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VETERANS HEALTH ADMINISTRATION

Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic

NATIONAL REVIEW | REPORT #20-03437-26 | NOVEMBER 10, 2021

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Executive Summary

The VA Office of the Inspector General (OIG) conducted a national review of select community care consults (stat community care consults) that were generated during a 103-day period at the outset of the COVID-19 pandemic to evaluate consult processes.[1] Patient involvement in care urgency disagreements and reporting of adverse events in community care were also reviewed.[2] When the OIG identified deficiencies in processes, electronic health records (EHRs) of the patients at issue were further examined for potential negative outcomes.[3]

Clinical consults are used when a referring provider seeks an opinion, advice, or expertise from a consulting provider (receiving provider) regarding evaluation or management of a specific clinical need. Upon submission of a consult request, the referring provider selects the urgency status to identify the time frame for care to be rendered to the patient. According to the Veterans Health Administration (VHA), the only two acceptable urgency statuses are routine and stat. Routine urgency indicates a patient should be seen according to the clinically indicated date (the date deemed by the referring provider as clinically appropriate), whereas stat urgency (stat) indicates an immediate need requiring completion within 24 hours.[4] Consults for community care undergo a clinical review and approval by the chief of staff or designee(s).

On March 20, 2020, VHA issued access standard guidance in response to COVID-19 to assist VHA providers with clinical determinations regarding individual veterans. VHA providers were instructed that referrals (consults) "to the community for emergent or urgent clinical needs will continue, and VA will work to ensure care coordination and safety given the increased risk environment with COVID-19."

In this report, the OIG addressed two components of the stat community care consult process—the clinical aspect and the administrative aspect. To review the clinical aspect, the OIG evaluated whether care was rendered within 24 hours. For the administrative aspect, the OIG evaluated

[1] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019. The directive was renumbered (1232(3)) when a 2021 amendment was issued after the OIG's inspection period of VHA operations discussed in this report; the 2021 amendment did not affect OIG findings or recommendations. According to the directive, stat consults "must be completed within 24 hours."

[2] VHA Office of Community Care, *Veterans Health Administration Office of Community Care Patient Safety Guidebook*, August 2019. Adverse events can be "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided to a Veteran in the community on behalf of the VA. Adverse events may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment)."

[3] Within the context of this report, the OIG defined a negative patient outcome as death, hospitalization, or significant change in the status of a patient's disease that may have been preventable if the care requested in the stat community care consult had occurred within the mandated 24-hour time frame.

[4] VHA Directive 1232(2), 2016, amended 2019.

whether the status of stat community care consults was changed to complete within 24 hours.[5] Facility processes were assessed through EHR reviews and survey responses.

Consult Process Deficiencies Reflected in EHR Reviews

For the 2,236 stat community care consults that were generated from March 20, 2020, through June 30, 2020, that were in active, scheduled, or completed status, the OIG reviewed medical documentation contained in patients' EHRs and determined that care was not provided within 24 hours for 379 (16.9 percent) consults. The inspection team did not identify negative care outcomes. The OIG was unable to determine if care was provided within 24 hours for 29 of the consults due to a lack of medical documentation from the community provider.

Of the 1,828 stat community care consults with care provided in 24 hours, 1,309 (71.6 percent) did not have the consult status changed to complete in 24 hours. The most frequently documented reasons for the delay in changing the consult status were awaiting medical documentation or attempting to obtain records. The OIG concluded that delays in receiving medical documentation could negatively affect VHA provider care coordination.

The OIG also evaluated whether care was provided regardless of the 24-hour time frame. The OIG found that care associated with 2,049 of the 2,236 stat community care consults (91.6 percent) was provided as requested.[6] For three patients whose care was not provided as requested, the OIG did not identify negative patient care outcomes. Provision of care could not be determined for 167 of the 2,236 consults (7.5 percent) primarily due to the lack of community provider medical documentation. For 1,122 of the 1,335 consults (84 percent) that indicated follow-up care was needed after the initial care episode, the OIG determined that community providers delivered care in the time frame requested.[7] Ten did not, but for these patients, the OIG did not identify negative patient care outcomes.

[5] Health Information Management Office of Informatics and Information Governance, HIM [*Health Information Management] Fact Sheet Office of Community Care – Consult Closure*, September 2017. There are two ways to complete a consult. Documentation from the community care provider is received and scanned into the patient's EHR, or under specific circumstances, a consult may be administratively closed when documentation from the community provider is not available. VHA Directive 1232(2), 2016, amended 2019.

[6] Of the 2,236 consults, 17 were duplicate, no longer needed, declined by patient, or for a patient who expired.

[7] Of the 1,335 consults that required follow-up care, 61 patients had a pending appointment, five patients declined care, and one patient expired. The OIG was unable to determine if follow-up care was provided within the time frame requested for 136 of the 1,335 consults primarily due to a lack of community provider medical documentation.

