



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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SUBCOMMITTEE ON HEALTH,
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CARE COORDINATION: ASSESSING VETERAN NEEDS
AND IMPROVING OUTCOMES
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Chairwoman Miller-Meeks, Ranking Member Brownley, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of how the Veterans Health Administration (VHA) coordinates the delivery of veterans' health care. The OIG's Office of Healthcare Inspections routinely reviews and publicly reports on the quality of health care provided across VHA and on risks to patient safety.

Coordination of health care defines a series of activities that must occur for a patient to achieve the most desirable outcomes of their treatment. There is nothing passive about these activities; the choreography of delivering care is often a complex interchange of clinical and administrative activities that must always be precise. From aligning appropriate specialty teams to ensuring essential medications and equipment are in place, providers must also work to anticipate the patient's future needs as well as potential complications. This complex coordination often occurs, as many of the OIG reports discussed below show, for patients facing serious illnesses. These patients rely on a comprehensive assessment of not only their specific condition but the supports in place to ensure their recovery, such as the safety and appropriateness of a patient's discharge environment, clear education and instructions to the patient and their caregivers, and reliable processes that ensure all participants have all relevant information. When there are breakdowns at any point in coordination, the safety of the patient is compromised and the trust placed in the system responsible for providing that care is lost.

This testimony highlights some of the many issues that care providers and patients have faced in navigating the complexities of care coordination. These reports recognize that VHA personnel often have to overcome inefficient and ineffective processes or system limitations to ensure safe transitions and quality care both within VHA and with outside care providers. The discussion that follows focuses on (1) the transition from the Department of Defense (DoD) to VA care, (2) barriers to care coordination

within VA, and (3) breakdowns that can occur when engaging community care providers. Ultimately, effective care coordination is dependent on dedicated and skilled staff consistently adhering to sound clinical and administrative policies and practices that result in desired outcomes for patients and their caregivers and families.

Although the specific OIG reports highlighted below detail deficiencies at various points of coordination or at a particular facility, the findings and recommendations should be considered by VHA leaders and staff participating in patient care across the nation.

CARE COORDINATION CHALLENGES DURING THE TRANSITION FROM THE DEPARTMENT OF DEFENSE TO VA

Many challenges can occur within the first 12 months of discharge from DoD associated with leaving active duty and transitioning to civilian life, such as homelessness, family reintegration, employment, posttraumatic stress disorder, and substance misuse, which can increase the risk for suicide.¹ While improvements have been made in the interoperability of VA and DoD electronic health record (EHR) systems, significant risks remain when VA providers find DoD records are not complete or accessible, or when VA providers have not thoroughly reviewed and evaluated those records during former service member's earliest encounters in VA.

The OIG is finalizing a national review in which a team evaluated the transition of clinical care for service members with opioid use disorder (OUD) from DoD to VHA.² Failure to identify and document a patient's known OUD history and related treatment during this critical transition period may decrease the likelihood of a patient receiving timely VA care and support. Of particular concern, veterans have been found to be "twice as likely to die from accidental overdose compared to non-veterans."³

The OIG reviewed a sample of discharged service members with a DoD-originated OUD diagnosis. The team then reviewed the patients' VHA electronic health records for evidence that care providers were aware of the OUD diagnosis and treatment. The OIG team found concerning gaps in the records review with a significant percentage of the VHA providers not recording the OUD diagnosis in VHA records,

¹ VA, [Executive Order 13822 Fact Sheet](#), accessed June 1, 2023.

² VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, Version 4.0, 2021. Care transition refers to the transition of healthcare from DoD to VHA for a service member upon separation from the military; Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, Text Revision (DSM-5-TR), "[Substance Related and Addictive Disorders](#)," accessed December 15, 2022. OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress" as manifested by at least two symptoms from a list of psychological, physical, occupational, interpersonal, or recreational consequences, within a 12-month period.

³ Elizabeth M. Oliva et al., "[Saving Lives: The Veterans Health Administration \(VHA\) Rapid Naloxone Initiative](#)," The Joint Commission Journal on Quality and Patient Safety 47-8, (August 2021): 469–80.

thus potentially hampering future medical decisions.⁴ Additionally, the OIG found providers perceived barriers to documenting OUD diagnoses during the transition of clinical care, and the OIG determined that while there was evidence of the use of risk-mitigation strategies, such as dispensing opioid reversal agents, improvements could be made.

