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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers

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Executive Summary

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

Inspection Summary

The OIG reviewed community care processes at eight South Central VA Health Care Network (VISN 16) medical facilities with a community care program from April 23 through May 10, 2024. The OIG evaluated these facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Urgent Care in the Community. The OIG issued 13 recommendations across the six domains of community care. The intent is for leaders to use recommendations as a road map to improve processes that support efficient delivery and coordination of community care going forward. The elements evaluated and OIG findings are summarized below.

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

Leadership and Administration of Community Care 	To determine how VISN and facility leaders supported community care services, the OIG evaluated the following elements: • Community care oversight councils • Resource utilization • Staffing and operations • Third-party administrator interactions • Patient safety event reporting • Medical documentation scanning performance • Community care concerns expressed by facility and VISN leaders • Primary care provider survey responses The OIG issued **five recommendations:** community care oversight councils function according to their charters (recommendation 1); facility leaders reassess community care staffing needs and act as necessary (recommendation 2); staff enter community care patient safety events into VHA's Joint Patient Safety Reporting system (recommendation 3); patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings (recommendation 4); staff import community care documents into the patient's electronic health record within five business days of receipt (recommendation 5).
Community Care Diagnostic Imaging Results 	To assess how VHA facility community care staff communicated diagnostic imaging results to the ordering VHA providers, the OIG determined whether staff used the required electronic health record progress note. The OIG also determined whether facility community care staff used the significant findings alert to notify VHA providers when those results were abnormal. The OIG issued **one recommendation:** staff use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results (recommendation 6).

Administratively Closed Community Care Consults 	To evaluate whether facility community care staff managed the administrative closure of consults as required, the OIG determined whether staff • contacted the patient to confirm appointment attendance, • documented the first attempt at obtaining medical documentation, • administratively closed the consult if they did not receive the medical documentation, and • made additional attempts to obtain the documentation after administratively closing the consult. The OIG issued **one recommendation:** staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults that are not low risk (recommendation 7).
Community Care Provider Requests for Additional Services 	To assess how facility staff coordinated the processing and notifications when community providers requested additional services not covered by the initial referral, the OIG determined whether facility staff • processed requests for additional services within three business days, • incorporated the requests and supporting medical documentation into electronic health records, • verified community care providers' signatures on the requests for additional services forms, and • sent letters to notify community providers of approved or denied requests, as required. The OIG issued **three recommendations:** staff process requests for additional services within three business days (recommendation 8) and send approval or denial letters to community providers (recommendation 9) and patients (recommendation 10) for requests for additional services.
Care Coordination: Activities for Patients Referred for Community Care 	To evaluate how effectively facility community care staff coordinated care for patients referred for community care, the OIG determined whether facility staff • contacted patients based on recommended frequencies, • used the Community Care–Care Coordination Plan note to document care coordination activities, and • confirmed patients attended their community care appointments. The OIG issued **two recommendations**: staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care other than basic (recommendation 11) and confirm patients attended their scheduled appointments (recommendation 12).

Urgent Care in the Community 	To determine how community care staff coordinated care for patients who received urgent care in the community, the OIG evaluated whether staff • created the Community Care–Urgent Care Record note in the patient's electronic health record, and • identified a provider to review the patient's medical documentation. The OIG issued **one recommendation:** community care staff create the Community Care–Urgent Care Record note in the patient's electronic health record when they receive medical documentation from the community provider (recommendation 13).

VA Comments and OIG Response

The Veterans Integrated Service Network Director concurred with the findings and recommendations and provided acceptable action plans (see appendixes D and E). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, M.D.
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
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Contents

Abbreviations

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

Introduction

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

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, VHA's Veterans Community Care Program simplifies the process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[2] VHA's Office of Integrated Veteran Care (IVC) aims to provide veterans referred to community care timely access to high quality patient-centered care through the Veterans Community Care Program in a way "that is easy to understand [and] simple to administer."[3] According to IVC leaders, the field guidebook outlines the program's requirements, "processes, and tools related to eligibility, referral, and care coordination."[4]

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

[2] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101, https://www.congress.gov/115/plaws/publ182/PLAW-115publ182.pdf; 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; VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

[3] VHA IVC, chap. 1 in *Community Care Field Guidebook,* November 21, 2022.

[4] Department of Veterans Affairs, "Office of Integrated Veteran Care (IVC) Community Care Field Guidebook," accessed July 1, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This website is not publicly accessible.)

South Central VA Health Care Network

The South Central VA Health Care Network, also known as VISN 16, serves veterans in Arkansas, Louisiana, Mississippi, and parts of Alabama, Florida, Missouri, Oklahoma, and Texas. It includes eight medical centers and 61 outpatient sites.[5]

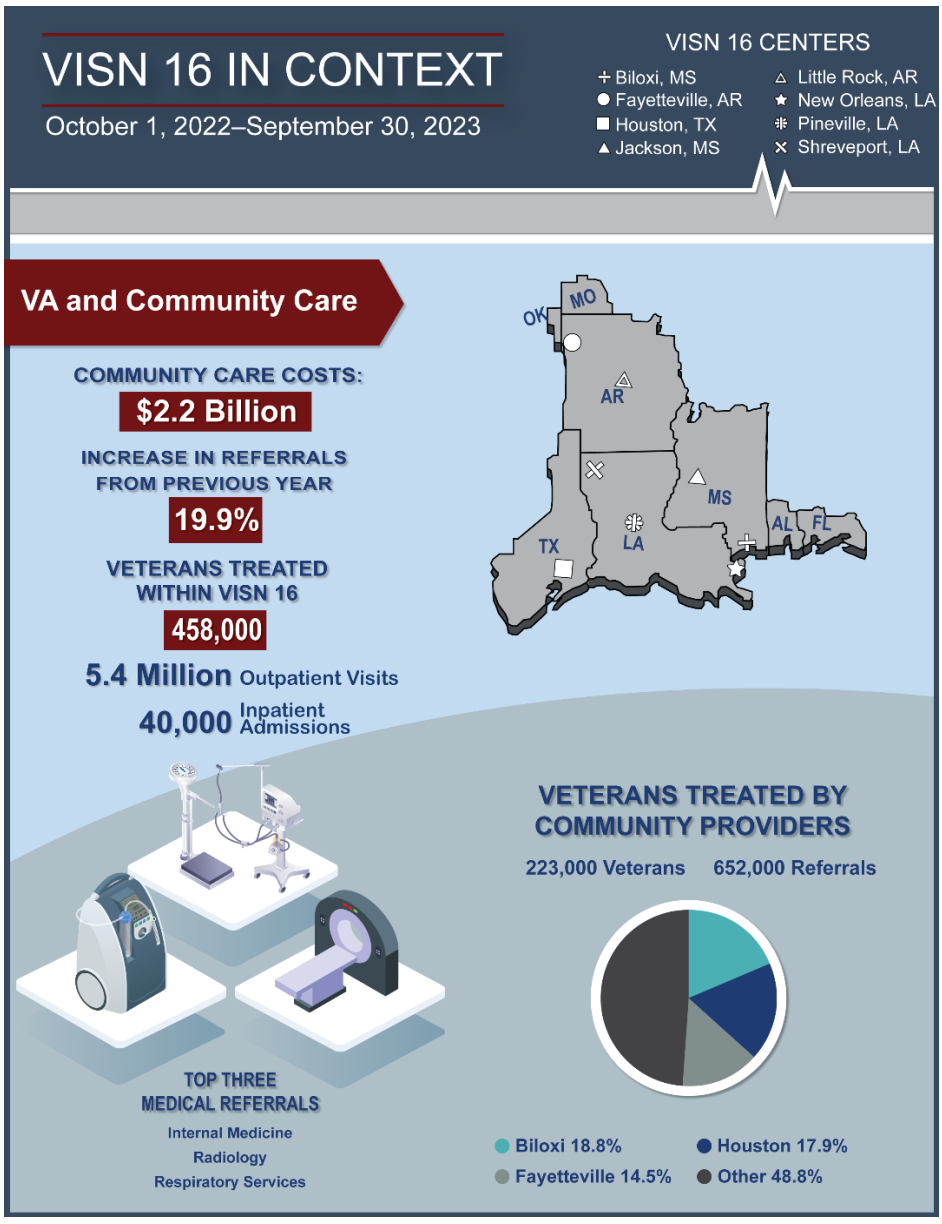

Figure 1. *Community care referral data for VISN 16: South Central VA Health Care Network.*

Source*: OIG analysis of VHA data. The OIG did not verify the accuracy of VHA data.*

[5] "Veterans Health Administration, VISN 16," Department of Veterans Affairs, accessed February 22, 2024, https://www.visn16.va.gov/about/index.asp.