Consult Process Deficiencies Reflected in VA Medical Facility Survey Responses

The OIG analyzed 138 VHA medical facilities' survey responses regarding stat community care consult processes from initial submission to completion.[8] Of the 138 VA medical facilities, approximately 10 percent reported that stat consults were not processed from submission to completion in community care.[9] Of these VA medical facilities, almost three-fourths referenced difficulties meeting stat community care consult requirements such as preauthorization of care, obtaining community provider medical documentation, and completing consults within 24 hours. Respondents from these VA medical facilities further indicated that patients were referred to the community for stat care through alternate processes. The OIG determined that VA medical facilities' use of alternate processes was not in alignment with VHA policy and could result in provider uncertainty regarding which process to use when requesting patient care.[10]

The OIG surveyed VA medical facilities to determine the process used for consults that a referring provider designates as stat urgency, but the chief of staff or designee deems to be routine urgency through clinical review.[11] Of the 138 VA medical facilities, almost one-fourth responded that the clinical reviewers changed the urgency status of consults from stat to routine without collaborating with the referring providers.[12] The OIG found that this lack of collaboration when changing a consult urgency from stat to routine could result in delays of care and negatively affect patient care outcomes.

The OIG assessed VA medical facilities' processes to manage adverse events related to community care. The goal of VHA's patient safety program is to prevent harm by identifying and reporting adverse events. All of the 138 VA medical facilities reported a process; approximately 85 percent of the facilities indicated that community care–related adverse events were reported to the patient safety manager, as required by VHA policy.[13] Nearly 15 percent of facilities' responses did not include reporting to the facility patient safety manager. These results

[8] A total of 139 VA medical facilities were included in this review. One facility requested to be excused from the OIG survey due to resource demands of veterans with COVID-19.

[9] The word *process* was used in the VA OIG survey question. Examples of VA medical facilities responses included "not process," "not support," "not have," "not entered," "not accepted," and "never be" when referring to stat community care consults.

[10] VHA Directive 1232(2), 2016, amended 2019.

[11] VHA Office of Community Care leaders were asked to describe the process used when a consult was initially entered as stat and determined to not be stat upon clinical review. The Action Special Advisor to Office of Community Care Assistant Under Secretary for Health for Clinical Services indicated that the chief of staff or designee is to collaborate with the referring provider to clarify questions and to determine alternate means of care, if appropriate.

[12] Eleven VA medical facilities responses could not be categorized. Clinical reviewers are the chief of staff or chief of staff's designee.

[13] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

may reveal a gap in reporting of adverse events that could negatively affect VHA's ability to identify and address system vulnerabilities.

The OIG made six recommendations to the Under Secretary for Health related to community care resources, facility practices, and VHA requirements that specifically focus on stat community care consults; retrieval of medical records and administrative closure of stat consults; collaboration between referring providers and clinical reviewers when changing the urgency of stat community care consults; patient involvement when clinical reviewers change stat community care consults to routine; time frames for adjudicating and communicating clinical appeals; and adverse event–reporting processes in community care.

Comments

The Acting Under Secretary for Health concurred with the recommendations and provided an acceptable action plan (see appendix B). The OIG will follow up on the planned actions until they are completed.

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Contents

Introduction

The VA Office of the Inspector General (OIG) conducted a national review to evaluate VA medical facilities' select community care consult processes. The review included an analysis of patient electronic health records (EHRs) of select community care consults (stat community care consults) that were generated during a 103-day period at the outset of the COVID-19 pandemic and responses to an OIG survey.[1] The OIG addressed two components of the stat community care consult process—the clinical aspect and the administrative aspect. To review the clinical aspect, the OIG evaluated whether care was rendered within 24 hours. For the administrative aspect, the OIG evaluated whether the status of stat community care consults was changed to complete within 24 hours. Facility processes to change consult urgency and to report community care–related adverse events were also assessed.[2] When the OIG identified deficiencies in processes, EHRs of the patients at issue were further examined for potential negative outcomes.[3]

Background

Clinical consults are used when referring providers seek opinions, advice, or expertise from consulting providers (receiving providers) regarding evaluation or management of specific clinical needs. Consults for community care undergo clinical reviews by the chief of staff or a chief of staff designee to determine appropriateness and to make approval or denial decisions.[4] The referring provider selects an urgency status to identify the time frame for care to be rendered

[1] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019. The directive was renumbered (1232(3)) when a 2021 amendment was issued after the OIG's inspection period of VHA operations discussed in this report; the 2021 amendment did not affect OIG findings or recommendations. According to the directive, stat consults "must be completed within 24 hours."

[2] VHA Office of Community Care, *Veterans Health Administration Office of Community Care Patient Safety Guidebook*, August 2019, updated December 2020. Adverse events can be "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided to a Veteran in the community on behalf of the VA. Adverse events may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment)." The definition of an adverse event was unchanged in the 2020 *VHA Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.* This facility process was evaluated through the OIG survey.