Veterans who are referred by VA to a DoD medical facility also may experience coordination problems due to limitations in the interoperability between the DoD and VA electronic healthcare records (EHR), such as the lack of full accessibility offered by the Joint Longitudinal Viewer (formerly known as Janus and the Joint Legacy Viewer). The OIG has released 14 oversight reports on the deficiencies with the new EHR system that is meant to provide a seamless health record for veterans between DoD and VA.⁵ Despite progress, there is still significant work to be done.

Staff from several OIG divisions worked on a joint project led by the DoD Office of Inspector General that was released in 2022.⁶ The project assessed internal controls and compliance with legal requirements, as well as actions by DoD, VA, and their joint Federal Electronic Health Record Modernization (FEHRM) program office to help ensure that healthcare providers serving veterans can access a complete healthcare record. The joint audit found that while the agencies took some actions to achieve the level of interoperability between DoD, VA, and external care providers specified by Congress in the National Defense Authorization Act (NDAA) of 2020, challenges remain. The audit found that VA and DoD did not consistently migrate patient healthcare information into the new EHR to create a single, complete patient health record, because DoD and VA have separate processes for bringing information into the new EHR. To access clinical information that hasn't been migrated to the new system, users have been instructed to use the Joint Longitudinal Viewer. This work-around does not meet NDAA requirements that healthcare providers access and exchange patient healthcare information without additional intervention. Second, the DoD and VA did not develop interfaces from all medical devices to the new EHR so that patient information will automatically upload to the system. For example, some medical devices, such as some blood pressure cuffs and IV pumps, did not have set national healthcare data standards and still require the departments to develop effective interfaces. One contributing factor to interoperability problems was the failure of FEHRM program office officials to develop and implement a plan to achieve all NDAA requirements and actively manage the program's success, as authorized by the FEHRM's charter. Because the FEHRM program office limited its role,

⁴ Currently, this report is in draft, but, consistent with OIG practices, has been reviewed by VA. This allows VA offices to comment on OIG findings and recommendations, as well as to provide responsive action plans. OIG staff is integrating that feedback into the final report. While it is not the OIG's routine practice to testify regarding pending reports, due to the timing of this hearing and VA having had the chance to review the report, the findings are discussed in general terms today.

⁵ VA OIG, [Statement of Deputy Inspector General David Case - Hearing on "VA's Electronic Health Record Modernization: An Update on Rollout, Cost, and Schedule"](#), September 21, 2022.

⁶ DoD OIG and VA OIG, [Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability](#), May 5, 2022.

DoD and VA took separate actions to migrate patient healthcare information and develop interfaces. These issues remain unresolved.

As part of the OIG's oversight of VA's development and implementation of the new EHR system, reports have been issued on care coordination concerns affecting patients at VA facilities that have transitioned to the new system.⁷ The OIG found several areas of unresolved issues that create barriers to various aspects of care delivery, such as appointment scheduling, laboratory orders, prescribed medications, and the utility of high-risk-for-suicide and behavioral patient record flags.

CARE COORDINATION CHALLENGES FOR VETERANS RECEIVING CARE WITHIN VHA

After veterans are enrolled and established in VHA, issues related to care coordination can arise in both acute and long-term care settings. For example, the OIG has repeatedly identified clinical failures caused by unclear or inadequate processes or in the oversight of personnel tasked with ensuring a safe transition for patients.

Facility Personnel Did Not Follow VA Processes or Failed to Properly Coordinate Care within a Facility or Clinic

Many OIG reports focus on personnel within medical facilities either not following policy and procedure or failing to properly communicate to other providers and clinical staff.

For example, the OIG has reported on the death of a veteran who was wrongly denied care at a VA emergency department. Despite being told of the veteran's serious condition and provided with identifying information, nurses and an administrative staffer wasted critical time analyzing the veteran's eligibility status, later having the veteran transported to a community hospital. In the end, it was determined the patient in fact was a veteran and proper policies had not been followed.⁸ Similarly, a veteran residing in a VA community living center was found deceased after a nurse failed to initiate that resident's transfer to an emergency department following the recommendation of the on-call resident.⁹

⁷ VA OIG, [Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), March 17, 2022.