Community Care Consult Management

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

Inspection Elements

The OIG evaluated VISN 16 facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Urgent Care in the Community. The inspection results describe the OIG's findings related to care coordination activities for patients referred for community care. The report highlights opportunities and challenges for VISN and facility staff as they navigate current community care referral processes (see appendix A for a list of all report recommendations).

Inspection Results

Leadership and Administration of Community Care

Effective leaders make decisions that directly or indirectly have an impact on every aspect of operations.[6] In health care, leaders create "policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services."[7] Leaders should ensure patients receive the same level of care whether it is delivered through the medical facility or care in the community.[8]

To determine how VISN 16 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook. The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when the OIG found noncompliance with requirements. The team also sought input from the leaders and primary care providers about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

VHA requires VISN directors to ensure that all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[9] The OIG examined the most recent council charters and meeting minutes for fiscal year 2023 and determined that all VISN 16 facilities had community care oversight councils that reviewed relevant issues, such as community care utilization and third-party administrator performance. However, the OIG also determined that the Jackson, Little Rock, and Shreveport councils did not meet according to the schedule in their charters. For example, Jackson's council met 9 times, but their charter specified a minimum of 10 meetings per year. Facilities without a consistently functioning oversight council might be unable to ensure patients receive quality community care. The OIG made one recommendation in this area.

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

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

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

[9] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to the Network Directors (10N1-23), October 17, 2017.

Recommendation 1

1. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care oversight councils function according to their charters and meet the required number of times per fiscal year.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Resource Utilization

When analyzing ongoing community care decisions, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[10]

All eight facilities' leadership teams reported evaluating whether to continue purchasing specific types of care in the community or providing the care internally and taking actions accordingly. For example, Houston leaders met regularly to assess whether services sent to the community could be more efficiently delivered within the facility. They identified magnetic resonance imaging and mammography as two high-cost, high-volume services referred to the community and therefore increased magnetic resonance imaging staffing and installed a new mammography machine.[11]

Leaders at Pineville reported they had hired an orthopedic surgeon in the last six to eight months to perform care previously sent to the community. At Shreveport, leaders identified physical therapy as one of their top community referrals and expanded the service to all three of their community-based outpatient clinics.

A leader at Little Rock stated that facility community care staff referred patients to community care due to driving distance from their home. The leader explained that because of their rural service area, many patients with these referrals still drove a distance to receive care, frequently the same distance they would drive if they came to the facility, where they would receive better care. The leader educated patients in these situations about their care options.

[10] VHA IVC, "RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document," updated January 26, 2022, https://dvagov.sharepoint.com/ReferralCoordination.aspx. (This website is not publicly accessible.)

[11] "Magnetic resonance imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues within your body." "MRI," Mayo Clinic, accessed November 21, 2024, https://www.mayoclinic.org/tests-procedures/mri. Mammography is an x-ray of the breasts, usually for cancer detection. *Merriam-Webster*, "Mammography," accessed September 12, 2024, https://www.merriam-webster.com/dictionary/mammography.

Additionally, VISN leaders described regularly considering care in the community referrals, as well as the productivity of VHA providers, when deciding the types of providers to hire at facilities to ensure maximized resources. The OIG made no recommendations in this area.

Staffing and Operations

VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[12] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their community care programs.[13] VHA requires facility leaders to assess staffing using the tool, then reassess staffing every 90 days.[14] When facility leaders do not reassess staffing at the required intervals, they may fail to meet workload demands, which could negatively affect community care program operations and patient care.

The OIG reviewed the community care staffing tool results provided by community care leaders at each facility for the fourth quarter of fiscal year 2023 and identified that Houston and Pineville needed additional clinical staff.[15] Houston's staffing tool results identified the need for 22.6 additional clinical full-time equivalent employees, which was the highest number needed for the VISN 16 facilities, and the tool showed that Pineville needed 2.6 additional clinical full-time equivalent employees.[16]

Community care program leaders at every facility reported the staffing tool did not accurately assess community care staffing needs. For example, Biloxi leaders established a call center to answer incoming calls to allow the scheduling staff to focus on scheduling. They found the staffing tool did not include staffing for a call center, so they used a different tool to assess the

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

[13] The tool uses average task times, workload data, types of staff (administrative or clinical), other nonclinical tasks (work that does not involve processing consults or coordinating care); and staff's projected time off to calculate program needs. Laura Osborne and John Leskovich, VHA OCC, "Office of Community Care (OCC): Staffing Tool Training," (PowerPoint presentation), February 2022.

[14] Assistant Under Secretary for Health for Operations (15), "National Implementation of the Community Care Operating Model Staffing Tool," memorandum to Veterans Integrated Service Network Directors (10N1-23), March 1, 2021.

[15] Some VISN 16 facility community care leaders reported the staffing tool underestimated their staffing needs. As such, the clinical staff needs in Houston and Pineville may be underestimated. The staffing tool results for the other VISN 16 facilities reviewed did not show any staffing needs but may also be underestimated.

[16] Full-time Equivalent Employment (FTEE) refers to "the total number of regular straight-time hours worked (i.e., not including overtime or holiday hours worked) by employees divided by the number of compensable hours applicable to each fiscal year." Office of Management and Budget A-11 Circular § 85.2, August 15, 2022. The staffing tool calculation showed clinical staff needed is the difference between the number of clinical staff authorized to the facility's community care program and the number recommended by the staffing tool.

call center's volume and workload. Fayetteville community care leaders found the tool did not consider the actual time needed to coordinate patient care. Further, they explained that their community care department appeared to be properly staffed according to the staffing tool, but it was understaffed, which made it more difficult to effectively advocate for new positions.

During interviews, facility community care program leaders discussed staffing needs and the associated effects on community care services. Biloxi, Houston, Jackson, New Orleans, and Pineville leaders reported needing additional administrative staff, such as medical or program support assistants. Houston, Jackson, New Orleans, and Pineville leaders mentioned having nursing shortages. Leaders at Biloxi and New Orleans stated they had vacancies for nurse practitioners or physician assistants, and New Orleans leaders said they also needed a physician. Community care leaders shared the associated effects of staffing shortages on community care services and department operations:

- Delays in patient care at Biloxi and Jackson
- Lack of care coordination activities at Jackson
- Increased overtime use at Houston
- Decreased staff morale in Houston and Little Rock

Fayetteville, Houston, and Jackson community care leaders shared challenges they experienced hiring additional community care staff. For example, Fayetteville leaders reported difficulties getting new positions approved but generally being able to fill positions when staff departed. Likewise, leaders at Jackson stated they did not have a hiring freeze but were approved only to replace staff who left, maintaining their current staffing level.

The OIG is concerned that facility community care departments may not be able to provide necessary services to patients without hiring additional staff. The OIG made one recommendation.

Recommendation 2

2. The Veterans Integrated Service Network Director, in conjunction with facility directors, reassess community care staffing needs and act as necessary.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Third-Party Administrator Interactions

VHA established contracts with third-party administrators to create regional networks of community providers able to provide care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues

that may affect the safety or quality of veterans' care provided in the community to ensure that, if needed, appropriate follow-up actions are taken.[17]

Facility patient safety managers and VISN patient safety officers may request status updates for potential quality issues from third-party administrator quality and patient safety representatives. Patient safety managers and officers may provide updates to their respective facility community care program teams. Except for Houston, whose third-party administrator was TriWest, all other VISN 16 facilities had contracts with Optum, allowing the OIG to learn about the performance of both of VHA's third-party administrators.

Leaders reported multiple concerns with the third-party administrators. A Pineville leader reported that community providers did not return medical documentation after appointments, estimating that providers did return documentation for nearly 20 percent of consults. This leader further explained that facility staff were unable to hold the providers accountable, and providers get paid whether or not they provide the documentation. A community care leader from Little Rock stated third-party administrators took a significant amount of time to credential new providers, which delayed patient referrals.[18] A Houston community care leader said some community providers overprescribed opioids or prescribed them to patients without performing urine drug screens. This leader stated that all but one community provider's prescribing practices improved after discussing the issue with the third-party administrator representative.

VISN leaders said they want to receive more detailed follow-up information on potential quality issues submitted to third-party administrators, explaining the only response they currently receive is that the administrators had investigated and closed the issues, with no details on findings or actions taken. The OIG is concerned that the limited information regarding outcomes of potential quality issues hinders VHA's oversight ability and efforts to ensure patients receive quality care from community providers. The OIG made no recommendation in this area but suggests VHA leaders discuss these concerns with third-party administrators.

