imaging site to the reader's location.[3637] Asynchronous telehealth services or SFT utilizes lower bandwidth, which may be an option for sites with lower bandwidth adequacy (light red).[38]

Eleven of the 17 sites visited could conduct more than 1.5 concurrent 720 pixels (blue) or 480 pixels (light gold) resolution quality sessions, meaning they had bandwidth to conduct video

[34] The three clinics without equipment were Vansant VA Clinic, Jonesville VA Clinic, and Gordon VA Clinic.

[35] VA.gov, Telehealth Expansion. https://vaww.telehealth.va.gov/pgm/vvc/expansion/index.asp. (The website was accessed on September 25, 2019.) This is an internal VA website and not available to the general public.

[36]VHA Telehealth Services, TeleDermatology - Training Resources. https://vaww.telehealth.va.gov/clinic/spc/tderm/index.asp (The website was accessed on January 15, 2020.) This is an internal VA website and not available to the general public.

[37] VA TeleDerm App User Manual, June 2018. The reader views the reader consult through VistA Imaging TeleReader, including clinical history and images, and writes a consult note in CPRS including impressions and recommendations to the referring clinician, completing the teledermatology reader consult

[38] Teledermatology Specialty Operations Manual, August 2016.

connect telehealth.[39] Two of the 11 that had bandwidth capabilities did not have telehealth equipment. Five sites (light red) had bandwidth challenges and could conduct less than one 480 pixels resolution quality video connect session. One site (gray) was missing key information necessary to determine bandwidth.

> According to VHA, a site that is less than one [light red] technically doesn't mean that a video connect can't be performed. Internet bandwidth availably can fluctuate based on other activities in the clinic. The calculation is a warning that sufficient bandwidth isn't sectioned off at that site to support that session.[40]

Because of the bandwidth limitations in the five light red clinics, utilizing VA Video Connect for patient visits could be unreliable and low quality.

Table 4: Bandwidth and Equipment for VA Video Connection Session[41]

Official Station Name	Telehealth Equipment	Used for Specialty Surveyed	Bandwidth Status
Fort Kent VA Clinic	Y	N	Light Red
Coudersport VA Clinic	Y	N	Blue
Wellsboro VA Clinic	Y**	N	Light Gold
Jonesville VA Clinic	N	N	Blue
Vansant VA Clinic	N	N	Light Gold
Tullahoma Clinic	Y	Y*	Blue
Plentywood VA Clinic	Y	N	Light Gold
Afton VA Clinic	Y	N	Light Gold
Homer VA Clinic	Y	N	Light Gold
Wallowa County VA Clinic	Y	N	Light Gold
Polacca VA Clinic	Y	N	Light Red
Kayenta VA Clinic	Y	N	Light Red
Wagner VA Clinic	Y	N	Blue

[39] Animoto. *Understanding Video Resolution.* A 720p HD video has 720 lines that are each 1,280 pixels wide, meaning that it is more than twice as sharp as the same video at 480p and can be viewed on a much larger screen. https://animoto.com/blog/news/hd-video-creation-sharing/. (The website was accessed on August 29, 2019.)

[40] MacMillan Dictionary. KBPS: kilobits per second: a unit for measuring the speed of a modem. https://www.macmillandictionary.com/us/dictionary/american/kbps. (The website was accessed on September 18, 2019.)

[41] VA.gov, *Telehealth Expansion*. https://vaww.telehealth.va.gov/pgm/vvc/expansion/index.asp. (The website was accessed on September 25, 2019.)

Official Station Name	Telehealth Equipment	Used for Specialty Surveyed	Bandwidth Status
Gordon VA Clinic	N	N	Gray
Pine Ridge VA Clinic	Y	N	Light Red
Mission VA Clinic	Y	N	Light Gold
McLaughlin VA Clinic	Y	N	Light Red

Blue *>1.5 concurrent 720p;* *Light Gold* *>1.5 concurrent 480p;* *Light Red* *<1.0 480p;* *Gray* *NA*

Source: VHA Telehealth Website and OIG Clinic visits
**Only used for dermatology services.*
***Had telehealth equipment at time of site visit but it was not set up.*

Overall, the OIG determined that most highly rural CBOCs had telehealth equipment and adequate bandwidth but were not utilizing it for the specialty care services of dermatology, orthopedics, and urology. However, 10 highly rural CBOCs were providing telemental health and six were providing other specialty care via telehealth. Of the 17 highly rural CBOCs, eight had both adequate bandwidth and telehealth equipment. Each of these sites had patients who needed at least one of the three specialty services reviewed in this report but ultimately only one site provided that care through telehealth.[42] Utilizing telehealth equipment when appropriate for dermatology, orthopedics, or urology, could increase access to specialty care visits and reduce the instances of patients making long trips to a parent facility or community providers.[43]

Care in the Community

One goal of community care is to provide veterans timely access to healthcare services.[44] However, the absence of specialists in the local community eliminates, or minimizes, this option for care and can inadvertently result in delays in care.