⁸ VA OIG, [Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida](#), June 3, 2021. Further, the OIG has numerous reports that describe issues associated with coordinating the after care for patients who visited emergency departments. VA OIG, [Quality of Care Concerns and Leadership Response at the Amarillo VA Health Care System in Texas](#), April 14, 2022; VA OIG, [Poor Emergency Department Care of a Patient](#), January 25, 2023. The OIG also reported on an emergency department physician whose delay in recognizing the need to transfer a patient to a facility that could provide needed life-saving treatment led to the patient's death. VA OIG, [Mismanagement of Emergency Department Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas](#), September 23, 2020.

⁹ VA OIG, [Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California](#), August 17, 2022.

Failures in Coordinating Discharge from Facility Care Place Veterans at Risk

Careful and thorough discharge planning is critical to support safe outcomes as patients move between providers and various care settings, especially when transitioning back to their homes.

During an inspection at the VA Southern Nevada Healthcare System's inpatient mental health unit, the OIG found serious gaps in discharge planning for a patient who died by suicide the same day as being released.¹⁰ The patient had been treated by various VHA facilities for significant mental health conditions for many years before this inpatient stay. The OIG found inadequate care by both inpatient and outpatient staff, a failure to reconcile critical clinical treatment and discharge plan information, delayed assignment of a required mental health treatment coordinator, and ineffective responses to the patient's complaints and requests. For example, staff did not request substance use disorder assessments despite a positive drug test; failed to understand the patient's suicide risk factors, like access to lethal means; and did not identify coping strategies among other aspects of unsatisfactory safety planning. These lapses placed this patient at significant risk during their transition to home. Even after the suicide event, the OIG found facility leaders did not properly handle institutional disclosure processes by failing to alert the veteran's next of kin to the deficiencies. The OIG made 10 recommendations, now closed, for corrective action focused on improving patient care coordination and mental healthcare delivery.

As part of a review of allegations that an elderly patient suffered verbal abuse and physical harm at the hands of facility staff at the VA community living center (CLC) in Miles City, Montana, after being discharged from an inpatient stay at the Fort Harrison VA Medical Center, the OIG found the patient experienced deficient care coordination and discharge planning.¹¹ Because Miles City CLC did not have a designated screening process for reviewing the appropriateness of admissions from a VA medical center, opportunities were lost in determining whether the CLC could support the veteran's clinical needs. Further complicating the tragic events surrounding his abuse, care providers in the CLC failed to ensure the patient received necessary imaging that would have revealed a terminal diagnosis. While the horrific events of patient abuse are inexcusable, recognizing that failures in inpatient discharge planning contributed to this same veteran being denied timely access to end-of-life care is devastating.

Failures with Coordination of Care in Non-Facility VHA Settings Can Result in Patient Harm

Veterans engage with VHA outside of traditional medical facility settings, often seeking additional or complementary services, particularly in support of mental health treatment. Similar to care coordination provided in VHA clinic and inpatient settings, prompt and clear communication is imperative to

¹⁰ VA OIG, [*Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas*](#), July 15, 2021.

¹¹ VA OIG, [*Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*](#), January 26, 2023.

ensuring a patient's needs are met when engaging with crisis hotline personnel, community-based vet centers that provide counseling, and VA-directed home-based mental health care.

Veterans Crisis Line

Since its establishment in 2007, the Veterans Crisis Line (VCL) has answered millions of calls from veterans in crisis. VCL responders are required to initiate emergency rescue services for those veterans identified as being in immediate danger to themselves or others. In addition, coordination activities for callers not in need of immediate rescue are critical to ensuring appropriate care. For example, in 2021, a VCL staff person told the veteran it was urgent that they go to a VHA emergency department in Augusta, Georgia, after the veteran expressed suicidal ideation.¹² The VCL staffer notified an emergency department nurse that the patient was directed there. The patient reported to the emergency department as directed; however, the nurse did not document for the emergency department physician evaluating the patient that this was due to a VCL referral because of suicidal ideation, and there was no evidence the physician was ever notified. On arrival, the patient reported a chief complaint of pain and denied suicidal ideation during a routine screening. Without knowledge of the VCL referral, the physician did not have a complete understanding of the patient's current condition and therefore did not ensure the patient's follow-up with mental health clinicians. Additionally, the facility's suicide prevention staff, despite being made aware by VCL staff of the veteran's contact with VCL, did not contact the veteran to schedule follow-on care as required.¹³ Approximately two months later, the veteran was found deceased from a self-inflicted gunshot wound in the parking lot of the Aiken, South Carolina, Community Based Outpatient Clinic. The OIG made nine recommendations to the Augusta facility in May 2023, including several focused on managing referrals and care coordination.