Patient Safety Event Reporting

The OIG found that staff at some facilities did not accurately log and track some patient safety events. Facility community care staff provided the OIG a list of potential quality issues reported to the third-party administrator in fiscal year 2023, and the OIG compared them with incidents

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

[18] Credentialing is "the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status." Department of Veterans Affairs, "Credentialing & Privileging," accessed September 18, 2024, https://dvagov.sharepoint.com/sites/VHA/Credentialing-Privileging.aspx. (This website is not publicly accessible.)

entered into VHA's Joint Patient Safety Reporting system.[19] The OIG noted discrepancies for Biloxi and Little Rock. For Biloxi, the OIG found that community care staff should have reported one potential quality issue in the reporting system and did not. For Little Rock, community care staff failed to enter two potential quality issues in the system.

Facility staff should refer all patient safety events involving a community provider to the third-party administrator for investigation.[20] In addition, VHA requires staff to enter these events into the Joint Patient Safety Reporting system, and facility patient safety managers to review the events to determine the need for any immediate actions.[21] If staff do not enter events, patient safety managers may miss events that could affect quality of care in the community and subsequently fail to take corrective action to address patient safety risks.

The OIG found that community care oversight council meeting minutes did not always contain evidence the councils addressed patient safety information. VHA requires facility patient safety managers or designees to brief the community care oversight council on patient safety event trends, lessons learned, and corrective actions.[22] Fayetteville's fiscal year 2023 community care oversight council meeting minutes included patient safety event discussions. Leaders at Houston and Pineville explained they did not talk about these events during community care oversight council meetings because leaders reported the information in other councils. Also, leaders at Biloxi, Little Rock, and Shreveport had not included the information in the councils' standing agendas. Failure to brief patient safety events could jeopardize safe, high quality patient care. The OIG made two recommendations.

Recommendation 3

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

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

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

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

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

Recommendation 4

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Medical Documentation Scanning Performance

VHA requires staff to import all community care documents into the patient's electronic health record within five business days of receipt.[23] All community care leaders stated their staff tracked medical documentation scanning to identify backlogs; Biloxi, Houston, Jackson, and Shreveport leaders reported backlogs. The Biloxi community care leaders said they had a backlog of 552 documents, including community providers' recommended plans of care and any significant findings. Leaders explained that most of the documents were waiting for a nurse's clinical review, and they planned to resolve the backlog by assigning additional nurses to help.

Facility community care leaders also shared barriers experienced while attempting to obtain medical documentation from community providers. Reported barriers included

- time required to make multiple requests,
- medical documents received without the community providers' signatures,
- smaller community provider offices lacking a fax machine,
- lack of incentive for community providers to provide medical documentation because they receive payment without it.

Jackson community care leaders also reported on the need for community care staff to spend additional time to identify and resolve duplicative documents submitted. This took resources away from promptly scanning medical documentation from community providers and could negatively affect care coordination and quality of care. The OIG made one recommendation.

[23] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirements," March 2021.

Recommendation 5

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns about their community care programs overall. Their worries included increased referrals and spending for community care, community providers failing to return medical documentation, and problems with drive and wait time eligibility.[24]

Increased referrals and spending for community care. VISN and Houston, Jackson, Little Rock, and Pineville leaders expressed concern with the increase in community care spending. One Jackson leader explained that 43 percent of their facility's consults were for community care, and their growth in community care was not sustainable.

Community providers failing to return medical documentation. Facility leaders at Biloxi, Houston, Little Rock, and Pineville discussed concerns about community providers failing to return medical documentation, which hinders VHA providers' efforts in coordinating care and determining the extent and quality of community care delivered. One Houston leader explained that the community care network contract only required community providers to send reports after performing diagnostic procedures and did not require them to provide the diagnostic images needed by VHA providers for continued patient care.

Drive and wait time eligibility. Facility leaders at Biloxi, Fayetteville, and the VISN shared concerns about patients referred to community care due to wait time eligibility who had appointments later than they would have had at the facility. Additionally, VISN leaders shared concerns about patients in rural settings referred to community specialty providers due to drive time eligibility who traveled to a provider near the VHA facility where they could have been treated instead.

[24] A patient meets community care drive time eligibility when their average drive time to a specific VA medical facility is 30 minutes for primary and mental health care, and "60-minute average drive time for specialty care." A patient meets community care wait time eligibility when appointment wait time at a specific VA medical facility is 20 days for primary and mental health care and "28 days for specialty care from the date of request, unless the veteran agrees to a later date." VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019; VHA IVC, chap. 2 in *Community Care Field Guidebook*, November 29, 2022.

VHA leaders shared concerns that provide insight into potential community care vulnerabilities, challenges, and areas for improvement that IVC leaders could consider for national program changes.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs, including diagnosis and management of conditions and coordination of their overall care, and may initiate referrals for care by community providers.[25] The OIG surveyed VISN 16 primary care providers anonymously for feedback about issues they encountered with the community care program, including questions about community care referrals (see appendix B for detailed survey information). The survey feedback could lead to process improvements at both the local and national levels.[26] Table 1 lists selected survey results.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community provider medical documentation	92
No call when results had a significant finding or required immediate attention for patients referred to community care for diagnostic testing	76
Appointment scheduling delays	72
Documentation receipt delays negatively affecting patient outcomes	71
Appointment delays negatively affecting patient outcomes	62
Quality of care concerns when referring patients to community care	33

Source: VA OIG survey of VISN 16 primary care providers' experience with community care.

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

VISN 16 primary care providers generally reported concerns similar to those of the VISN and facility leaders regarding quality of care. Some providers who reported concerns about quality of community care submitted additional comments. The OIG identified the following issues:

- Lack of community provider medical documentation or images resulting in delayed appointments for follow-up care
- Concerns with the quality of community care
- Community providers who perform additional services whether needed or not

[25] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[26] Survey responses may not be representative of all primary care providers in VISN 16 due to the low response rate.

Community Care Diagnostic Imaging Results

Patients may receive diagnostic imaging by community providers if the imaging service is not available at a VHA facility or if access to the facility is an obstacle for the patient. VHA staff must ensure the results are entered into the electronic health record correctly, so providers are able to locate the results, especially when they are abnormal.[27]

The OIG selected diagnostic imaging results as an inspection domain because imaging was one of the services most often referred to community providers during fiscal year 2023. The OIG found that community care staff at four facilities did not consistently alert VHA providers of abnormal diagnostic imaging results, as detailed below.[28]

VHA providers may refer patients to community care if a required diagnostic service is not available at a VHA facility or if the patient meets eligibility criteria, such as standards for wait time for an appointment or drive time to the facility.[29] When facility staff receive the imaging results, VHA requires them to attach the results to a progress note titled Community Care Consult Result.[30] The note title indicates to VHA providers where the results can be found. If the results are abnormal, VHA expects facility community care staff to use the significant findings alert to notify ordering providers.[31]

The OIG reviewed diagnostic imaging results at these VISN 16 sites:

Fayetteville, AR
Jackson, MS
Little Rock, AR
New Orleans, LA
Shreveport, LA

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

[28] The OIG did not select the Community Care Diagnostics Imaging Results domain for Biloxi, Houston, and Pineville and instead selected a new domain, Urgent Care in the Community, as the OIG team that developed this new domain reviewed those facilities.

[29] "Diagnostic radiology helps health care providers see structures inside your body." Examples of diagnostic imaging procedures are ultrasound and computed tomography (commonly called CT) scans. National Institutes of Health, National Library of Medicine, MedlinePlus, *A.D.A.M. Medical Encyclopedia*, "Imaging and Radiology," accessed August 18, 2023, https://medlineplus.gov/ency; VHA Office of Community Care, "Veteran Community Care General Information."

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

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

The OIG found that Fayetteville, Little Rock, New Orleans, and Shreveport community care staff failed to consistently use the significant findings alert to notify providers of abnormal diagnostic imaging results as expected.[32]

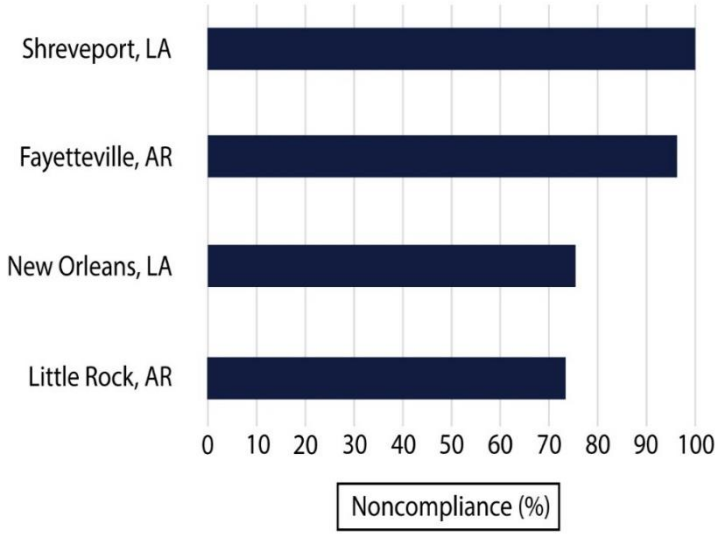

Figure 2. *Provider notification of abnormal diagnostic imaging results via a significant findings alert.*

Source: OIG analysis of VHA data.

