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US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
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"ROLES AND RESPONSIBILITIES: EVALUATING VA COMMUNITY CARE"
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Chairwoman Dr. Miller-Meeks, Ranking Member Brownley, and subcommittee members, thank you for the opportunity to discuss the oversight conducted by the Office of Inspector General (OIG) related to VA community care. The OIG's Office of Healthcare Inspections (OHI) has reported on the many challenges VA faces in consistently providing high-quality care to eligible veterans. Meeting their healthcare needs requires coordinating highly skilled multidisciplinary teams as well as efficient processes that prioritize the safety and timely delivery of that care. Additional complexities often arise when veterans are referred by VA to the community for care. The OIG recognizes the efforts of VA staff to provide veterans with the care and services they need and deserve, particularly when care in the community is the patient's best or only option.

For years, a top focus of the OIG's body of work has been ensuring veterans receive high-quality, coordinated care when using community providers. Since the start of fiscal year 2024 alone, the OIG has issued 21 reports detailing the challenges VA faces in administering community care, and many additional work products have touched on aspects of the program. Through numerous ongoing inspections, reviews, and audits, the OIG continues to examine VA's community care program. For example, OHI's Care in the Community (CITC) teams conduct cyclical VISN-level reviews and on-site inspections of individual medical facilities to evaluate compliance with VA's community care referral and coordination processes.[1] Additionally, OHI conducts healthcare inspections to evaluate complaints or concerns specific to individual episodes of community care. Finally, both OHI and the OIG's Office of Audits and Evaluations have conducted national reviews of community care that highlight issues

[1] VA has 18 Veterans Integrated Service Networks, known as VISNs, across the nation. They comprise a regional network of care in which each VISN oversees VHA local healthcare facilities in their assigned area. Under the CITC program, the OIG reviews VISNs and individual medical facilities on an approximate three-year schedule.

across the system. This statement highlights specific findings from OIG healthcare inspections on quality and timely coordination of care as well as audits related to contractor oversight, staffing, information technology (IT) systems, and financial management processes that together illustrate the major challenges VA faces in this area.

Through this collective oversight, the OIG consistently finds that (1) VHA struggles to ensure veterans experience timely and seamless coordinated care when they are referred to the community, (2) VHA cannot ensure the quality of care community providers deliver, (3) staffing challenges and inadequate oversight of community care providers further challenge coordination efforts, and (4) substandard IT systems and inaccurate and incomplete data significantly restrict VA's ability to manage community care payments.

VA STRUGGLES TO ENSURE VETERANS EXPERIENCE TIMELY AND SEAMLESS COORDINATED CARE WHEN REFERRED TO THE COMMUNITY

When a veteran is referred for care in the community, there are a series of processes that must occur within a required timeframe to ensure the patient receives timely and appropriate care. As shown through the examples that follow, the OIG has consistently found breakdowns in these processes that have resulted in delays, placed patients at risk and, in some instances, have actually caused patients harm.

Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at the Buffalo VA Medical Center

The OIG initiated this healthcare inspection at the VA Western New York Healthcare System in Buffalo to assess allegations regarding community care consult appointment scheduling practices and delays for patients with serious health conditions who received community care.[2] The OIG substantiated that community care staff did not schedule patients within set timelines for radiation therapy and neurosurgery appointments, which resulted in delays in patient care and, in some cases, caused or increased the risk of patient harm. In particular, had there not been a delay in scheduling, and eventual cancellation of, community care radiation therapy to treat a patient's cancer-related pain, efforts could have been made to alleviate that pain and improve the quality of life in the patient's final months. Facility leaders also failed to conduct an institutional disclosure to the patient's family.[3]

The Buffalo healthcare system and its community care leaders did not resolve the scheduling delays, despite advocacy by care providers and staff. Leaders relied on inaccurate assurances from the healthcare system's community care managers that urgent, high-risk patient care consults (referrals)

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[2] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, September 27, 2024.

[3] An institutional disclosure is made when a healthcare provider informs a patient or their family when a medical error or unexpected complication occurs during treatment that resulted in harm (an adverse event).

were reviewed and prioritized, even as they received ongoing alerts about care concerns regarding those patients. The healthcare system and community care leaders' inactions were inconsistent with VA's stated commitment to the principles and values of high-reliability organizations, as they failed to consistently focus on patients, get to the root causes of concerns, and predict and eliminate risks before causing patient harm. This widespread breakdown in community care processes should serve as a cautionary tale for other VA facilities and reinforces the need for leaders at all levels to be aware of and responsive to concerns brought forward by staff.