Vet Centers

Vet centers are community-based clinics that provide a wide range of psychosocial services to clients that include eligible veterans and current service members. Vet center counselors communicate with local VA medical facilities to coordinate care for shared clients, most importantly, those who are high risk for suicide. The counselors are required to provide timely notification to VA medical facility suicide prevention coordinators when shared clients have a significant safety risk. They must follow confidentiality requirements when communicating with local VA medical facilities to coordinate care. Since 2021, the OIG has published findings from its vet center inspection program, which provides a focused evaluation of key aspects of the quality of care delivered at vet centers. The OIG has consistently found in the sites reviewed that vet center staff across the country have not consistently

¹² VA OIG, [*Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia*](#), May 10, 2023.

¹³ In a different OIG healthcare inspection, emergency department staff failed to inform suicide prevention staff of a patient in crisis, and the patient died by suicide six days later. VA OIG, [*Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center*](#), July 28, 2020.

complied with these requirements.¹⁴ For example, the OIG found that of the 30 client records reviewed in vet centers in district 1 zone 3, 18 records had documented coordinated care with the supporting VA medical facilities as required, and only three of the 18 followed confidentiality requirements.¹⁵ The OIG also found most records did not reflect mandatory notifications to VA staff were made for patients with significant safety risks.

Home-Based Mental Health Care

To coordinate the complex care of veterans with serious mental illness and to mitigate negative outcomes, VHA utilizes Intensive Community Mental Health Recovery programs (ICMHR). ICMHR provides case management to veterans diagnosed with serious mental illness who are deemed able to live in the community with the frequent support of a multidisciplinary team coordinating the clinical and social services of each veteran. To reduce the burden on the veteran, these visits occur in the veteran's home and, as required during the pandemic, can be supported when necessary via the use of telehealth.¹⁶ The OIG reviewed ICMHR programs from 2019 to 2021 and found they did not meet VHA's required visit frequency for high-intensity services. Without meeting the evidence-based number of visits to support veterans and ultimately reduce their risk of being in crisis, opportunities for early and less intensive interventions are lost. Realizing that these patients also often require long-acting injectable antipsychotic medications, the OIG reviewed ICMHR-specific contingency plans for emergency situations such as a pandemic, when injectable medications may be challenging to secure. The OIG found the majority of VHA healthcare systems did not have ICMHR-specific contingency plans for ensuring veterans' access to needed medication.

¹⁴ VA OIG, [Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers](#), December 20, 2021; [Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers](#), January 19, 2023.

¹⁵ Locations visited included City Center and Northeast Philadelphia, Pennsylvania; Scranton, Pennsylvania; and Huntington, West Virginia. VA OIG, [Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers](#), May 25, 2023. While a veteran using a vet center may be referred to a VHA medical facility when in crisis, VHA facility staff must ensure they coordinate care with vet center staff when appropriate. For example, the OIG substantiated that a patient died by suicide within three days of discharge from an inpatient mental health unit in the VA OIG report, [Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri](#), issued on January 5, 2021. While the patient received medication and discharge instructions that included suicide prevention materials, the OIG identified care coordination and discharge planning deficiencies that included the failure to coordinate the patient's mental health treatment or include vet center staff in the discharge planning. The vet center could have helped to facilitate the patient's engagement with outpatient resources and timely follow-up.

¹⁶ VA OIG, [Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs](#), January 31, 2023.

Opportunities Exist to Support Care for Veterans Who Face Challenges in Accessing Care

Care coordination between care providers and their patients can be challenging for veterans who experience obstacles in getting to any healthcare facility. In particular, accessing in-person care can be a formidable task for older veterans, those with mobility issues, and individuals living in rural areas.

One way that VA has been working to reduce barriers to care is by increasing the use of telehealth. Because providing telehealth services is not without obstacles, the OIG recently assessed the implementation and use of VA Video Connect (VVC) prior to and during the pandemic.¹⁷ VVC provides a secure environment for patients and providers to carry out video telehealth visits, regardless of where the veteran and provider are located. Specifically, the review team explored factors affecting why primary and specialty care providers used telephone communication more frequently than VVC at the onset of the pandemic and in lieu of in-person encounters, and how VHA resolved technology issues. The OIG also examined VHA provider experience with VVC prior to and during the pandemic to identify the benefits of and barriers to VVC use. When the pandemic started, VHA was not readily able to support the increased demand of VVC use, leading providers to provide patient care by telephone. This occurred despite VHA having developed telehealth strategic plans, which focused on improving technology to support VVC, increasing provider capability, and identifying emergency preparations for disaster scenarios.