When staff do not use the significant findings alert, providers may be unaware of abnormal results, which could delay patients' diagnosis and treatment. Facility community care leaders at noncompliant facilities reported many reasons why their community care teams did not use the significant findings alert, including staff

- notifying the ordering provider through phone calls or instant messages,
- sending an alert to the ordering provider requesting their signature on the note with the results to acknowledge their receipt and review, and
- using a critical findings note created by the facility that acknowledges the ordering provider's receipt of the results.

Additionally, Little Rock community care leaders reported conducting an audit prior to the OIG visit that confirmed staff did not use the significant findings alert to notify ordering providers of abnormal diagnostic imaging results. As a result, these leaders retrained community care staff on the significant findings alert process. The OIG made one recommendation.

[32] Statistical analysis for facility noncompliance appears in appendix C.

Recommendation 6

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Administratively Closed Community Care Consults

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

The OIG reviewed administratively closed consults at these VISN 16 sites:

Biloxi, MS
Fayetteville, AR
Houston, TX
Jackson, MS
Little Rock, AR

The OIG determined that community care staff at five selected facilities did not consistently make the required continued attempts to obtain medical documentation from community providers after they administratively closed community care consults, as detailed below.[33] Within VHA, staff close consults to other VHA providers after they provide the requested services and make the documentation of care readily available in the electronic health records.[34] VHA established a process for staff to administratively close community care consults if they do not get the medical documentation following their first attempt. After the date of the community care appointment, facility community care staff

- contact patients to confirm they attended their appointments,
- attempt to obtain the community providers' medical documentation and record the effort in the electronic health records if they have not received it within 14 days of the scheduled appointment, and

[33] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed Biloxi, Fayetteville, Houston, Jackson, and Little Rock for this domain.

[34] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. VHA rescinded and replaced this directive with VHA Directive 1232, *Consult Management*, November 22, 2024.

- close the consults administratively and make two additional attempts to obtain the documentation within 90 days of the appointment.[35]

The OIG found that Biloxi, Fayetteville, Houston, Jackson, and Little Rock community care staff failed to consistently make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults.[36]

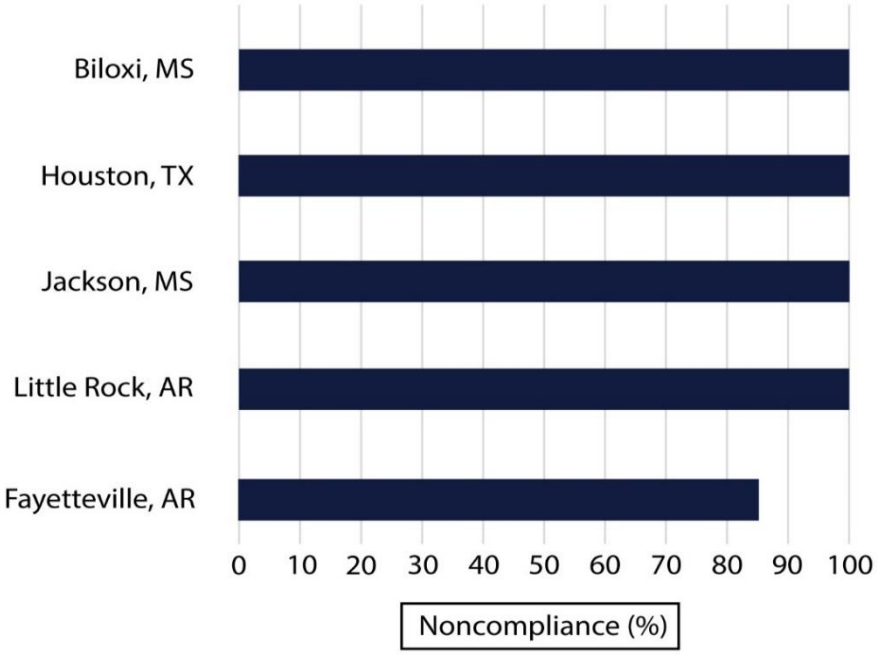

Figure 3. *Additional attempts to obtain documentation after administrative consult closure.*

Source: OIG analysis of VHA data.

Community care leaders at Fayetteville, Houston, and Little Rock facilities explained that staff made all three attempts to obtain community providers' medical documentation prior to administratively closing the consults. Jackson leaders said they made two attempts and then closed the consult. The leaders reported reasons such as staff

- being unaware of the requirement;
- managing a large volume of community care consults, making additional attempts after administrative closure difficult; and

[35] This requirement does not apply to community care consults VHA designates as low risk, such as massage therapy or smoking cessation clinic, which require one attempt to obtain records. VHA IVC, chap. 4 in *Community Care Field Guidebook.*

[36] Statistical analysis for facility noncompliance appears in appendix C.

- believing that making all three attempts before they closed the consult was a more efficient process that resulted in fewer consults being closed without medical documentation.

If staff do not administratively close the consult after making the first attempt to obtain medical documentation, the consult remains in an open status and staff cannot track these consults using VHA's administrative closure report, which was created to monitor their continued efforts to obtain the documentation.[37] The OIG made one recommendation.

Recommendation 7

7. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults that are not low risk.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Community Care Provider Requests for Additional Services

Community providers may submit requests for additional services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA clinical staff review and make timely decisions on the requests.[38]

The OIG determined that community care staff did not consistently process community providers' requests for additional services in a timely manner and send approval and denial letters to community providers and patients, as detailed below. VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[39] The process requires community providers to submit the request and supporting medical documentation on a VHA-provided form. Then, facility community care staff must

- review the request for the provider's signature and supporting documentation;
- approve or deny the request within three business days of receipt;

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

[38] Tamika Taylor, VHA IVC, "Requests for Services (RFS) Form 10-10172 Training," (PowerPoint presentation), September 2023; VHA IVC, chap. 3 in *Community Care Field Guidebook*, June 2022.

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

- incorporate the request and supporting medical documentation in the electronic health record; and
- send a letter to the community provider and patient to inform them of the decision and explain the reasons for a denied request.[40]

Requests for Additional Services Approvals or Denials

The OIG determined that Biloxi, Houston, Jackson, Little Rock, Pineville, and Shreveport community care staff did not consistently process requests for services within three business days of receipt.[41]

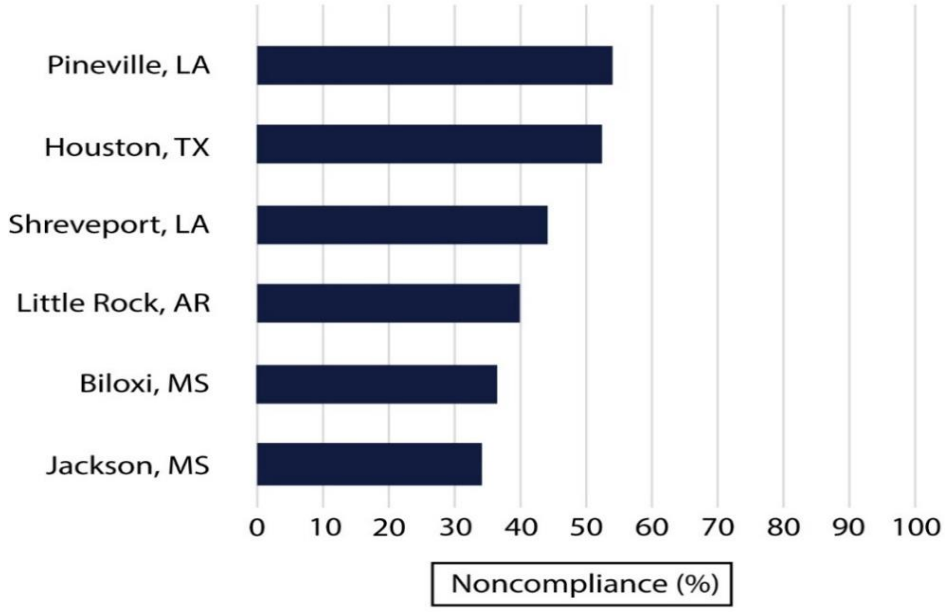

Figure 4. *Requests for additional services processed within three business days of receipt.*

Source: OIG analysis of VHA data.

When staff do not process requests for additional services in three business days, it may delay needed care and negatively affect patient outcomes. Community care staff at Houston, Little Rock, and Pineville shared that they did not process the requests within three business days because of staffing shortages and large volumes of requests for additional services. Houston staff also described the negative impact of duplicate requests from community providers which further overwhelmed limited resources. The OIG made one recommendation.