[3] Within the context of this report, the OIG defined a negative patient outcome as death, hospitalization, or significant change in the status of a patient's disease that may have been preventable if the care requested in the stat community care consult had occurred within the mandated 24-hour time frame.

[4] VHA Office of Community Care, *VHA Office of Community Care Field Guidebook*, Chapter 2.

to the patient. According to the Veterans Health Administration (VHA), the only two acceptable urgency statuses are routine and stat. Care must be provided within 24 hours for stat consults.[5]

On March 20, 2020, VHA issued access standard guidance in response to COVID-19 to assist VHA providers with clinical determinations regarding individual veterans. VHA providers were instructed that

> referral to the community for emergent or urgent clinical needs will continue, and VA will work to ensure care coordination and safety given the increased risk environment with COVID-19. VHA cannot curtail emergent or urgent care.

Guidance further stated that "scheduling of non-emergent care with community providers should be reviewed on a case-by-case basis, regardless of wait time or drive time eligibility, until such time as VHA determines that it will restart routine care."[6]

VHA Office of Community Care

According to its website, the VHA Office of Community Care

> administers multiple community care programs that enable eligible Veterans and beneficiaries to receive health care services from providers outside of a VA medical facility. OCC [Office of Community Care] also manages all national billing and collection activities for medical care and services provided by VA medical centers. These activities primarily include billing Veteran copayments and third party health insurance companies for nonservice-connected care provided to Veterans.[7]

[5] VHA Directive 1232(2), 2016, amended 2019. VHA requires that a referring provider identify the time frame for completion of the consult (urgency status) upon submission. The two acceptable urgency statuses are—routine and stat. Care must be provided within 24 hours for stat consults.

[6] Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Access Standards in response to Coronavirus (COVID-19)*, Attachment, March 20, 2020. An updated memo, issued on March 30, 2020, provided additional instructions:

> Scheduling decisions should be reviewed on a case-by-case basis and should take into account the individual Veteran's needs, including COVID-19 related risks, market variation regarding local community provider availability, or community level emergency response efforts including social distancing. Where the severity or immediacy of the Veteran's medical need (e.g., certain chronic disease management, maternity care, pain management therapies) outweighs the COVID-19 related risks, care should be scheduled within VA or in the community as appropriate.

[7] "Community Care-About Us," VA, accessed August 30, 2021, https://www.va.gov/COMMUNITYCARE/programs/overview.asp.

Prior OIG Reports

The OIG published two reports related to COVID-19 response and readiness in 2020:

- *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness,* March 26, 2020[8]
- *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness,* July 16, 2020[9]

Selected facility response plans for the COVID-19 pandemic were discussed.[10] For the March 2020 report, the OIG interviewed facility leaders regarding the possible need of referring patients to other facilities or community providers if care could not be provided by VHA. For 34 of 54 facilities, no barriers were noted that limited coordinating with community resources during that time.[11] The second report, published in July 2020, indicated facility leaders experienced and met many challenges while providing access to community care providers. Facility leaders identified difficulties rescheduling community care appointments canceled due to COVID-19. No recommendations were made.[12]

Scope and Methodology

The OIG's inspection included a review of patient EHRs and analysis of electronic survey responses from VA medical facilities. The OIG used the VHA Support Service Center to identify 139 VA medical facilities that received and processed stat community care consult requests.[13] Facility providers generated 3,146 stat community care consults from March 20, 2020, through June 30, 2020.[14]

[8] VA OIG, Report No. 20-02221-120; https://www.va.gov/oig/pubs/VAOIG-20-02221-120.pdf.

[9] VA OIG, Report No. 20-03076-217; https://www.va.gov/oig/pubs/VAOIG-20-03076-217.pdf.

[10] VA OIG, Report No. 20-02221-120; VA OIG, Report No. 20-03076-217.

[11] VA OIG, Report No. 20-02221-120.

[12] VA OIG, Report No. 20-03076-217.

[13] The 139 VA medical facilities included 133 VA medical centers, three healthcare centers, two multispecialty community-based outpatient clinics, and one other outpatient services site.

[14] VHA Directive 1232(2), 2016, amended 2019. Of the 3,146 consults, 2,237 were in an active, scheduled, or completed status, and 909 were in a discontinued or canceled status. Upon EHR review, it was identified that one active consult was updated to a discontinued status. The OIG focused on consults that were in active, scheduled, or completed status. An active status consult is one that has been "received" and "efforts are underway to fulfill" it. A scheduled consult indicates an appointment has been made and linked to the consult request. Complete status designates the requested service has been done. Discontinue status is used by the referring or receiving provider to discontinue a consult that is no longer wanted or needed. Cancel/Deny is selected by the receiving service to return the consult to the referring provider if the request did not include an appropriate question, did not provide sufficient information, or there was an obvious error in the consult order.

Documents reviewed included VHA directives, Deputy Under Secretary for Health for Operations and Management memorandums, VHA's *Office of Emergency Management the COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan,* March 23, 2020, and other VHA publications specific to stat community care consult processing requirements during the COVID-19 pandemic. The OIG developed an EHR review tool and an electronic survey tool based on documents reviewed.