The OIG made two recommendations to the VISN director related to the healthcare system leaders' response to patient concerns and oversight of community care. Two recommendations were also directed to the Buffalo system's director related to establishing community care policies aligned with VHA standards, as well as the institutional disclosure of the adverse event (which has now been completed).

Issues with Scheduling and Communication with Patients Referred for Community Care

The OIG's CITC program examines key clinical and administrative VA processes that are associated with providing quality community care, specifically focusing on processes for community care referral and care coordination.[4] OIG teams interview VHA staff and analyze data to identify deficiencies that hinder the proper administration of VHA's community care program. The CITC teams have found consistent care coordination challenges related to processing requests for additional services and timely managing information in patients' medical records.

Community Care Provider Requests for Additional Services

When a patient is evaluated by a community provider, additional care needs may be identified that were not included in the initial referral from VA. The community provider can send a request for additional services back to VA for approval. The OIG's inspection teams evaluated whether the requests for additional services were processed according to VA requirements and determined that the majority of VA community care staff did not consistently process requests for additional services within the required three business days of receipt. Additionally, some community care staff did not consistently incorporate the community provider's requests for additional services from the community provider into patients' electronic health records. Lastly, the OIG found that VA community care staff routinely failed to send required letters to community providers when requests for additional services were denied. These deficiencies in processing and documenting important clinical information can further delay needed follow-up diagnostic evaluations and treatment.

[4] All CITC reports can be found on the OIG website.

Obtaining and Importing Community Care Documents to the Patient's VA Electronic Health Record

Many VA leaders reported having a backlog from the time records are received by the facility, assuming they are received from community providers, to when they are scanned into the patient's electronic health record. Such delays in importing incoming medical documentation from community care providers compromises timely coordination and quality of care oversight.

While community care consults should be administratively closed after staff make one attempt to receive medical documentation from community providers, VHA staff are still expected to make two additional attempts after closure to obtain the records. Without the medical documentation from community care appointments, a veteran's VHA providers are tasked with providing comprehensive care with incomplete information. OIG inspection teams found community care staff did not consistently meet requirements to make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults. During interviews, the inspection team learned that many leaders direct their staff to keep community care consults in an open status in order to better track the status of documentation return. VHA's Office of Integrated Veteran Care (IVC), which manages the community care program, has since notified the OIG that they are in the process of revising this policy.[5]

Finally, CITC teams evaluated compliance with processes related to community care diagnostic imaging results by reviewing patients' electronic health records. The teams found that community care staff did not consistently attach diagnostic imaging results to the correct progress note in the electronic medical record. The failure to attach diagnostic imaging results to the correct note affects VA providers' ability to locate results efficiently and could delay patients' diagnosis and treatment or lead to repeat studies and procedures. CITC teams evaluated how effectively facility community care staff communicated results of diagnostic imaging by community providers to the ordering VA providers, especially for abnormal results. The teams found that community care staff consistently failed to use the significant findings alert to notify the ordering VA providers of abnormal diagnostic imaging results as required. With this failure, the ordering VA providers may be unaware of abnormal test results, and patients' diagnosis and treatment may be delayed or never initiated.

VA CANNOT ENSURE THE QUALITY OF CARE THAT IS PROVIDED TO VETERANS REFERRED TO THE COMMUNITY

The OIG has repeatedly found significant barriers to ensuring that veterans referred to the community are receiving health care that meets the quality standards established by VHA. As the following OIG reports demonstrate, deficiencies in the credentialing process, inadequate oversight of community

[5] IVC coordinates veterans' access to community care services by developing and overseeing contracts for veterans' healthcare services and payments to third-party administrators.

providers' prescribing practices, and the failure to record and track patient safety events in the community all impede VHA's efforts to oversee the safe provision of care for every veteran.

Deficiencies in the Credentialing Process Allowed a Former VA Surgeon with Competency Concerns to Operate in the Community Care Network

In this follow-up inspection, the OIG reviewed a former VA surgeon's eligibility to provide health care as a participant in VA's community care network and how the Marion VA Healthcare System in Illinois managed community care patient safety events.[6] Previously, the OIG had substantiated concerns with the surgeon's quality of patient care at the VA medical center in Biloxi, Mississippi.[7] Biloxi facility leaders missed opportunities to clearly convey, record, and take action against the surgeon in response to identified clinical competence concerns. Specifically, the facility failed to provide the surgeon with a written proposal to terminate VA employment before the surgeon resigned and failed to record the departure as a "resignation in lieu of involuntary action."