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

[41] Statistical analysis for facility noncompliance appears in appendix C.

Recommendation 8

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Community Provider Notification of Requests for Additional Services

The OIG found some facilities' community care staff failed to consistently send letters to community providers when they approved or denied requests for additional services, as required.[42] The OIG determined that community care staff at Biloxi, Fayetteville, Little Rock, New Orleans, Pineville, and Shreveport did not consistently send community providers approval letters for requests for additional services.[43]

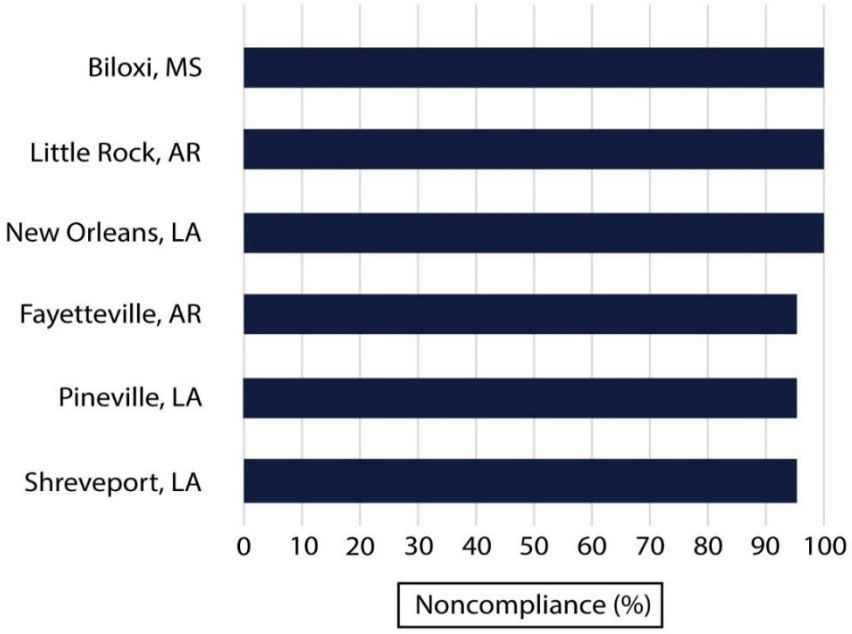

Figure 5. *Community provider notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

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

[43] Statistical analysis for facility noncompliance appears in appendix C.

The OIG also found that community care staff at Jackson and Little Rock did not consistently send community providers denial letters for requests for additional services. Specifically, Jackson community care staff did not send letters to 80 percent (95% CI: 68 to 92) of community providers, and staff at Little Rock did not send letters to any community providers.[44]

Failure to send approval letters may delay patient care because community providers could be unaware of the approvals. When community care staff do not send denial letters, it may delay community providers in coordinating alternative treatment options or addressing deficiencies with the initial request. Additionally, when staff fail to send denial letters, they miss opportunities to educate community providers on the requests for additional services process.

Community care leaders at noncompliant facilities reported several reasons for staff not sending letters to community providers when they approved or denied requests for additional services, including staff

- calling providers instead,
- sending providers a new authorization, and
- being unaware of the requirement.

The OIG made one recommendation.

Recommendation 9

9. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to community providers for requests for additional services.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Patient Notification of Requests for Additional Services

The OIG found some facilities' community care staff failed to consistently send letters to patients when they approved or denied requests for additional services, as required.[45] The OIG determined that Biloxi, Fayetteville, Houston, Little Rock, New Orleans, Pineville, and

[44] A confidence interval is reported for random samples when the noncompliance percentage is not equal to 100 or 0 since there is no variation in compliance. A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time. Little Rock was 100 percent noncompliant; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance appears in appendix C.

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

Shreveport community care staff did not send patients approval letters for any requests for additional services.[46] Failure to send approval letters to patients may cause them to miss care coordination steps, which may result in delayed care or no care at all.

The OIG determined that Houston, Jackson, and Little Rock community care staff did not send letters to any patients when they denied requests for additional services, as required.[47] Failure to send denial letters to patients may prevent them from potentially resolving the reasons for denial or delay working with the VHA referring provider to find an alternative source of care.

Community care leaders at Biloxi reported that staff did not send letters to patients when they approved or denied requests because they were still developing a process, and the VISN was creating the notification letters. Community care leaders of other noncompliant facilities added that staff either were unaware of the requirement, believed it was the community provider's responsibility to inform patients, or lacked a decision letter template. The OIG made one recommendation.

Recommendation 10

10. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to patients for requests for additional services.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

[46] Biloxi, Fayetteville, Houston, Little Rock, New Orleans, Pineville, and Shreveport were 100 percent noncompliant; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance appears in appendix C.

[47] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Houston, Jackson, and Little Rock were 100 percent noncompliant; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance appears in appendix C.

Care Coordination Activities for Patients Referred for Community Care

Facility community care staff use care coordination to organize services and resources with patients and community care providers based on an individual patient's needs. A VHA care coordination plan addresses activities, such as appointments, follow-up, communication with the patient and community providers, and transition back to VHA medical care.[48]

The OIG found that community care staff at the three facilities reviewed did not consistently contact patients according to VHA recommendations and create and use the Community Care–Care Coordination Plan note. Additionally, two of the three facilities did not consistently confirm patients attended their scheduled appointments.[49] VHA has established a care coordination model as a framework for overseeing care and aligning resources based on the individual patient's needs. The model details the principles of care coordination, defines staff roles and responsibilities, and describes specific ways to accomplish goals, such as improved care transitions between VHA and community providers.[50]

The OIG reviewed care coordination at these VISN 16 sites:

New Orleans, LA
Pineville, LA
Shreveport, LA

Patient Contacts According to Recommended Frequencies

Facility community care staff use an automated algorithm called the Screening Triage Tool to determine the appropriate level of care coordination for each consult.[51] Levels are based on the intensity, frequency, duration, and type of care coordination each patient needs. As care complexity increases, so does the type and frequency of care coordination activities, including contact with the patient.[52] Table 2 lists the levels of care and corresponding recommended frequency of patient contact.[53]

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

[49] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed New Orleans, Pineville, and Shreveport for this domain.

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

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

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

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

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

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

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

The OIG estimated that community care staff at New Orleans and Pineville did not consistently contact 81 percent (95% CI: 69 to 92) and 89 percent (95% CI:79 to 98), respectively, of patients according to the recommended frequency for consults requiring a complex/chronic level of care coordination. The OIG also found that Shreveport community care staff did not consistently contact any patients according to the recommended frequency.[54] Pineville community care leaders stated that staff did not contact patients at the recommended frequency because they had a large volume of consults and an increased workload. Shreveport leaders said that they did not have a process to ensure compliance. The OIG is concerned that VHA does not require VHA staff to follow-up with patients according to assigned levels of care and associated frequencies because patients may not receive adequate care coordination and follow-up, which could compromise patient safety.[55]

Documentation of Care Coordination Activities

VHA also developed a standardized progress note called the Community Care–Care Coordination Plan that facility community care staff use to document aspects of care coordination, such as clinically indicated services and a patient's psychosocial needs, preferences, and goals. Staff are required to document all care coordination activities for each consult in the note, except for consults with a basic level of care coordination.[56]

[54] Shreveport was 100 percent noncompliant; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance appears in appendix C.

[55] VHA IVC, chap. 2 in *Community Care Field Guidebook*.

[56] Deputy Under Secretary for Health for Operations and Management (10N), "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum to Veterans Integrated Service Network Directors (10N1-23), September 16, 2019; VHA IVC, chap. 3 in *Community Care Field Guidebook*. Direct scheduling allows patients to schedule an outpatient appointment without a providers consult or order. VHA, *Patient Self-Referral Direct Scheduling (PSDS) Standard Operating Procedure (SOP)*, September 3, 2024.

The OIG found that New Orleans, Pineville, and Shreveport community care staff did not consistently create and use the Community Care–Care Coordination Plan note to document care coordination, as required. Specifically, for patients referred to community care

- by New Orleans providers, community care staff did not create the note for 29 percent (95% CI: 17 to 43) of records reviewed, and for those notes created, they did not use 88 percent (95% CI: 76 to 97) of those notes;
- by Pineville providers, community care staff did not create the note for 27 percent (95% CI: 14 to 40) and did not use any of the notes created; and
- by Shreveport providers, community care staff created the notes most of the time but did not use any of them.[57]

When facility community care staff fail to create and use the Community Care–Care Coordination Plan note as required, patients' medical information may be more difficult to locate and delay their follow-up care. Community care leaders at New Orleans explained that staff did not consistently document care coordination activities in the correct note, which would be corrected. The OIG made one recommendation.