During EHR reviews, the OIG evaluated administrative and clinical criteria regarding consult processing, care coordination, and patient care outcomes. The OIG found that VHA did not specifically define the parameters of the 24-hour period required for consult completion. For the purpose of this review, the OIG considered the date and time of submission of the consult as the starting point for the 24-hour period. EHRs with potential adverse events (as defined by VHA) underwent second-level reviews for negative patient care outcomes.[15] Information gathered from the EHR reviews was aggregated and trended to identify patterns in practices across VA medical facilities.

The OIG survey included questions regarding the VA medical facility's stat community care consult policies, practices, and barriers faced during the pandemic. The OIG requested the participating139 VA medical facilities provide two points of contact with detailed knowledge of the respective community care programs to complete the electronic survey. The request was coordinated by the VHA Government Accountability Office OIG Accountability Liaison Office. On January 5, 2021, the survey was emailed to two points of contact for 139 VA medical facilities with a requested completion date of January 19, 2021. All surveys, except one, were completed by January 29, 2021.[16] After initial review of the 138 completed surveys, the OIG contacted 44 VA medical facilities for follow-up with additional questions or requests for survey response clarification. The OIG analyzed the survey responses after trending and aggregating by question. Information gathered from survey results was used to identify stat community care consult utilization, barriers, and compliance with VHA requirements.

Significantly, the OIG did not assess the responses from the VA medical facilities' two points of contact for accuracy or completeness.

On May 10, 2021, the OIG presented trended survey data to VHA leaders at their request. Following the presentation, the OIG emailed questions to the VHA Government Accountability

[15] VHA Office of Community Care, *Patient Safety Guidebook*, August 2019, updated December 2020. The OIG defined a negative patient outcome as death, hospitalization, or significant change in the status of a patient's disease that, in the OIG's assessment, may have been preventable if the stat community care consult occurred within the time frame as requested by the referring provider.

[16] One facility did not participate in the survey; however, patient EHR reviews from the nonparticipating facility were included in the OIG's evaluation.

Office OIG Accountability Liaison Office for response from the VHA Office of Community Care leaders regarding policy mandates, practice expectations, and insights on survey results.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). 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 the national review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

The OIG's review of VA medical facility processes focused on stat community care consults that must be completed within 24 hours. The OIG identified deficiencies in stat community care consult processes through evaluation of EHR reviews and analysis of survey results.

1. Consult Process Deficiencies Reflected in EHR Reviews

The OIG used the EHR review tool to collect patient care details contained in stat community care consults to determine whether

- care was provided and the consult was completed within 24 hours,
- a reason was documented when consults were not completed in 24 hours, and
- a reason was documented when consults were changed to discontinued status.

EHRs with potential adverse events (as defined by VHA) underwent second-level reviews for potential negative patient care outcomes.

Clinical Processes—Care Not Consistently Provided Within 24 Hours

The OIG reviewed community provider medical documentation contained in patients' EHRs and determined care was delivered within 24 hours for 1,828 consults; however, care was not provided within 24 hours for 379 of the 2,236 stat community care consults (16.9 percent) reviewed. No negative patient care outcomes were identified for patients who did not receive care in the 24-hour time frame. The OIG was unable to determine if care was provided in the 24-hour time frame for 29 of the 2,236 consults (1.3percent) because documentation from the community provider was not available.

Overall, the majority of care was provided within 24 hours as required. Sixteen VA medical facilities did not provide care within 24 hours for 50 percent or more of stat community care consults.[17] Of these, three VA medical facilities did not provide care within 24 hours for

[17] The VA medical facilities included the VA Ann Arbor Healthcare System, VA Maine Healthcare System – Togus, VA Boston Healthcare System, Canandaigua VA Medical Center, Chalmers P. Wylie Ambulatory Care Center, Durham VA Medical Center, Fayetteville VA Medical Center, North Florida/South Georgia Veterans Health System, Manchester VA Medical Center, Captain James A. Lovell Federal Health Care Center, Orlando VA Medical Center, VA Portland Health Care System, Providence VA Medical Center, Salisbury-W.G. (Bill) Hefner VA Medical Center, James A. Haley Veterans' Hospital, and Hunter Holmes McGuire VA Medical Center. For some VA medical facilities, there was a small number of stat community care consults ordered during the time frame of this review.

100 percent of stat community care consults.[18] The OIG noted that failure to provide stat community care to patients within 24 hours does not meet VHA requirements and could result in negative patient care outcomes.[19]

Clinical Processes—Care Not Consistently Provided as Requested

After determining that 16.9 percent of stat community care consults did not result in care provided within 24 hours, the OIG questioned whether patients received care regardless of time frame. While evaluating patient EHRs to ascertain if patients received care, the OIG also evaluated whether the care received was what the referring provider requested.