The OIG found that, when compared to total visits for dermatology, orthopedics, and urology, the rate of community care utilization varied greatly (see table 5). Utilization ranged from zero percent to 100 percent. Ten highly rural CBOCs had a community care utilization rate of 50 percent or greater for at least one of the three specialty services reviewed.

In addition, community care utilization rates varied within the same highly rural CBOC when comparing the three types of specialty care. For example, the Fort Kent VA Clinic utilized

[42] Tullahoma Clinic provides teledermatology.

[43] RAND Health, Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans, 2015.

[44] VHA Office of Community Care, *Field Guidebook Introduction*. https://vaww.vha.vaco.portal.va.gov/DUSHCC/DC/DO/CI/FGB/Pages/Introduction.aspx (The website was accessed on March 9, 2020.) This is an internal VA website and not available to the general public.

urology and orthopedics community care for all visits, and dermatology community care for only 20 percent of the visits. This may be an indication that certain types of community care are more available in the highly rural communities. Of the three specialties, patients at highly rural CBOCs appear to be more likely referred for urology care in the community, followed closely by orthopedic care.

Table 5. Utilization of Community Care by Highly Rural CBOCs

Official Station Name	Dermatology			Orthopedics			Urology		
	Total Visits	CC Visits	% CC Utilization	Total Visits	CC Visits	% CC Utilization	Total Visits	CC Visits	% CC Utilization
Fort Kent VA Clinic	10	2	20	7	7	100	8	8	100
Coudersport VA Clinic	10	0	0	21	2	10	6	3	50
Wellsboro VA Clinic	39	0	0	76	21	28	17	14	82
Jonesville VA Clinic	12	4	33	10	3	30	13	2	15
Vansant VA Clinic	9	0	0	12	4	33	6	1	17
Tullahoma VA Clinic	131	27	21	44	15	34	30	4	13
Plentywood VA Clinic	3	2	67	2	0	0	1	0	0
Afton VA Clinic	22	16	73	79	79	100	38	37	97
Homer VA Clinic	8	8	100	29	29	100	7	7	100
Wallowa County VA Clinic	2	0	0	4	4	100	1	1	100
Polacca VA Clinic	0	0	0	0	0	0	0	0	0
Kayenta VA Clinic	0	0	0	0	0	0	2	2	100
Wagner VA Clinic	19	16	84	41	22	54	19	6	32
Gordon VA Clinic	7	3	43	6	1	17	4	0	0
Pine Ridge VA Clinic	1	0	0	6	1	17	0	0	0
Mission VA Clinic	4	1	25	14	6	43	4	3	75
McLaughlin VA Clinic	0	0	0	0	0	0	0	0	0

Source: CDW

The variability in community care utilization suggests that some highly rural CBOCs rely on VHA to provide specialty services. Providing care locally limits the longer distances patients need to travel, while providing ancillary services increases convenience for the patient and potentially increases the efficiency of care when laboratory tests and studies or both are required prior to seeing a specialist. When patients opt out of community care, or when community care has limited availability, VHA has the opportunity through existing eConsults and telehealth programs to facilitate care. A potential solution utilized by a few highly rural CBOCs is to refer patients to CBOCs closer to their homes, rather than the parent or non-parent VA facility, that are equipped and staffed to provide telehealth.

Coronavirus Disease 2019

Following the conclusion of this review, on March 11, 2020, the World Health Organization classified coronavirus disease 2019 (COVID-19) as a pandemic and VHA implemented the Office of Emergency Management COVID-19 Response Plan. According to the plan, CBOCs are to

> postpone routine and 'non-urgent' care of patients who do not have known COVID-19, symptoms of COVID-19, or high-risk exposure to COVID-19 or shift to Telehealth. The plan further indicated that facilities will need to determine how smaller CBOCs will function, including whether suspected COVID-19 patients will be seen at these locations. Clinics may also be closed, and staff directed to work from home or assist at other facility locations. Clinics should attempt to shift to an "all telehealth" mode, with phone, video, and/or electronic communication to meet the immediate needs of ambulatory patients, with the exception of some "standard" urgent care (including primary and mental health).[45]

As a result, 4 of the 17 highly rural CBOCs discussed in this report closed and 13 maintained pre-pandemic operating hours, as indicated on the clinic websites. The OIG reviewed data from February 1, 2020, through April 20, 2020, and did not find an increased usage of telehealth or community care consults at the open sites.