Notably, the VHA Office of Connected Care's chief officer said video visits increased from 2,000 to 40,000 per day and emphasized that, "the technical infrastructure was not scaled to that kind of . . . unexpected and unplannable [*sic*] for growth." As the pandemic continued, providers continued to use VVC, recognizing its value in increasing access to care and enabling more comprehensive evaluations than telephone encounters could offer. There were identifiable barriers, however, including patient difficulties with technology, lack of clinical and administrative support during the encounters, and challenges with scheduling VVC appointments. VHA concurred with the OIG's three recommendations to address those barriers that were issued in April 2023.

OIG REPORTS HAVE FOUND CONCERNS WITH COMMUNITY CARE COORDINATION

Coordinating medical care between VHA and community providers remains a tremendous challenge, particularly for managing patients with complex health needs. The OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies, often a result of personnel errors or policy implementation, undermine the considerable efforts of VHA personnel to ensure a seamless experience for veterans.

¹⁷ VA OIG, [Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic](#), April 26, 2023.

VA has made considerable efforts to increase the use of technologies that enable better information sharing with the community. As one example, VA's participation in health information exchanges advances the sharing of veterans' information outside VA, whether through the community care program or not. Many OIG reports have described the frustrations and various risks experienced by patients referred to the community.

Administrative Failures Challenge the Coordination of Healthcare Services

VHA has detailed numerous steps in the process to obtain healthcare services for a veteran through its community care programs. This process requires staff from clinical service lines and administrative support offices in the medical facility to work with the veteran or caregiver, the VA's third-party administrator, and the community provider. The OIG reviewed VA's implementation of the Referral Coordination Initiative (RCI) that sought to facilitate consult (referral) scheduling for specialty care within VHA facilities and in the community for eligible veterans.¹⁸ RCI was designed to improve veterans' timely access to care, empower patients to make informed care decisions, reduce providers' administrative burden and increase their time on patient care, and enhance access to community care for veterans eligible under the MISSION Act of 2018.¹⁹

Under the non-RCI consult referral process, a provider first determines whether a patient requires a specialist and then assesses whether the patient is eligible for community care provided by a non-VA practitioner. If the patient is eligible for care in the community, the healthcare provider submits a referral to the facility's community care department staff to confirm eligibility and to call the patient to discuss appointment preferences (including provider and location). Then, the community care staff either help schedule the appointment or provide the patient with the information to do so.

Under the RCI process, after a facility provider (usually a primary care physician) enters a consult for a patient requiring specialty services, a Referral Coordination Team (RCT) determines the veteran's eligibility for community care.²⁰ A clinical RCT member, typically a triage nurse, determines the available care options for the patient (in-house, in another VA facility, or in the community); assigns the

¹⁸ VA OIG, [Additional Actions Needed to Fully Implement and Assess Impact of the Patient Referral Coordination Initiative](#), October 27, 2022.

¹⁹ The OIG reported in 2020 on the community care consult process, with an audit team finding patients experienced community care appointment delays in Veterans Integrated Service Network 8 due to the facilities' insufficient staffing and consult-processing structure at community care departments that review, authorize, and schedule community care. There was insufficient staffing for administrative functions such as contacting patients and coordinating appointments. Also, merging the consult authorization and scheduling tasks within community care departments could allow scheduling to begin promptly. The OIG's five recommendations focused on key process improvements. VA OIG, [Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities](#), January 16, 2020.

²⁰ VHA, *Referral Coordination Initiative Implementation Guidebook*, December 2021. The guidebook states that the RCT is a multidisciplinary team of clinical and administrative staff, which includes doctors, physician assistants, licensed nurse practitioners, registered nurses, and schedulers.

consult a priority level indicating how urgently the patient needs to be seen; determines whether any medical tests are needed; and contacts the patient to discuss care options.