For 2,049 of the 2,236 stat community care consults (91.6 percent), the OIG identified patients received care as requested, although some received care outside of 24 hours. Of the remaining patients, the OIG was unable to determine if care associated with 167 consults was provided as requested, primarily due to lack of community provider medical documentation. Three other patients did not receive community care as requested.[20] For these three patients, the OIG did not identify negative patient care outcomes.

Clinical Processes—Timeliness of Follow-Up Care

The OIG also reviewed medical documentation to determine if community providers indicated follow-up care was needed after the initial stat community care visit and, if so, whether the follow-up care was provided within the requested time frame. For the 1,335 consults that were identified as needing follow-up care, the OIG determined care was provided in the time frame requested for 1,122 (84 percent) consults.[21] Ten did not receive follow-up care within the recommended time frame. The OIG did not identify negative patient care outcomes for patients who received delayed follow-up care. The OIG was unable to determine if the needed follow-up

[18] The three facilities were the VA Ann Arbor Healthcare System, Captain James A. Lovell Federal Health Care Center, and Providence VA Medical Center. For the three VA medical facilities, there was a small number of stat community care consults ordered during the time frame of this review.

[19] VHA Directive 1232(2), 2016, amended, 2019.

[20] One of the other three patients was admitted to hospice care; a second patient moved in with a family member after a hospital discharge and could not be reached by VA. Care for the third patient could not be obtained from available contracted providers. It appeared from documentation in the patient's EHR that care was being provided by family. Of the remaining 17 patients, reasons for patients not receiving care included the care was no longer needed, the patient declined care, the patient expired, or the consult was a duplicate.

[21] For 159 of the 2,236 stat community care consults (7.1 percent), the OIG was unable to determine if follow-up care was needed primarily due to a lack of community provider medical documentation in the patients' EHRs. For 2 of the 159 consults, the OIG was unable to determine if follow-up care was required due to EHR documentation being illegible. Of the 1,335 consults that needed follow-up care, 61 had pending appointments at the time of the OIG EHR review, 5 patients declined care, and 1 patient expired.

care was provided within the time frame requested for 136 of the 1,335 consults (10.2 percent) primarily due to the lack of community provider medical documentation.[22]

Administrative Processes—Consults Not Consistently Completed Within 24 Hours

The retrieval of community provider medical records is necessary not only for continuity of patient care but also for completion of the consult process by facility community care staff.[23] Of the 1,828 stat community care consults with care provided in 24 hours, the consult status of 1,309 (71.6 percent) patients' EHRs was not changed to complete in 24 hours.

VHA states that, "every effort must be made to work with the community provider to ensure that the facility receives authenticated information, and it is scanned and/or uploaded into the Veteran's health record."[24] According to the VHA Office of Community Care, when VHA staff do not receive community provider medical records within 14 days of a patient's scheduled appointment, community care consults shall be administratively completed after the following criteria are met:[25]

- "Confirmation is made that the Veteran attended the requested community care appointment"
- "One documented attempt to retrieve medical documentation is recorded in the Consult Toolbox in the Consult Completion Tab"

[22] For 14 of the 136 consults, the OIG was unable to determine if follow-up care was provided within the time frame requested due to a variety of EHR documentation reasons such as date of service not indicated on documentation.

[23] *VHA Office of Community Care Field Guidebook*, Chapter 4.

[24] *VHA Office of Community Care Field Guidebook*, Chapter 4.

[25] *VHA Office of Community Care Field Guidebook*, Chapter 4.

- "Administrative closure MUST occur within ninety (90) days of the initial scheduled appointment" [emphasis in original]
- "Two additional attempts to retrieve medical documentation must be recorded in the consult toolbox within 90 days of the scheduled appointment, except for low risk consults."[26]

Of the 139 VA medical facilities, 109 had stat community care consults with care provided in 24 hours. The OIG found that 85 of these facilities did not complete 50 percent or more of the consults within 24 hours. In 31 of these facilities, no consults were completed within 24 hours.[27]

While the OIG was unable to locate a requirement to document the reason a consult is not completed, the OIG found that facility staff entered reasons in 483 of the 1,309 consults to explain why the consults were not completed in the 24-hour time frame. The most frequently documented reasons, found in 353 patients' EHRs, were awaiting or attempting to obtain medical documentation. The OIG concluded that delays in receiving medical documentation could negatively impact VA provider care coordination.

Discontinued Consults

Referring or receiving providers can discontinue consults that are no longer needed or wanted.[28] Additionally, the chief of staff or designee can discontinue a consult based on a clinical review.[29] VHA Directive 1232(2) states that discontinued consults "should always document the reason" for discontinuation.[30]

Of the 3,146 stat community care consults, 817 were discontinued. The OIG found 200 (24.5 percent) discontinued consults that had no reason documented.