Issue 2. Barriers to Providing Specialty Care

In order to better understand barriers to providing specialty care in highly rural settings, the OIG conducted a survey in which providers and nursing staff at highly rural CBOCs were asked to identify the top three barriers experienced when referring patients for dermatology, orthopedic, and urology services. The OIG provided a list of potential barriers that providers and nursing staff could choose from, but also allowed them to write in any additional barriers they had experienced. Sixteen sites responded, but not all provided three barriers.[46]

The OIG list of potential barriers included

- Limited access in the community
- Limited access at the parent facility
- Limited access at a non-parent facility
- Lack of staff to coordinate care for the appointment

[45] Veterans Health Administration - Office of Emergency Management, *COVID-19 Response Plan*, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, Version 1.6, March 23, 2020.

[46] Surveys were conducted during site visits. One of the seventeen sites was not visited so only 16 sites completed the survey.

- Transportation difficulties
- Community provider payment delays/issues resulting in access issues
- Lack of technology to share medical information with community providers
- Not applicable

Highly rural CBOC providers and nursing staff reported similar barriers for all three specialties (see figure 2). Most sites (12 of 16 visited) reported access issues due to limited or no specialists in the community to provide the services. The OIG found that the second most reported barrier was limited access in the non-parent VA facility typically used when care was not available at parent facilities or locally in the community. Eight highly rural CBOCs reported access at the parent facility as either the first or second barrier.

CBOC providers and nursing staff also indicated the lack of technology to share medical information with community providers as the third most reported barrier to providing specialty care. Providers described delays in getting medical information back from community providers such as completed consults, laboratory, and imaging results to manage a patient's symptoms in a timely manner.