Recommendation 11

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Confirmation Patients Attended Community Care Appointments

According to VHA, facility community care staff must contact patients to confirm whether they attended their scheduled appointments. If staff are unable to reach the patient, they contact the community provider to confirm.[58] The OIG found that New Orleans community care staff did not confirm 39 percent (95% CI: 24 to 54) of the patients reviewed attended their community

[57] Deputy Under Secretary for Health for Operations and Management, "National Deployment of the Community Care Coordination Model," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*. Pineville and Shreveport were 100 percent noncompliant for the use of the Community Care–Care Coordination Plan note to document care coordination when created; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance is reported in appendix C.

[58] VHA IVC, chap. 3 in *Community Care Field Guidebook*, March 6, 2023; VHA IVC, chap. 4 in *Community Care Field Guidebook*.

care appointments, and Shreveport community care staff did not confirm 53 percent (95% CI: 39 to 67) of patients.[59] Shreveport community care leaders attributed the noncompliance to lack of staff training and knowledge. The OIG made one recommendation.

Recommendation 12

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

The VISN Director concurred and provided an action plan with a completion date of June 2025.

Urgent Care in the Community

Urgent care services include the treatment of injuries and illnesses that need immediate attention but are not life threatening, such as skin infections, minor burns, and influenza.[60] VHA must "ensure continuity of care" for patients who receive community urgent care services.[61]

The OIG found that Biloxi, Houston, and Pineville facility community care staff did not consistently create the Community Care–Urgent Care Record note in the electronic health record of patients who received urgent care in the community, as detailed below.[62] VHA requires facility community care staff to enter the Community Care–Urgent Care Record note into the patient's electronic health record when they receive the community urgent care medical documentation.[63] VHA also requires staff to identify a provider (typically the primary care provider) to review the patient's medical documentation. When staff receive the patient's medical documentation, they are required to create the

The OIG reviewed community care urgent care visits at these VISN 16 sites:

Biloxi, MS
Houston, TX
Pineville, LA

[59] Statistical analysis for facility noncompliance appears in appendix C.

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

[61] MISSION Act § 105.

[62] OIG leaders selected a new domain, Urgent Care in the Community, at Biloxi, Houston, and Pineville as the OIG team that developed this new domain reviewed those facilities.

[63] Department of Veterans Affairs, Veterans Health Administration, Office of Community Care Delivery Operation, *Community Care–Urgent Care Record Note Setup Guide*, February 1, 2018.

Community Care–Urgent Care Record note, attach the documentation to it, and send the note to the provider using a signature request alert.[64]

The OIG found that Biloxi and Pineville community care staff did not create the required note for any of the patients who received community urgent care, and staff from Houston did not create the note for 94 percent (95% CI: 86 to 100) of patients.[65] Community care staff for these facilities reported the following reasons for not creating the Community Care–Urgent Care Record note in the electronic health records:

- Biloxi community care staff stated they did not receive notification when patients went to community urgent care providers
- Houston community care staff explained they used a locally created note instead of the required one[66]
- Pineville community care staff said they did not receive the medical documentation[67]

Facility community care staff's failure to create the correct note in patients' electronic health records may result in their primary care providers or designees being unaware of follow-up care needs. The OIG made one recommendation.

Recommendation 13

13. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create the Community Care–Urgent Care Record note in the patient's electronic health record when they receive medical documentation from the community provider.

The VISN Director concurred and provided an action plan with a completion date of June 2025.

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

[65] Biloxi and Pineville were 100 percent noncompliant; a confidence interval cannot be calculated since there was no variation in compliance. Statistical analysis for facility noncompliance appears in appendix C.

[66] The OIG found eight instances where staff used a different note to document community urgent care visits.

[67] For 10 patients who received urgent care in the community, the OIG found the medical documentation in the Veterans Health Information Exchange but not in their electronic health records. The Veterans Health Information Exchange allows VA and participating community care partners to share health information through tools known as VA Exchange and VA Direct Messaging. Department of Veterans Affairs, *Veterans Health Information Exchange (VHIE),* accessed February 11, 2020, https://www.va.gov/VLER/about-vler-health.asp.

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at selected facilities within VISN 16, the OIG conducted a detailed inspection from April 23 through May 10, 2024. Addressing six domains of community care across eight VISN facilities with community care programs, the inspection resulted in 13 recommendations on systemic issues that may adversely affect patient outcomes. The total number of recommendations does not necessarily reflect the overall quality of all services delivered by facility community care staff within this VISN. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A. Summary of Recommendations

Domain	Recommendation
Leadership and Administration of Community Care	1. Facility community care oversight councils function according to their charters and meet the required number of times per fiscal year. 2. Facility directors reassess community care staffing needs and act as necessary. 3. Facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system. 4. Patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings. 5. Facility staff import all community care documents into the patient's electronic health record within five business days of receipt.
Community Care Diagnostic Imaging Results	6. Facility community care staff use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.
Administratively Closed Community Care Consults	7. Facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults that are not low risk.
Community Care Provider Requests for Additional Services	8. Facility community care staff process community providers' requests for additional services within three business days of receipt. 9. Facility community care staff send approval or denial letters to community providers for requests for additional services. 10. Facility community care staff send approval or denial letters to patients for requests for additional services.
Care Coordination Activities for Patients Referred for Community Care	11. Facility community care staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care other than basic. 12. Facility community care staff confirm patients attended their community care appointments.
Urgent Care in the Community	13. Facility community care staff create the Community Care–Urgent Care Record note in the patient's electronic health record when medical documentation is received from the community provider.

Appendix B: Methodology

The OIG reviewed community care processes at eight VISN 16 medical facilities with a community care program from April 23 through May 10, 2024. The facilities were the VA Gulf Coast Healthcare System (Biloxi), Veterans Health Care System of the Ozarks (Fayetteville), VA Houston Healthcare System (Houston), VA Jackson Healthcare System (Jackson), Central Arkansas Veterans Healthcare System (Little Rock), VA Southeast Louisiana Healthcare System (New Orleans), VA Alexandria Healthcare System (Pineville), and VA Shreveport Healthcare System (Shreveport).

The OIG reviewed results from facilities' electronic health records, the OIG's survey that was distributed to VHA facility primary care providers, and facilities' urgent care policy or standard operating procedures.[1] The OIG also examined the most recent Community Care Oversight Council charters and meeting minutes for fiscal year 2023 to determine whether facilities had a council and if it met the minimum number of times per year, as specified by their charter. The OIG interviewed leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance.

The OIG electronically distributed a survey to primary care providers from April 29 through May 9, 2024. The OIG emailed 469 surveys to VISN 16 primary care providers and received 183 replies, a 39 percent response rate.[2]

The inspection team examined operations and electronic health records from October 1, 2022, through September 30, 2023. The OIG reviewed each facility for performance in the Leadership and Administration of Community Care domain. After reviewing facility performance data relevant to each respective domain, the OIG selected three domains for review, Administratively Closed Community Care Consults (Biloxi, Fayetteville, Houston, Jackson, and Little Rock), Community Care Provider Requests for Additional Services (Biloxi, Fayetteville, Houston, Jackson, Little Rock, New Orleans, Pineville, and Shreveport), and Care Coordination Activities for Patients Referred for Community Care (New Orleans, Pineville, and Shreveport). The OIG also selected the Community Care Diagnostic Imaging Results domain for Fayetteville, Jackson, Little Rock, New Orleans, and Shreveport and implemented a new Urgent Care in the

[1] Each VA Medical Center identified primary care providers. The OIG contacted them using their VA email addresses, and staff from the OIG Office of Data Analytics analyzed the responses. Participation in the survey was voluntary. The OIG requested a facility policy for urgent care procedures. While New Orleans had a standard operating procedure, the other facilities said they followed the urgent care procedures in the VHA IVC *Community Care Field Guidebook* and did not have a local policy.

[2] VA OIG Survey of VISN 16 Primary Care Providers' Experience with Community Care. Survey responses may not be representative of all primary care providers in VISN 16 due to the low response rate.

Community domain for Biloxi, Houston, and Pineville.[3] OIG leaders approved all domain selections based on content and professional judgment.

The domains selected for each VISN 16 facility are shown in figure 6.

Figure 6. *Domain selections for VISN 16 facilities.*
Source: OIG analysis of VHA data.

For the Leadership and Administration of Community Care domain, the OIG interviewed VISN and facility executive and community care leaders, identified participants according to their roles or titles, and used standardized interview questions to maintain consistency. The OIG also reviewed facilities' policies, standard operating procedures, and Community Care Oversight Council charters and meeting minutes.