The OIG reviewed the distribution of discontinued consults that did not have a documented reason by VA medical facilities. Of the 130 VA medical facilities with discontinued stat

[26] *VHA Office of Community Care Field Guidebook*, Chapter 4; VHA Directive 1232(2), 2016, amended 2019. VHA defines "low risk clinics nationally to include: [clinics such as] physical therapy, occupational therapy, kinesiotherapy, acupuncture, smoking clinic, MOVE clinic, massage therapy, chiropractic care and erectile dysfunction clinic."

[27] See appendix A. Facilities with consults that resulted in care being rendered within 24 hours but did not result in completion of the consult within 24 hours are marked with an asterisk (*). For some of these VA medical facilities, there was a small number of stat community care consults ordered during the time frame of this review.

[28] VHA Directive 1232(2), 2016, amended 2019.

[29] *VHA Office of Community Care Field Guidebook*, Chapter 2.

[30] VHA Directive 1232(2), 2016, amended 2019.

community care consults, 27 (20.8 percent) facilities did not have reasons documented on 50 percent or more of the consults.[31]

Referring providers are unable to determine next steps if the chief of staff or designee discontinue the referral without documenting the rationale. This lack of information may cause a delay in the coordination of patient care.

Stat Community Care Consults Not Accepted at Facility

During review of discontinued consults, the OIG noted 17 VA medical facilities that either did not process stat community care consults or did so inconsistently.[32] For 6 of the 17 VA medical facilities, all stat community care consults were discontinued or canceled.[33] The remaining 11 VA medical facilities processed some stat community care consults.[34]

The OIG analyzed the 11 VA medical facilities to identify reasons why some stat community care consults were discontinued or canceled. Despite some consults having a comment indicating that stat consults were not processed by community care, some were processed. Based on EHR reviews and follow-up emails, 2 of the 11 VA medical facilities discontinued or canceled certain types of stat community care consults:

[31] The VA medical facilities were the VA Maryland Health Care System, Battle Creek VA Medical Center, Dayton VA Medical Center, Michael E. DeBakey VA Medical Center, Lexington VA Health Care System, VA Hudson Valley Health Care System, Roseburg VA Health Care System, Washington DC VA Medical Center, Amarillo VA Health Care System, VA Ann Arbor Healthcare System, Bay Pines VA Healthcare System, Beckley VA Medical Center, Cincinnati VA Medical Center, Clarksburg - Louis A. Johnson VA Medical Center, Coatesville VA Medical Center, Harry S. Truman Memorial, Columbia VA Health Care System, VA Black Hills Health Care System - Fort Meade Campus, VA Texas Valley Coastal Bend Health Care System, Oscar G. Johnson VA Medical Center, VA Greater Los Angeles Healthcare System (GLA), William S. Middleton Memorial Veterans Hospital, Minneapolis VA Health Care System, Omaha VA Medical Center--VA Nebraska-Western Iowa HCS, Tuscaloosa VA Medical Center, White City or VA Southern Oregon Rehabilitation Center, and Wilkes-Barre VA Medical Center. For some VA medical facilities, there was a small number of stat community care consults ordered during the time frame of this review.

[32] Word variations documented by 17 VA medical facilities in EHR when referring to stat community care consults included "not process," "not be used," "not accept," "not been allowed," "not appropriate," and "Per policy, routine is the only authorized category of urgency to be applied to consults." For some VA medical facilities, a small number of the total stat community consults had comments reflecting this language.

[33] The six facilities were VA Maryland Health Care System, VA North Texas Health Care System, VA Eastern Colorado Health Care System (ECHCS), Michael E. DeBakey VA Medical Center, Miami VA Healthcare System and Oklahoma City VA Health Care System. For some VA medical facilities, there was a small number of stat community care consults ordered during the time frame of this review.

[34] The 11 facilities were the New Mexico VA Health Care System, Battle Creek VA Medical Center, Bay Pines VA Healthcare System, VA Western New York Healthcare System, Cheyenne VA Medical Center, VA Illiana Health Care System, Columbia VA Health Care System, North Florida/South Georgia Veterans Health System, Providence VA Medical Center, VA Puget Sound Health Care System, and James A. Haley Veterans' Hospital.

- One VA medical facility discontinued or canceled stat home health consults.[35]
- One VA medical facility discontinued a hematology consult due to community providers' inability to address through an office visit.[36]

Analysis of the remaining 9 of 11 VA medical facilities revealed no specific reasons to explain the discontinuation or cancelation of some stat community care consults while others were processed. The OIG concluded the discontinued and canceled consults may reflect inconsistencies within the VA medical facilities when processing stat community care consults. Inconsistencies have the potential to create challenges in medical management for providers requesting care via a stat community care consult.

2. Consult Process Deficiencies Reflected in VA Medical Facility Survey Responses

To gain insight on processes for managing stat community care consults, the OIG surveyed staff from 138 VA medical facilities.[37] Survey questions focused on six areas of interest:

- Processing of stat community care consults
- Override of stat community care consult decisions and notification of the referring provider[38]
- Resolution of patients' disagreements with stat community care consult override decisions
- Processes for reporting community care adverse events
- Barriers experienced by VA medical facility community care staff when referring stat consults
- Impact observed by VA medical facility community care staff due to community provider access limitations when referring stat consults

[35] This involved the New Mexico VA Health Care System. This information was obtained through a follow-up email to the facility.