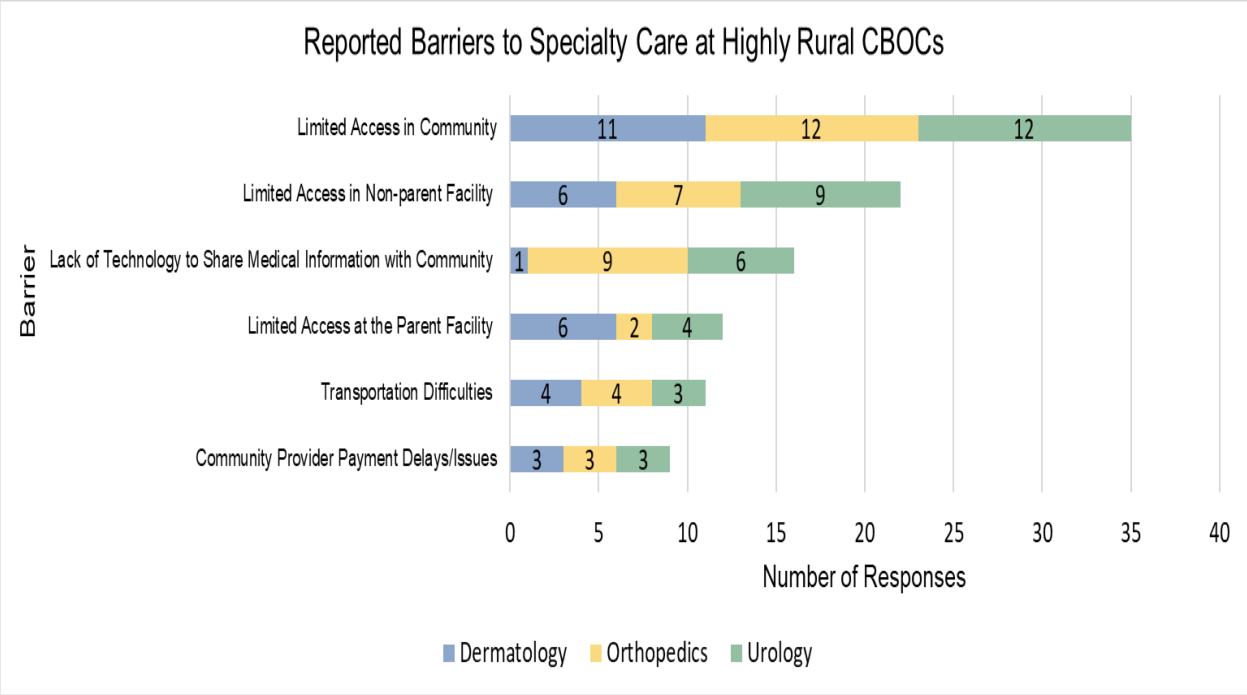

Figure 2. Reported barriers to specialty care at highly rural CBOCs
Source: Survey data from OIG CBOC visits

The identified barriers represent some of the difficulties that providers in rural settings experience when trying to utilize available resources. At times, it may be unavoidable for

patients to travel long distances for care or wait longer than desired for an appointment. Utilization of telehealth or eConsults for specialty care could increase access and minimize the need for patients to travel long distances for care.[47]

Issue 3. Highly Rural CBOC Operations

In order to assess the daily operations at highly rural CBOCs, the OIG reviewed the accuracy of operational information internal to VHA, as well as information that is available to the public via the CBOCs' websites. In addition, staff at highly rural CBOCs co-located with non-VA community healthcare providers were queried to assess non-VA community provider resources and VHA's utilization of those resources. Finally, elements of the environment of care were reviewed at each of the 16 sites visited.

Accuracy of Operational Details

VAST is VHA's web-based authoritative system of sites of care and is essential to the operations of VHA as it maintains details about each VHA site delivering clinical care to veterans, including the address and operating hours. According to VHA, "Ensuring the accuracy of the information in VAST is critical to VHA's mission to serve veterans and their families."

Quarterly, the VHA Planning Systems Support Group sends a report to each VAST facility point of contact (POC) and VISN POC. The facility POC has two weeks to review and validate the accuracy of certain fields of data. If discrepancies are found, they should be corrected immediately within VAST by either the facility or VISN POC. Corrections to hours and days of operation are considered minor changes and can be made at any time by the VISN Planner or VISN POC. In addition to the validation process of operational information in VAST, VHA requires that facilities, as content owners of their websites, monitor and maintain all posted web content and ensure that the information is accurate and current.[48]

The OIG compared the highly rural CBOCs' days and hours of operation from VAST to the information provided by each parent facility POC and the information listed on the highly rural CBOCs websites at the time of the review. The OIG identified several discrepancies. Of the 17 review sites, 13 had discrepancies in hours and days of operation; VAST did not match information provided by the facility POC and the highly rural CBOC clinic websites.

Additionally, four of the 17 sites had discrepancies in operating days or operating hours within their website. Discrepancies in hours and days of operation may cause confusion for patients presenting to the clinic for care as walk-ins or when scheduling an appointment. This in turn could negatively influence patient perception of clinic access and patient satisfaction. For

[47] Jessica Young et al., *Telehealth: Essential to Access, Enduring Barriers*, January 2019; eConsult Implementation Guide, December 2014.

[48] VA Directive 6515, Use of Web Based Collaboration Technologies, June 28, 2011.

example, ill patients may present to the clinic during non-operating days/hours, rather than seeking care elsewhere, thus possibly delaying needed care. In addition, these discrepancies could lead to difficulties for stakeholders, both internal and external to VHA, when trying to contact highly rural CBOCs regarding patient care.

Clinic Utilization of Co-Located Resources

Some highly rural CBOCs are stand-alone clinics, while others are located in a non-VA community hospital or health care center that provides a variety of medical services. Of the highly rural CBOCs included in this review, five are located in either a community hospital or health care center (see table 6). Of those five, two highly rural CBOCs reported utilizing orthopedic services, and one reported utilizing urology services provided by the community hospital or health care center. Dermatology services were not available in the co-located sites.

The OIG also found that four of the five reported utilizing laboratory services, imaging services, or both at these facilities. The other highly rural CBOC located in a community hospital had laboratory services available on-site during patient visits and used a courier to take the lab samples to a VHA facility for processing. This site is over 400 miles from the VHA facility. In addition, emergency services were available for three of the sites.