During this follow-up inspection, the OIG identified multiple failures by IVC and the third-party administrator (TPA) that served to undermine credentialing and oversight processes and ultimately allowed the surgeon to practice in the VA community care program.[8] First, the TPA failed to address concerns identified by a company responsible for independently verifying the surgeon's 2018 credentialing file. Second, imprecise language in the VA's contract with the TPA did not provide adequate guidance for determining whether to exclude the surgeon from the community care network. Additionally, IVC failed to identify inconsistencies in the surgeon's file that should have influenced credentialing decisions. Finally, the TPA misapplied privacy rules, which prevented its leaders from releasing important information to IVC relevant to the surgeon's voluntary relinquishment of their Florida medical license. The OIG concluded that the facility's patient safety training did not include completing patient safety reports for events in the community and the patient safety manager was unaware of the option to contact the TPA for updates on the status of patient safety concerns reported to the TPA.

Given the potential for these issues to be repeated across the country, the OIG made two recommendations to the under secretary for health related to a review of the surgeon's eligibility to participate in the community care network and contract; four recommendations to the IVC executive director related to ensuring the TPA's sufficient review, documentation, and compliance of network providers; one recommendation to the VISN director to review all community care provided by the surgeon; and one recommendation to the facility director related to patient safety event report education

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[6] VA OIG, *Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures*, January 4, 2024.
[7] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi*, August 28, 2019.
[8] TPAs are responsible for developing and maintaining a pool of community providers who meet VA's quality standards and process care claims.

and follow-up. Five of the eight recommendations are currently open, and the OIG continues to monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

VHA Did Not Provide Necessary Oversight of Community Care Providers' Opioid Prescriptions

Veterans have a higher risk of opioid overdose often due to higher rates of chronic pain caused by military related trauma as well as a variety of mental health issues such as PTSD and Military Sexual Trauma that increase the likelihood of misuse and abuse of opioids. When veterans receive care in the community, it is of vital importance that opioid prescriptions are appropriately tracked and coordinated with VA. The failure to do so puts patients at increased risk of opioid misuse and overdose.

The MISSION Act of 2018 requires VA to ensure that non-VA providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.[9] These guidelines require providers to query state prescription drug monitoring programs to determine whether veterans already have other opioid prescriptions before writing a new opioid prescription. In an audit published in September 2023, the OIG assessed whether VA ensured non-VA providers were provided a copy of the OSI guidelines and certified that they have reviewed them, whether a sample of non-VA providers conducted required queries, and whether sampled veterans' medical records included opioid prescriptions, as required by the MISSION Act.[10] The OIG found that IVC did not provide adequate oversight for either the TPA or non-VA providers to ensure the providers received and certified they reviewed the OSI guidelines. IVC also did not monitor the TPA to ensure non-VA providers completing prescription drug monitoring programs queries as required. The sampled medical records generally contained the non-VA provider opioid prescription information as required. However, this information was documented in different sections of VA medical records, which may make it difficult for providers to access this critical information. The OIG made three recommendations to improve compliance with *MISSION Ac*t requirements and OSI guidelines.

In a separate healthcare inspection, an OIG team assessed care coordination for patients of the VA Eastern Kansas Health Care System (VA Eastern Kansas) who also received community care and were dually prescribed opioids and benzodiazepines from community care network providers.[11] The inspection team also reviewed compliance with public law and VHA policies and guidelines specific to the oversight of community providers' opioid prescribing practices. The OIG found issues related to

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[9] P.L. 115-182, The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.
[10] VA OIG, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, September 26, 2023.
[11] VA OIG, *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth*, September 26, 2023.