The OIG used the following criteria to select electronic health records during the review period for each domain:

- Community Care Diagnostic Imaging Results: community care diagnostic imaging referrals for computed tomography, ultrasound, or magnetic resonance imaging.
- Administratively Closed Community Care Consults: community care consults administratively closed without medical documentation, excluding referrals for low risk, dental, imaging, and geriatrics and extended care services.
- Community Care Provider Requests for Additional Services: patients with requests for additional services submitted by community providers, excluding requests for dental or geriatrics and extended care services. If a patient had more than one request, the OIG evaluated the earliest request during the study period.

[3] The OIG conducted the Urgent Care in the Community review in place of the Community Care Diagnostic Imaging Results review for Biloxi, Houston, and Pineville.

- Care Coordination Activities for Patients Referred for Community Care: community care consults for which facility community care staff scheduled the community care appointment for the patient and did not complete the consult within 90 calendar days, excluding referrals for low risk, optometry, audiology, and dental care, future care, imaging, and geriatrics and extended care services. This domain also excluded patients who scheduled their own appointments.
- Urgent Care in the Community: paid invoices for urgent care visits of patients with cardiac, respiratory, pain, and mental health needs, excluding patients referred for emergency care the same day as the urgent care visit.

For all the above domains, the OIG randomly selected 50 electronic health records that met the criteria for the review period. During the review process, the OIG may have excluded some records, which resulted in the analysis of fewer than 50 records. The OIG statistically analyzed all randomly selected samples. The OIG reported the results of statistical analysis in appendix C.

The OIG reported a confidence interval for the statistical analysis for all random samples. The OIG also did not calculate a confidence interval if the noncompliance percent was equal to 100 or 0. A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. A 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence interval 95 percent of the time. The OIG made a finding and recommendation when the noncompliance percentage was statistically significantly above the 10 percent deficiency benchmark and the lower bound of the 95% confidence interval was above 10 percent.

This report is a review of VISN 16 and facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Findings cannot be generalized across VHA. The OIG's analysis relied on inspectors identifying information from surveys, interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*[4]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability. The OIG conducted

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

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

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.

Appendix C: Statistical Analysis

Please refer to appendix B for a detailed description of the OIG's methods for selecting and statistically analyzing data and determining findings based on analysis of results.

Based on the electronic health records reviewed for selected facilities in VISN 16, the OIG estimated that community care staff at Fayetteville, Little Rock, New Orleans, and Shreveport did not consistently use the significant findings alert to notify providers of abnormal diagnostic imaging results, as shown in Table C.1.

Table C.1. Facility Community Care Staff Using the Significant Findings Alert to Notify Providers of Abnormal Diagnostic Imaging Results

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fayetteville	37	97	91 to 100
Jackson	9	n/a*	n/a*
Little Rock	22	73	53 to 91
New Orleans	12	75	50 to 100
Shreveport	11	100	n/a‡

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients in the sample was less than 11.*

‡*A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed for selected facilities, the OIG estimated that Biloxi, Fayetteville, Houston, Jackson, and Little Rock community care staff did not consistently make two additional attempts to obtain medical documentation after administratively closing consults that are not low risk within 90 days of appointments, as shown in Table C.2.

Table C.2. Facility Community Care Staff's Additional Attempts to Obtain Medical Documentation after Administratively Consult Closure

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	19	100	n/a*
Fayetteville	20	85	68 to 100
Houston	24	100	n/a*
Jackson	32	100	n/a*
Little Rock	29	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed for facilities in VISN 16, the OIG estimated that community care staff at Biloxi, Houston, Jackson, Little Rock, Pineville, and Shreveport did not consistently process requests for additional services within three-day time frame, as shown in Table C.3.

Table C.3. Facility Community Care Staffs' Processing Requests for Additional Services Within Three Business days of Receipt

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	50	36	24 to 50
Fayetteville	48	17	6 to 28
Houston	40	52	37 to 68
Jackson	47	34	21 to 48
Little Rock	50	40	26 to 54
New Orleans	50	2	0 to 6
Pineville	49	53	39 to 67
Shreveport	43	44	30 to 59

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG estimated that Biloxi, Fayetteville, Little Rock, New Orleans, Pineville, and Shreveport community care staff did not consistently send approval letters for requests for additional services to community providers, as shown in Table C.4.

Table C.4. Facility Community Care Staff Sending Approval Letters to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	42	100	n/a*
Fayetteville	42	95	88 to 100
Houston	22	18	4 to 35
Jackson	6	n/a‡	n/a
Little Rock	37	100	n/a*
New Orleans	44	100	n/a*
Pineville	41	95	88 to 100
Shreveport	39	95	87 to 100

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

‡*Estimates are omitted when the number of patients in the sample was less than 11.*

Based on the electronic health records reviewed, the OIG estimated that Little Rock and Jackson community care staff did not consistently send denial letters to community providers for requests for additional services, as shown in Table C.5.

Table C.5. Facility Community Care Staff Sending Denial Letters to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	8	n/a*	n/a
Fayetteville	6	n/a*	n/a
Houston	18	11	0 to 28
Jackson	41	80	68 to 92
Little Rock	13	100	n/a‡
New Orleans	6	n/a*	n/a
Pineville	8	n/a*	n/a
Shreveport	3	n/a*	n/a

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients in the sample was less than 11.*

‡*A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed, the OIG estimated that Biloxi, Fayetteville, Houston, Little Rock, New Orleans, Pineville, and Shreveport community care staff did not consistently send approval letters to patients for requests for additional services, as shown in Table C.6.

Table C.6. Facility Community Care Staff Sending Approval Letters to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	42	100	n/a*
Fayetteville	42	100	n/a*
Houston	22	100	n/a*
Jackson	6	n/a‡	n/a
Little Rock	37	100	n/a*
New Orleans	44	100	n/a*
Pineville	41	100	n/a*
Shreveport	39	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

‡*Estimates are omitted when the number of patients in the sample was less than 11.*

Based on the electronic health records reviewed, the OIG estimated that Houston, Jackson, and Little Rock community care staff did not consistently send denial letters to patients for requests for additional services, as shown in Table C.7.

Table C.7. Facility Community Care Staff Sending Denial Letters to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	8	n/a*	n/a
Fayetteville	6	n/a*	n/a
Houston	18	100	n/a‡
Jackson	41	100	n/a‡
Little Rock	13	100	n/a‡
New Orleans	6	n/a*	n/a
Pineville	8	n/a*	n/a
Shreveport	3	n/a*	n/a

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients in the sample was less than 11.*

‡*A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed, the OIG estimated that New Orleans and Shreveport community care staff did not consistently confirm patients attended community care appointments, as shown in Table C.8.

Table C.8. Facility Community Care Staff Confirming Patients Attended Community Care Appointments

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
New Orleans	41	39	24 to 54
Pineville	38	16	5 to 28
Shreveport	47	53	39 to 67

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG estimated that New Orleans and Pineville community care staff did not consistently create the Community Care–Care Coordination Plan note to document care coordination for consults with an assigned level of care other than basic, as shown in Table C.9.

Table C.9. Community Care Staff Creating the Community Care–Care Coordination Plan Note to Document Care Coordination for Patients with an Assigned Level of Care other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
New Orleans	48	29	17 to 43
Pineville	45	27	14 to 40
Shreveport	49	2	0 to 6

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG estimated that New Orleans, Pineville, and Shreveport community care staff did not consistently use the Community Care–Care Coordination Plan note when it was created to document care coordination for consults with an assigned level of care other than basic, as shown in Table C.10.

Table C.10. Facility Community Care Staff Using the Community Care–Care Coordination Plan Note When Created to Document Care Coordination for Consults with an Assigned Level of Care other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
New Orleans	34	88	76 to 97
Pineville	33	100	n/a*
Shreveport	48	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed, the OIG determined that New Orleans, Pineville, and Shreveport community care staff did not consistently contact patients according to the recommended frequency for consults with complex/chronic levels of care, as shown in Table C.11.

Table C.11. Facility Community Care Staff Contacting Patients According to Recommended Care Coordination Frequencies for Consults with Complex/Chronic Levels of Care

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
New Orleans	48	81	69 to 92
Pineville	45	89	79 to 98
Shreveport	49	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed, the OIG estimated that Biloxi, Houston, and Pineville community care staff did not consistently create the Community Care–Urgent Care Record note in the electronic health record for patients who received community urgent care, as shown in Table C.12.

Table C.12. Facility Community Care Staff Creating the Community Care–Urgent Care Record Note for Patients Who Received Community Urgent Care

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Biloxi	45	100	n/a*
Houston	36	94	86 to 100
Pineville	43	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 31, 2025

From: Network Director, South Central VA Health Care Network (10N16)

Subj: Office of Inspector General (OIG) Draft Report: Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers

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

Executive Director, Office of Integrity and Compliance (10OIC)

1. Thank you for the opportunity to review and comment on OIG Draft Report, Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers.
2. The South Central VA Health Care Network reviewed and concurs with recommendations 1-13. Action plans are provided in the attachment.
3. If you have additional questions or need further information, please contact the VISN 16 Accreditation Specialist.