With respect to primary care, one site provided primary care services once per week by staff who traveled 155 miles from the parent facility, but was located in a community hospital that could provide primary care services to patients five days per week.[49] Another site, that was only open two times a month, was within walking distance of an Indian Health Service (IHS) hospital that offered primary care services five days a week.[50]

Four of the five highly rural CBOCs located in non-VA facilities were not utilizing all the medical services available in the community hospital or health care center where they were located. Staff at the CBOCs could not explain why they were not utilizing all available medical services. VHA has the opportunity to increase patient access to care and decrease appointment wait times through fully utilizing the services available in highly rural community hospitals and IHS centers in their locality.[51] This would also conserve VHA staffing, vehicles, and contracting funds resources.

[49] Gordon Memorial Hospital Services. www.gordonmemorial.org/services-offered-0. (This website was accessed on September 25, 2019.)

[50] Pine Ridge Hospital Services. //www.ihs.gov/greatplains/healthcarefacilities/pineridge//. (This website was accessed on September 25, 2019). VA Pine Ridge Clinic Website. www.blackhills.va.gov/locations/PineRidge.asp. (This website was accessed on September 25, 2019.)

[51] Gordon Memorial Hospital Services. www.gordonmemorial.org/services-offered-0. (This website was accessed on September 25, 2019). VA Pine Ridge Clinic Website. www.blackhills.va.gov/locations/PineRidge.asp. (This website was accessed on September 25, 2019.)

Table 6. Highly Rural CBOCs Located in Non-VA Facilities

Official Station Name	Located In	Type of Agreement	Services Utilized at Community Hospital or Health Care Center	Specialty Services (of those assessed in this review) available at Hospital
Homer VA Clinic	Community Hospital	Lease	All	Orthopedics, Urology
Gordon VA Clinic	Community Hospital	Contract	Lab, ED	None
Plentywood VA Clinic	Community Hospital	Contract	None	None
Kayenta VA Clinic	IHS Health Care Center	Sharing Agreement - IHS/Tribal Agreement	Lab, Imaging, ED	Orthopedics
Polacca VA Clinic	IHS Health Care Center	Sharing Agreement - IHS/Tribal Agreement	Lab, Imaging, ED	None

Source: VAST

Environment of Care

The OIG's review of the environment of care in highly rural CBOCs assessed patient privacy during medical and telehealth sessions, protection of patient information, clear access to exits, monitoring of equipment maintenance, contingency planning for telehealth equipment failure, posting of the patient complaint procedure, and overall clinic cleanliness.

Of the 17 highly rural CBOCs, six were in free standing VHA sites, six were co-located in buildings that housed other community services, three were in community hospitals, and two were located in IHS Health Care Centers. The OIG found that all 16 of the visited sites generally met the standards of the environment of care reviewed.

Conclusion

VHA utilizes a variety of mechanisms to provide specialty care services in highly rural settings. Each mechanism has barriers that must be navigated for the provision of care.

Limited access to community care providers was reported by 12 of the 16 highly rural CBOCs visited, making it the most reported barrier. The second most reported barrier was limited access to non-parent facilities, which are typically used when care is not available at the parent facility or in the local community. Eight highly rural CBOCs reported access at the parent facility as either their first or second barrier.

The ability to offer telehealth services provides options for patients and provides a potential path to address a health issue timely and conveniently but was reported to be impacted by barriers regarding the availability of equipment and adequate bandwidth. The OIG found that highly rural CBOC resources varied in availability for community care, telehealth, and clinical consults to their parent facilities. Sites more commonly utilized referrals to their parent facility and community specialty providers and rarely utilized telehealth, IFCs, and eConsult resources.

The OIG identified several discrepancies regarding the hours and days of operation for the highly rural CBOCs as indicated in VAST, on clinic websites, and provided by the facility points of contact. Discrepancies in hours and days of operation may cause confusion for patients presenting to the clinic for care as walk-ins or when scheduling an appointment. This in turn could negatively influence patient perception of clinic access and patient satisfaction.

Although the majority of highly rural CBOCs are stand-alone, five were located in a non-VA community hospital or health care center that provided a variety of medical services. Highly rural CBOCs co-located with community medical services were not fully utilizing all the services available where they were located. VHA has the opportunity to increase patient access to care and decrease appointment wait times through fully utilizing the services available in highly rural community hospitals and IHS centers in their locality. All the highly rural CBOCs generally met standards related to the aspects of environment of care reviewed.

Following the completion of this review, VHA implemented a plan to respond to the COVID-19 pandemic. As a result of the plan, four of the 17 highly rural CBOCs in this report closed and 13 maintained pre-pandemic operating hours, as indicated by the clinic websites. The OIG reviewed data from February 1, 2020, through April 20, 2020, and did not find an increased usage of telehealth or community care consults at the open sites.