incomplete and delayed community provider documentation, OSI prescribing risk-mitigation strategies, prescriptions dispensed at VHA pharmacies versus non-VA pharmacies, and lack of medication reconciliation and VHA medication profile updates. These deficiencies place patients at risk for adverse opioid-related events. Additionally, the team identified two examples in which patients received multiple controlled substance prescriptions from a combination of VA Eastern Kansas, non-VA Eastern Kansas VHA providers, and community care network providers. The OIG found the VISN director and medical center staff were not conducting oversight of the community providers' opioid prescribing practices as required under the MISSION Act and as recommended by the OIG in 2019. In addition, they were not reporting concerns of unsafe community care network provider practices to the TPA. The OIG made seven recommendations to the under secretary for health related to community care provider documentation, evidence of network providers' training and use of OSI risk-mitigation strategies, state prescription drug monitoring program queries, and the capture of community-provider-prescribed medications in electronic health records. The OIG made two recommendations to the VISN director related to ensuring VA Eastern Kansas has processes in place to conduct oversight of community care network providers' prescribing practices. The OIG made four recommendations to the VA Eastern Kansas director related to documenting the use of OSI risk-mitigation strategies, capturing community-provider-prescribed medications in the electronic health record, filling vacant pain management positions, and educating staff on reporting patient safety concerns involving community care providers. Six of the thirteen recommendations remain open.

CITC Inspections Repeatedly Find Patient Safety and Quality of Care Incident Reports from Community Providers Are Not Properly Tracked

OIG's CITC program also evaluates performance and facility staff compliance with requirements that are critical to ensuring the provision of high-quality care.

For example, the CITC teams compared community care patient safety and quality of care reports to the TPA with those entered in the VHA's Joint Patient Safety Reporting system, which standardizes the process for medical teams to identify and document medical errors, near-miss events, and close calls within their facilities. The teams found recurring issues with staff not entering and tracking events related to community care patient safety or quality of care in VA's reporting system. VA requires staff to report these events internally. Facility patient safety managers then review the events to determine the need for any immediate action. When staff do not report these community care events internally, patient safety managers miss opportunities to take corrective actions to address community care patient safety risks. Adding to this concern, there is a lack of transparency in the process for TPAs to review and respond to reported quality and patient safety issues. VA does not participate in or have visibility over the process by which a TPA determines if the standard of care was met and is only made aware of the end result of a review. The TPA then has sole discretion as to which providers may continue to operate and receive referrals within VA's community care network, regardless of the concerns raised by veterans who have received care from the provider.

VHA LACKS ADEQUATE STAFFING AND OVERSIGHT TO MANAGE COMMUNITY CARE

VHA uses staffing data to assess whether medical facilities have the necessary resources to manage community care needs. Accurate staffing data are critical for decision-making and allocating funds to support veterans' access to community care. As more and more veterans are referred to the community, VA must continually assess needs and reinforce staffing to respond to the workload demands. Further, VHA is responsible for overseeing community care networks and TPAs to ensure sufficient qualified providers are available and that their performance and competency is monitored.

Community Care Departments Need Reliable Data to Ensure Adequate Resources for Timely Scheduling and Care Coordination

An OIG audit team assessed whether medical facility leaders identified, authorized, recruited, and retained nurses and medical support assistants (MSAs) to process referrals for community care.[12] The team found that VHA does not have reliable data or sufficient tools to assess community care staffing levels and needs at the network or national level. Notably, facility leaders do not use consistent organizational codes to identify community care staff across VA medical facilities. Additionally, VA's staffing assessment tool relies on self-reported data that cannot be effectively verified. Due to data entry errors and a lack of consistent validation or quality review, VHA included inaccurate information in congressionally mandated reports. Despite these limitations on the VISN or national level, facility community care leaders generally identified local staffing needs, and their resource management committees authorized the requested staff. Although most facilities could adequately recruit and retain community care nurses, many could not recruit and retain MSAs. To compensate for the lack of MSAs, some facilities used strategies such as hiring incentives or consolidated community care units to help process community care referrals. The undersecretary for health concurred with the OIG's five recommendations to improve the reliability of community care staffing data and recruitment and retention of MSAs. One recommendation remains open at this time.

Staffing needs were also assessed by OIG CITC teams. As part of these reviews, the OIG teams requested each VA facility provide evidence that leaders reassessed community care staffing every 90 days as required using the staffing tool created by IVC. Teams found that VA staff could not provide evidence that these reassessments occurred at the required intervals. Failures to conduct these assessments as required could negatively affect community care program operations, and thus timely patient care. Notably, during their on-site inspections over the past year, CITC teams have repeatedly heard concerns about the lack of community care staff to keep up with increases in referrals.

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[12] VA OIG, *Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff*, July 19, 2023.

VA Needs Better Oversight to Evaluate Network Adequacy and Contractor Performance

VHA purchases community care for veterans through geographically based networks managed by the TPAs or through veteran care agreements, which are contracts with community providers in limited situations where the network is not provided or insufficient. IVC is responsible for overseeing execution of community care network contracts, while individual VA medical facilities establish the veteran care agreements.