(*Original signed by:*)

Shannon Novotny for
Skye McDougall, PhD
Network Director

Appendix E: Action Plans

Recommendation 1

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care oversight councils function according to their charters and meet the required number of times per fiscal year.

VISN concurs.

Target date for completion: June 2025

VISN response: Veterans Integrated Service Network (VISN) 16 will ensure facilities update their Facility Community Care Oversight Council charters and conduct Community Care Oversight Council meetings according to their charters. Currently the VISN 16 Access Office requires facilities to upload their monthly Community Care Oversight minutes to a VISN SharePoint via monthly action item. Compliance will be reported at the VISN 16 Access Oversight Council through the governance structure.

Recommendation 2

The Veterans Integrated Service Network Director, in conjunction with facility directors, reassess community care staffing needs and act as necessary.

VISN concurs.

Target date for completion: June 2025

VISN response: The Office of Integrated Veteran Care (IVC) has implemented a quarterly suspense, requiring the completion of the Community Care operating model staffing tool since 2022. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager will continue to ensure facility community care staff complete the Community Care Operating Model Staffing Tool Reassessment every 90 days.

Identified staffing needs and recommendations will be acted upon by the individual facilities based on analysis and evaluation of the individual facility priority need.

Recommendation 3

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

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 will collaborate with Office of Integrated Veteran Care (IVC) and VHA National Center for Patient Safety (NCPS) to ensure facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting System (JPSR) and, when applicable, submit a Potential Quality Issue (PQI) form to the Third-Party Administrator (TPA). VISN 16 recently received updated guidance from NCPS (Patient Safety Guidebook v6.2). This updated guidance has been disseminated to all VISN 16 Community Care staff. The VISN 16 Business Implementation Manager, in collaboration with the VISN 16 Patient Safety Officer, will continue to monitor compliance with community care patient safety events being entered in JPSR in addition to submission of a PQI forms to the TPA for patient safety events. Compliance will be reported to the VISN 16 Access Oversight Council for two consecutive quarters.

Recommendation 4

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

VISN concurs.

Target date for completion: June 2025

VISN response: The VISN 16 Patient Safety Officer reports community care patient safety event trends, lessons learned, and corrective actions reported in JPSR quarterly at the VISN 16 Access Oversight Council Meetings. In addition, the VISN 16 Patient Safety Officer reports community care patient safety events reported in JPSR on a recurring basis during our VISN 16 Program Managers meeting at least quarterly. The VISN 16 Patient Safety Officer will continue to report community care patient safety events quarterly to the VISN 16 Access Oversight Council. VISN 16 will ensure the Patient Safety Manager or designees brief on community care patient safety event trends, lessons learned, and corrective actions reported in JPSR quarterly at the facility Community Care Oversight Council Meetings. Compliance monitoring will occur through evidence of VISN 16 and facility Community Care Oversight Council meeting minutes, with a goal of two consecutive quarters of sustainment.

Recommendation 5

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

VISN concurs.

Target date for completion: June 2025

VISN response: The VISN 16 Business Implementation Manager, through the Health Information Management (HIM) Program Office monitors the five business days scanning standard. VISN 16 reports Community Care Scanning backlogs of greater than five business days to the National HIM Office with facility action plans during monthly calls. The VISN 16 Deputy Business Implementation Manager, in collaboration with the VISN 16 Business Implementation Managers, will monitor the HIMs/Community Care scanning backlog of greater than five business days. The VISN 16 Business Implementation Manager is currently tracking scanning backlogs via a weekly action item to the facilities. The facility status will be reported weekly during the VISN 16 Executive Leadership Council. Compliance will be reported at the VISN 16 Access Oversight Council through the governance structure.

Recommendation 6

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

VISN concurs.

Target date for completion: June 2025

VISN response: The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager, in collaboration with facility Community Care Leadership, will ensure all Community Care staff, are provided education on attaching diagnostic imaging results to the Community Care Consult Result note and utilizing the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results. VISN 16 Business Implementation Manager will submit an Action Item to each facility to ensure the training is completed. The VISN Business Manager will work with the VISN Chief Information Officer and facility Clinical Applications Coordinators to eliminate all facility-level created consult result notes. This will allow standardization of the VISN 16 facilities use of the VHA Community Care Consult Result national template as recommended in the Office of IVC Community Care Field Guidebook. The VISN 16 Business Implementation Manager will develop an audit and track monthly compliance of utilizing the significant findings alert for abnormal results and the attachment of diagnostic imaging results to the Community Care Consult Result note. Compliance will be monitored with a goal of three consecutive months of sustainment. Compliance will be reported at the VISN 16 Access Oversight Council through the governance structure.

Recommendation 7

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults that are not low risk.

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 will ensure alignment with the current Office of IVC Community Care Field Guidebook. After one documented attempt and administrative closure, Community Care staff will make two additional attempts to obtain community providers' medical documentation within 90-days of the appointment. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager, in collaboration with facility Community Care Leadership, will ensure all Community Care staff are provided education regarding the required attempts to obtain community providers' medical documentation within 90 days following administrative consult closure. The VISN 16 Business Implementation Manager will send an Action Item requiring each facility to validate the training is completed. The VISN Business Implementation Manager will track compliance. Compliance will be reported at the VISN 16 Access Oversight Council through the governance structure.

The Office of Integrated Veterans Care is currently working on developing additional guidance regarding the required additional documentation attempts for administrative closure of community care consults.

Recommendation 8

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

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 monitors compliance via an Action Item submitted to the VISN Access Office on a weekly basis requiring facility to annotate the volume of Requests For Additional Services (RFS) that are greater than three business days. The VISN will expand the Action Item to address compliance with documentation of the VHA RFS in the patient's electronic health record using the national template. The Action Item response will include the date the RFS was received and the adjudication (approval or denial) date. Requests For Additional Services not processed within 3 business days will be tracked and trended to identify gaps, barriers, and opportunities for improvement. Compliance will be reported at the VISN 16 Access Oversight Council through the governance structure.

Recommendation 9

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to community providers for requests for additional services.

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 is monitoring that the facility Community Care teams are appropriately sending Community Care related Request For Additional Services (RFS) approval/denial letters to community providers in response to RFS documents received. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager will require VISN 16 facilities attestations ensuring facilities have implemented RFS letters to community providers via an Action Item. Compliance will be monitored through facility attestation. Compliance will be reported at the VISN 16 Access Oversight Council through the Governance structure.

Recommendation 10

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to patients for requests for additional services.

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 is monitoring that the facility Community Care teams are appropriately sending Community Care related Request For Additional Services (RFS) approval/denial letters to patients and community providers in response to RFS documents received. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager will require VISN 16 facilities attestations ensuring that facilities have implemented RFS approval or denial letters to community providers and patients via an Action Item. Compliance will be monitored through facility attestation. Compliance will be reported at the VISN 16 Access Oversight Council through the Governance structure.

Recommendation 11

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

VISN concurs.

Target date for completion: June 2025

VISN response: All VISN 16 sites are required to utilize the Community Care–Care Coordination Plan Note as outlined by Integrated Veteran Care Field Guidebook guidance.

Continued training and tracking will be monitored by the VISN Business Implementation Manager using the Integrated Veteran Care dashboard. A facility-level review will be conducted by facility Community Care Leadership and reported to the facility-level Community Care Oversight Council. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 16 Access Oversight Committee through the VISN Governance structure.

Recommendation 12

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

VISN concurs.

Target date for completion: June 2025

VISN response: VISN 16 will ensure facility community care staff confirm patients attended their appointments. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager will develop an audit utilizing the Integrated Veteran Care dashboard. The VISN will require recurring review by the facility Community Care Leadership. This audit will be required to be submitted to the VISN 16 Access Office on a recurring basis via Action Item. Compliance will be reported at the VISN 16 Access Oversight Committee through the VISN Governance structure.

Recommendation 13

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create the Community Care–Urgent Care Record note in the patient's electronic health record when they receive medical documentation from the community provider.

VISN concurs.

Target date for completion: June 2025

VISN response: If a VISN 16 facility is notified that an Urgent Care Visit occurred, an Urgent Care note is to be developed, and documentation attached. The current process does not require the Veteran and/or treating facility to notify the VA that an episode of Urgent Care has occurred. The VISN 16 Business Implementation Manager and Deputy Business Implementation Manager, in collaboration with facility Community Care Leadership, will ensure Community Care staff are provided education on attaching Community Care–Urgent Care Record notes in the patient's electronic health record when received. The VISN 16 Business Implementation Manager will submit an Action Item to each facility to ensure the training is complete.

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