In 2019, VHA began implementing the RCI at 139 VA medical facilities, with expected completion across all facilities and all specialty services by June 30, 2021. VHA staff generally agreed the RCI had the potential to achieve its stated goals. However, facilities struggled with implementation for several reasons, including insufficient staffing and resources, unreliable data (such as a lack of accurate wait times for community care), and a lack of required training. The RCI describes two implementation models, centralized and decentralized, but facility staff were sometimes confused about which model to apply and noted slow responses from VHA to questions. Without clear direction on staffing models, some facilities tested different implementation methods. Given the staffing strain, initiative leaders from one facility said they were planning to roll out the initiative to only two services every month; at this time, completion may still take several years.

The Office of Integrated Veteran Care (IVC) predecessor, the program office responsible for overseeing the RCI, also lacked the ability to monitor progress due to insufficient data. Because of these deficiencies, no VA facility had fully implemented the RCI almost a full year after VA's own June 2021 deadline, and facilities are currently working to fully implement the process. IVC had not developed a mechanism for facilities to evaluate whether staff were meeting the initiative's goals. VHA did not have data to measure whether the initiative reduced the average time to schedule appointments—one of its key goals. Also, VHA lacked measures to evaluate whether veterans received key information to inform care decisions, a second key goal. The review team identified instances when facility staff did not provide patients with key information—for example, there was a provider who said he generally decides what is best for patients and does not usually give them an option. Similarly, IVC had not evaluated if the initiative reduced administrative burdens on providers, a third key goal, and none of the four facilities the review team visited had conducted this type of analysis.

The under secretary for health concurred with the OIG's seven recommendations issued in October 2022 to improve RCI implementation by better assigning responsibilities and roles, improving training, establishing local procedures for sharing community care data to more fully inform patients, sharing best practices among all facilities, ensuring accurate tracking of RCI consults, and developing measures of how well facilities meet the initiative's requirements. Five recommendations remain open at this time.

After a veteran receives services from a community care provider, VHA has contracted for those providers to return the treatment records to VA. These records from non-VA care settings enable continuity of care by VHA providers and inform treatment decisions. An OIG audit team found in a June 2021 report that staff at six of the seven VA medical facilities reviewed did not always index or

categorize these records accurately.²¹ Inaccurate indexing of medical records poses a risk to veteran care and increases the burden on the VHA staff who locate and correct the errors, reducing their time for other tasks. Errors included using ambiguous or incorrect document titles, indexing records for non-VA care to the wrong referral or veteran, and entering duplicate records. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, as well as a lack of local facility-level policies. The OIG recommended the under secretary for health improve non-VA medical records scanning and indexing by ensuring VHA facilities create and fully implement standard operating procedures. Besides clearly defining responsibilities and procedures for accurately scanning, importing, and indexing non-VA medical records, the OIG also made recommendations related to training and oversight of facility community care staff responsible for medical record management.

In addition to errors while indexing returned medical documents, the OIG has also examined the impact of the backlogs at VA facilities in scanning these documents.²² Beyond the continuity of care risks, backlogs can lead to delays or denials of veterans' claims for reimbursement of non-VA emergency care and the expiration of checks sent to VA for payments, as the OIG reported after reviewing the contents of unopened mail at the Atlanta VA Healthcare System.²³ The OIG has repeatedly found VHA staff did not enter documents into EHRs in a timely manner, nor did they perform appropriate reviews and monitoring to assess the overall quality and legibility of scanned documents. The OIG also found leaders' poor communication and follow-through, as well as staffing shortages, contributed to these backlogs.

Veterans Have Experienced Poor Outcomes When Care Was Not Coordinated with Community Care Providers

In a March 2021 report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the OIG review team found that numerous administrative errors and confusion in the Phoenix VA healthcare facility's community referral process delayed a patient's specialized psychological testing. VA's third-party administrator (the contractor that manages the community provider network and appointment scheduling) incorrectly scheduled the veteran for therapy, not testing. The patient died by suicide not having received the appropriate testing and resulting treatment.²⁴

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the

²¹ VA OIG, [Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records](#), June 17, 2021.

²² VA OIG, [Health Information Management Medical Documentation Backlog](#), August 21, 2019.

²³ VA OIG, [Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims](#), April 27, 2022.