The OIG conducted an audit to determine whether VHA provided effective oversight of its TPAs and VA medical facilities.[13] The review team evaluated IVC's oversight of the TPAs' adherence to four contract requirements designed to ensure facilities have enough community providers to administer care within the timeliness and drive-time standards established in the contracts. The OIG found that IVC did not hold TPAs accountable for implementing these contract requirements, causing facility staff to struggle to convince TPAs to add community providers to their networks at the eight facilities the audit team visited.

While IVC provided proof of TPAs discussing community care needs with three facilities, similar evidence for other facilities was not produced. Furthermore, IVC did not conduct any analyses of facilities' network adequacy needs to help TPAs build provider networks and did not ensure TPAs maintained provider networks that were accepting VA patients. IVC also did not position itself to defend facilities' needs for additional community care providers.

The OIG recommended to the undersecretary for health that the IVC hold future TPAs accountable for operational readiness and provider network adequacy. IVC should also develop processes to update and maintain community care network data, challenges, and needs. Advanced Medical Cost Management Solution training also needed to be conducted on evaluating network adequacy through the tool for community care staff. Finally, IVC should not only develop its own network adequacy performance reports but also evaluate TPAs' reports, holding them accountable for resolving identified issues. Six of the eight recommendations are closed, and the OIG will continue to follow up on the open recommendations until they have been satisfactorily implemented.

OIG AUDITS HAVE FOUND ADDITIONAL CHALLENGES RELATED TO IT SYSTEMS AND FINANCIAL MANAGEMENT

The OIG's Office of Audits and Evaluations teams have published multiple reviews that found deficient IT systems and data has hindered VA's ability to properly manage community care billing and payment. The reports summarized here further detail these issues.

[13] VA OIG, *Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance*, April 9, 2024.

VHA Continues to Face Challenges with Billing Private Insurers for Community Care

VA has a right to recover community care treatment costs for conditions unrelated to military service from veterans' private health insurers. The OIG conducted an audit to determine how effectively the VHA billed private insurers.[14] Prior OIG work had shown that VHA has missed opportunities to recover funds that could be used to help finance care for other veterans. VHA's Office of Community Care (OCC), the precursor to IVC, managed community care programs and billed private insurers when needed. OCC was required to submit reimbursement claims before insurers' deadlines are reached, or they may be denied. The OIG found OCC did not establish an effective process to ensure staff billed veterans' private health insurers as required. An estimated 54 percent of billable community care claims paid between April 20, 2017, and October 31, 2020, were not submitted before filing deadlines expired. As a result, OCC did not collect an estimated $217.5 million that should have been recovered, a figure that could have grown to $805.2 million by September 30, 2022, if problems were not corrected. OCC's billing and revenue collection process also was not synchronized with insurers' filing deadlines, and claims information was not always available for billing. Also, pending workload volume and staff shortages hindered effective billing. Although OCC was broadly aware of challenges to its process to bill and collect revenue from private insurers, its responses were not sufficient to correct these issues. VHA concurred with the OIG's recommendations to develop procedures that prioritize processing to meet insurers' filing deadlines and strengthen its information system controls to ensure information needed to process bills for reimbursement is complete and accurate. VHA should have also assessed staff resources and workload to make certain they are sufficiently aligned to process the anticipated volume of claims to be billed.

Although this report was issued in May 2022, all three recommendations remain open as unimplemented, signaling the challenges VHA faces in maintaining adequate processes and systems to carry out these tasks.

The Pause of the Program Integrity Tool Impeded Community Care Revenue Collections and Related Oversight Operations

VA must have the ability to accurately forecast budget needs for its administrations and staff offices, and then properly execute appropriated funds. The OIG has documented how the absence of well-functioning IT and internal quality monitoring systems can exacerbate financial management problems. A recent example affecting revenues is the OIG's July 2024 management advisory memorandum to VHA regarding the pause in using its Program Integrity Tool (PIT).[15] VHA uses PIT data to determine if

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[14] VA OIG, *VHA Continues to Face Challenges with Billing Private Insurers for Community Care*, May 24, 2022

[15] VA OIG, *The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations*, July 16, 2024. While the OIG made no recommendations in this memorandum, the OIG remains concerned about whether VHA's Revenue Operations will have sufficient resources to timely bill the backlog of community care claims, and how the pause will affect fraud, waste, and abuse activities for community care claims.