[36] This involved the Battle Creek VA Medical Center. This information was obtained through a follow-up email to the facility.

[37] One VA medical facility requested to be excused from the OIG survey due to resource demands of veterans with COVID-19.

[38] In the context of this report, the OIG defined an override as a decision by the chief of staff or designee to change the urgency of a stat consult to routine.

Consult Processing

As noted above, VHA requires that a referring provider identify the time frame for completion of the consult (urgency status) upon submission.[39] According to VHA, the only two acceptable urgency statuses are routine and stat.[40] Routine urgency indicates a patient should be seen according to the clinically indicated date, whereas stat indicates an immediate need requiring clinical care to be rendered within 24 hours.[41] VHA Directive 1232(2) and the Guidebook outline stat community care processes for VA medical facilities.[42] The OIG did not find any VHA guidance that allows VA medical facilities to not provide stat community care consults. Referring providers who submit stat community care consults are required to perform multiple tasks:[43]

- Contact the intended receiver of the consult request to discuss the patient's situation
- Enter "Today" in the clinically indicated date field of the consult
- Enter "Stat" in the urgency field of the consult
- Before the patient leaves the clinic, either schedule an appointment or document when the patient will be seen

Consults received by the facility community care office are reviewed by clinical staff who are designees with authority from the VA medical facility chief of staff to determine the appropriateness of requested services prior to authorization for care to be delivered in the community.[44]

One step of the community care clinical review process for stat consults is the evaluation of the urgency classification. If the consult urgency is determined to be incorrect or needs additional information, the consult may be canceled and returned to the referring provider. If determined not to be clinically appropriate, the consult is sent back to the referring provider and should include clinical recommendations from the physician or nonphysician provider performing the clinical review.[45]

The OIG surveyed 138 VA medical facilities and gathered information regarding stat community care consult processes from initial submission to completion. Of the VA medical facilities surveyed, approximately 10 percent reported that stat consults were not processed from

[39] VHA Directive 1232(2), 2016, amended 2019.

[40] VHA Directive 1232(2), 2016, amended 2019.

[41] VHA Directive 1232(2), 2016, amended 2019. The clinically indicated date is the date care is deemed clinically appropriate by the VA referring provider.

[42] VHA Directive 1232(2), 2016, amended 2019; *Office of Community Care Field Guidebook*, Chapter 2.

[43] VHA Directive 1232(2), 2016, amended 2019.

[44] *VHA Office of Community Care Field Guidebook*, Chapter 2.

[45] *VHA Office of Community Care Field Guidebook*, Chapter 2.

submission to completion for community care.[46] Examples of survey and follow-up email responses from these facilities are provided below:

- "Our facility does not process STAT consults through Office of Community Care, as stated in several other answers they are sent back to the ordering service. For a STAT consult—by definition—the patient should be seen within 48 hours of consult entry. The likelihood of a consult being processed properly and care being coordinated in 48 hours from a STAT consult placement is not realistic for Office of Community Care business rules. If a patient is in dire need of this type of care and they cannot be treated by the facility they should be sent to the ER [emergency department]."[47]
- The "service does not accept STAT consults because the consult processing policies and procedures mandate that consults be completed with a consult completion note and medical records sent to HIMS [health information management system] within 48 hours of consult entry. Although there are avenues to expediently process consults, create authorizations, and schedule care for Veterans needing care on an urgent basis, there is no mechanism by which it is possible to compel a community provider to supply medical documentation immediately after the rendering of services to permit consult closure within the 48-hour timeframe."[48]
- "Our facility process is not to accept stat consults in community care. Consults do not show up on community care reports until the following day so completing within 24 hours is not possible."
- "STAT requires that the consult be completed within 48 hours. Completion of a community care consult is not possible until records of the treatment have been received and scanned into VISTA [Veterans Health Information Systems and Technology Architecture] or the required effort has been made and this is not possible within 48 hours. Therefore, we do not process [stat] community care consults as they are required to be in scheduled status for longer than 24-48 hours."
- "Community Care does not accept STAT consults, since CC [community care] consults are considered admin [administrative] consults per the consult directive."
- "OCC [Office of Community Care] consults will never be STAT as they are not an immediate need for VA resources. The decision to not process STAT Consults in OCC

[46] The word *process* was used in the VA OIG survey question. Examples of VA medical facilities responses included "not process," "not support," "not have," "not entered," "not accepted," and "never be" when referring to stat community care consults.

[47] In a follow-up email, the facility points of contact indicated that "48 hours" in the response was an error; the correct response should have been "24 hours."

[48] In a follow-up email, the facility indicated that "48 hour timeframe" in the response was an error; the correct response should have been "24 hours."