Recommendations 1–4

1. The Under Secretary for Health completes a specialty care needs assessment for highly rural community-based outpatient clinics to include internet bandwidth and telehealth equipment and develops options for the delivery of safe patient care.[52]

2. The Under Secretary for Health ensures that the Veterans Health Administration Site Tracking system validation process is completed by each Veterans Integrated Service Network as required and monitors for compliance.

3. The Under Secretary for Health ensures that facilities and Veterans Integrated Service Networks maintain accurate and current information on websites as required and monitors for compliance.

4. The Under Secretary for Health completes an assessment to determine whether highly rural community-based outpatient clinics that are located in a non-VA community hospital or health care center are fully utilizing the resources available at the non-VA facilities and takes action as indicated.

[52] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: June 2, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care

To: Assistant Inspector General for Healthcare Inspections (54)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the Office of Inspector General's draft report: Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care. I concur with the findings and conclusions in the draft report and have attached an action plan addressing the four recommendations.
2. If you have any questions, please contact Karen Rasmussen, M.D., Director, GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.
Executive in Charge

Executive in Charge Response

Recommendation 1

The Under Secretary for Health completes a specialty care needs assessment for highly rural community-based outpatient clinics to include internet bandwidth and telehealth equipment and develops options for the delivery of safe patient care.

Concur.

Target date for completion: March 2021

Executive in Charge Comments

The Office of Veterans Access to Care in collaboration with the Office of Connected Care and the Office of Rural Health, will mount a data collection effort to verify and elaborate on the data used during the OIG's review. Included in the review will be a more detailed inventory of telehealth equipment, telehealth personnel and current demand for specialty care services across all outpatient clinics classified as "Highly Rural." Once the data is assessed, VHA will develop appropriate options for the delivery of safe patient care.

Recommendation 2

The Under Secretary for Health ensures that the Veterans Health Administration Site Tracking system validation process is completed by each Veterans Integrated Service Network as required and monitors for compliance.

Concur.

Target date for completion: December 2020

Executive in Charge Comments

The VHA Site Tracking System (VAST) is the authoritative source of VHA sites of care. The technical components of the database are managed by the Office of Reporting, Analytics, Performance, Improvement and Deployments (RAPID) VHA Support Service Center (VSSC) team. The site content is maintained by the Veterans Integrated Service Network (VISN) Planners and the Deputy Under Secretary for Health for Operations and Management (DUSHOM).

VSSC currently has a quarterly validation process that requires facility and VISN points of contact to review VAST information and correct inaccuracies within 14 days of the initiation of the quarterly validation. RAPID will partner with the DUSHOM to establish a process to ensure compliance with the validation requirement. RAPID will also collaborate with the DUSHOM's

office to issue internal guidance to the VISNs about the requirement to complete the quarterly validation process.

Recommendation 3

The Under Secretary for Health ensures that facilities and Veterans Integrated Service Networks maintain accurate and current information on websites as required and monitors for compliance.

Concur.

Target date for completion: October 2020

Executive in Charge Comments

VHA will conduct a review and certification of the highly rural Community-Based Outpatient Clinics to ensure that both the website and VHA Site Tracking System (VAST) have accurate information. VHA is actively working on a long-term solution to ensure accurate information is reflected on all VHA facility websites. In 2019, the Office of Information & Technology (OIT) and VHA began implementation of an Application Programming Interface (API) to automatically update VHA facility websites to show accurate location and hours of operation. VHA is working closely with OIT to refine the interaction between VAST, the API and VHA's websites.

Recommendation 4

The Under Secretary for Health completes an assessment to determine whether highly rural community-based outpatient clinics that are located in a non-VA community hospital or health care center are fully utilizing the resources available at the non-VA facilities and takes action as indicated.

Concur.

Target date for completion: March 2021

Executive in Charge Comments

The Office of Veterans Access to Care in collaboration with the Office of Community Care and the Office of Rural Health will conduct a data call for all "Highly Rural" clinics located in a non-VA community hospital or health care center to determine what resources are available at the non-VA facilities and the extent to which they are being utilized by these five outpatient clinics. The data call will also inquire on the process for reviewing and offering community care to Veterans who are determined eligible for community care based on the MISSION Act eligibility standards. VHA will then determine whether increased utilization of community resources is appropriate and act as appropriate.

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