²⁴ VA OIG, [Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona](#), March 31, 2021.

patient's care among the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.²⁵ The patient also suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community. In addition, a September 2022 OIG healthcare inspection examined the failure of a facility's community care staff to adequately convey the seriousness of a patient's cancer diagnosis to VHA and community health providers.²⁶ Due to bureaucratic issues and a lack of standard guidance, the facility incorrectly denied the patient's initial radiation therapy request.

Managing care for veterans who have been seen in the community and are coming back into VHA facilities for treatment presents similar coordination risks. The OIG examined concerns related to a lack of care coordination for patients receiving ketamine for treatment-resistant depression (depression that has failed to respond to multiple attempts of more conventional treatments) in the community after authorizations for the care lapsed in September 2019 at the VA San Diego Healthcare System in California.²⁷ The OIG substantiated that the facility ended authorizations for community care for patients receiving ketamine in October 2019 and again in March 2020, negatively affecting 35 patients. The OIG also identified deficiencies in facility processes. The OIG concluded that risks for negative patient outcomes increased due to communication and care coordination deficits, terminating community care authorizations, accelerating timelines for care transition, and uncertainties from suddenly changing treatment for complex patients. Four recommendations were made to the facility director related to community care processes for coordination of non-VA care and ensuring coordinated, clinically informed plans for transitioning remaining patients to care at the facility.

VHA MUST DO BETTER AT TRACKING AND RESOLVING HEALTHCARE COMPLAINTS

It is imperative that veterans and their caregivers have a voice in their care and an avenue for redress when mistakes have been made. The Patient Advocacy Program is VHA's effort to improve customer service, support veterans' access to quality care, and provide a mechanism to resolve healthcare delivery or coordination issues. When a veteran submits a complaint at a VA medical facility regarding care delivered within VHA or through a community partner, a patient advocate begins the process of documenting the concern, communicating a resolution, and providing follow-up and feedback. Patient

²⁵ VA OIG, [*Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee*](#), September 3, 2020.

²⁶ VA OIG, [*Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*](#), September 12, 2022.

²⁷ VA OIG, [*Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California*](#), August 24, 2021. In a separate report discussing the administration of ketamine for treatment-resistant depressions, the OIG found VHA-internal care coordination failures, including inconsistent prescribing practices. VA OIG, [*Deficiencies in the Implementation and Leadership Oversight of Ketamine at the Eastern Oklahoma VA Health Care System in Muskogee*](#), March 9, 2023.

advocates also are expected to identify trends to signal potential opportunities for medical facility improvements. However, a March 2022 report found that VHA did not effectively issue and implement adequate policy, monitor complaint practices, and provide guidance to medical facility directors responsible for local program management.²⁸ The OIG also found that patient advocates were not entering complaints into their tracking system or the documentation to show how complaints were being resolved. Further, coordinators, managers, and VHA-level Office of Patient Advocate staff were not monitoring and reviewing patient advocate activities. In addition to quality concerns, this leads to missed opportunities to improve veterans' experiences because facility leaders may not fully understand the scope of problems that veterans encounter. The three recommendations made to VHA to update policy, implement controls, and fulfill oversight duties of the program all remain open.

CONCLUSION

High-quality care demands that patients receive the necessary care provided by qualified clinicians in a timely manner. The reports highlighted in this testimony call attention to the risks introduced when care is not coordinated properly, whether due to clinical or administrative problems. The OIG is committed to ongoing and meaningful oversight of these issues. As VA continues to purchase an increased amount of community care, it must redouble its efforts to make care coordination efforts more efficient, and it must refocus attention on patients transitioning between care providers and venues. Without an efficient strategy to consistently monitor the access to and quality of care provided to veterans in the community, VHA and other stakeholders—and most importantly, veterans and their caregivers—can have no assurance of the quality or safety of that care.

Almost every report published by the OIG's Office of Healthcare Inspections details aspects of care coordination, whether it is a hotline inspection detailing missteps or failures in that coordination, or the cyclical reviews that provide VHA leaders with a risk assessment of their medical facilities' current practices. The OIG encourages VHA leaders to broadly distribute these healthcare oversight publications to alert all facilities of potential risks and to promote the robust exchange of local success stories in preventing or correcting them. The OIG will continue to enhance our proactive tools, while revealing the complex findings of our inspections in responding to allegations of substandard care. Additionally, teams across the OIG will continue their efforts to assess the various VHA program offices' operations and monitor the issues raised in this testimony.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

²⁸ VA OIG, [Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints](#), March 24, 2022.