healthcare claims should be billed to veterans or private insurance companies for the treatment of conditions unrelated to military service. VHA paused using the PIT in February 2023 after becoming aware of numerous issues, including inaccurate or duplicate claims and defective code. The pause had two major impacts: First, VHA could not bill veterans or private insurance companies for community care copayments or coinsurance because VHA relies on PIT data to do so. Second, the pause impeded internal oversight efforts that utilize the PIT to prevent, detect, and mitigate fraud, waste, and abuse related to community care claims. While VHA has reported that use of the PIT partially resumed in recent months, they now must review the backlog of claims to determine which are eligible to be billed to veterans or private insurers. The OIG estimated that VHA would be delayed in billing an estimated 2.8 million community care claims totaling about $2 billion that were paid between February 1, 2023, and February 1, 2024. According to VHA, the pause resulted in veteran copayment billings that were approximately $23 million lower for the first two quarters of FY 2024 than the same period in 2023. The pause could also have negatively affected veterans because VHA may have sent them copayment bills for care over a year old. To ensure the PIT fully recovered from these issues and would be reliable moving forward, the OIG determined that VHA must commit to providing strong governance, updated IT systems, and effective quality assurance and monitoring.

THE OIG WILL SOON RELEASE ADDITIONAL REPORTS THAT SHOW COMMUNITY CARE CONCERNS PERSIST

The OIG continues to focus on VA community care and has many ongoing projects that explore new areas and highlight continual concerns with the program. Below are previews of two such reports that will soon be published.

An OHI inspection at the VA Eastern Kansas Healthcare System found deficiencies in community care staff's efforts to retrieve records that may have contributed to a delay in a patient's cancer diagnosis and care. The patient had a scan completed at a community hospital, with abnormal results consistent with lung cancer with metastatic spread to the lymph nodes of the chest. That same day, the community hospital faxed the scan results to the wrong VA facility. It was not until the patient presented with concerning symptoms and was admitted to a VA facility over three months later that the abnormal scan results were identified and reviewed. The OIG also determined Eastern Kansas VA leaders did not meet institutional disclosure requirements as crucial components of the disclosure were not documented, and it was not possible to discern the nature of the adverse event disclosed or what was explained to the patient.

A review conducted by the OIG's Office of Audits and Evaluations found that the Veteran Self-Scheduling (VSS) process needs better support and stronger controls and oversight. VSS allows eligible veterans to schedule their appointments directly with community providers once they receive an

authorization for a community care provider and an approved consult.[16] Importantly, this process is only designed for consults designated as requiring basic care coordination. The OIG found that IVC needs to improve its oversight of the VSS process to strengthen support and mitigate the risk of potential misuse of the scheduling option. Neither IVC nor facility leaders implemented controls to identify the potential misuse of VSS. For example, staff at the four facilities the OIG team visited processed VSS consults inappropriately by selecting the VSS option for veterans without their permission. Staff also opted veterans into VSS with urgent consults, despite the fact that veterans with these needs are not eligible for the VSS process. In addition, clinical staff are required to initiate contact with veterans that have more complex consults to help manage the "opt-in" process, a step the review team found was not generally completed at the facilities they visited. Finally, neither IVC nor facility leaders provided effective oversight of VSS. Without better oversight, inappropriate use of the VSS option may go undetected, and veterans may experience delays in care.

CONCLUSION

Time and again, the OIG finds engaged and highly qualified VA clinical staff providing direct care to veterans. Despite the efforts of dedicated staff, VA continues to experience challenges in coordinating and streamlining care when veterans are referred to the community. Our oversight work has repeatedly identified gaps in assessing the safety and quality of community care and repeated deficiencies in coordinating that care. Through over 50 community care reports and hundreds of recommendations, OIG has identified risk, noncompliance with policy, and unclear guidance to the field. Our teams have also supported solution-focused conversations between IVC, VISNs, and facility leaders and staff, which have helped leaders target many significant operational deficiencies. OIG recognizes the need for community providers to partner with VA to meet the often-complex needs of veterans, and we will continue our independent oversight efforts to ensure veterans and their families are receiving the timely high-quality care they need.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance VHA's provision of care to veterans, regardless of where it is delivered. I would be happy to answer any questions you may have.

[16] If a veteran chooses self-scheduling and opts in, VHA staff collect the veteran's additional scheduling preferences, such as which community providers the veteran wants to see, and then informs the veteran they will receive a letter about scheduling their own appointment with instructions on how to notify VHA staff of their appointment details.