> was made by the Consult Committee several years ago as it was identified as a delay in care to refer a Veteran through Community Care for a STAT episode of care due to our lack of agility/availability on the weekends and holidays to pre-authorize the care."

- "The care in the community cannot meet the stringent STAT timeline requirements, due to the process our dept follows to generate a community care authorization. The Care in the community is not a 24/7 department and consults that are placed late on a Friday or over a holiday are not processed until the next business day. The CITC [Care in the Community] Department gets a large volume of consults per day. If the CITC staff is not aware of an urgent matter the consults may not get processed quickly."

The OIG identified a common theme in these VA medical facility responses that indicated stat community care consults were not processed at the facilities. Almost three-fourths referenced difficulties meeting VHA stat community care consult requirements such as preauthorizing care, obtaining community provider medical documentation, and completing the consult by facility community care staff within 24 hours.

According to the responses from the VA medical facilities that did not process stat community care consults from submission to completion, patients were referred to the community for stat care through alternate processes:[49]

- Patients were sent to the closest emergency department, whether at a VA medical facility or in the community.
- Referring providers contacted community providers and arranged care.
- Consults were sent back to the referring provider. Patients were either sent to a local emergency department or routine consults were placed and community care staff were given a warm handoff.
- If a stat community care consult was placed, the facility followed the stat process but changed the consult to routine once it was determined the care would be delivered quickly.

In response to an OIG question regarding whether VA medical facilities were allowed not to accept or process stat community care consults, VHA Office of Community Care leaders responded,

> No, while these consults are utilized less frequently for community care, there may be clinical indications that meet the criteria and need for a stat consult. Stat consults are defined as an 'immediate' need and must be completed within 24 hours.

[49] The OIG summarized the responses for the purpose of conciseness and readability.

The OIG concluded that VA medical facilities' use of alternate processes to request stat care in the community was not in alignment with VHA Directive 1232(2).[50] Alternate processes for requesting stat care may result in provider uncertainty when requesting care.

Override of Stat Community Care Consults

The OIG found no VHA policy or guidance for changing stat community care consults to routine during the clinical review by the chief of staff or designee. To identify processes, the OIG asked VHA Office of Community Care leaders to describe action taken when a stat community care consult is determined not to be stat upon clinical review. The Action Special Advisor to Office of Community Care Assistant Under Secretary for Health for Clinical Services (Special Advisor) did not recall guidance being provided to VA medical facilities for definitively determining a consult was not stat. The Special Advisor indicated that the chief of staff or designee "is to work directly" with the referring provider to clarify any questions and come up with an alternate means of care, if appropriate.

In the survey, the OIG asked VA medical facilities to describe the process used when a consult is initially entered as stat but determined not to be stat upon clinical review by the chief of staff or designee. Of the 138 VA medical facilities, nearly 70 percent indicated that under those circumstances, collaboration occurs between the referring providers and designees.[51] Some responses further indicated that collaboration allowed referring providers to clarify questions and provide additional information not contained in the consults or known by the designees regarding the urgency of the care requested. In contrast, almost one-fourth of the VA medical facilities surveyed responded that the designees changed the urgency status of consults from stat to routine without collaborating with the referring providers.[52] The lack of collaboration indicated by these VA medical facilities did not align with the process described by the Special Advisor. The OIG concluded that a lack of collaboration between the referring providers and the designees could result in a delay of care and negatively affect patient care outcomes.

Patient Involvement When Clinical Reviewers Changed Stat Community Care Consults to Routine

As noted above, VHA issued specific guidance during the pandemic regarding community care consults to the community. Emergent or urgent clinical needs would continue to be referred and

[50] VHA Directive 1232(2), 2016, amended 2019.

[51] The OIG categorized responses into three categories: (1) referring providers were contacted for confirmation, discussion, clarification, consult review, warm handoff, or to change the status; (2) or the consult was returned to the referring provider for the status to be changed; (3) or no override made. Contact with the referring provider could have been through phone call, instant message, or other means that allows for live two-way discussion. Responses from 11 VA medical facilities could not be categorized.

[52] The OIG defined lack of collaboration as no real-time, two-way communication contact between the referring provider and clinical reviewer when changing consult urgency from stat to routine.

nonemergent care with community providers would be reviewed on a case-by-case basis until VHA determined routine care could be restarted.[53] Consults reviewed by the designees and changed from stat to routine during the pandemic could result in care not being scheduled in accordance with provider or patient expectations.

VHA directive requires facilities to have processes in place to allow for resolution of clinical disputes at the patient's healthcare team level. Clinical disputes not resolved at this level should be elevated to the VA medical facility's chief of staff for review, attempted resolution, and determination within five business days.[54] Also, VA medical facility directors are required to ensure

> that patients and their representatives are aware of their right to dispute a clinical decision and the process involved in appealing that decision, and staff are aware of the appeals process when a patient or patient's representative expresses disagreement with clinical decisions.[55]

The OIG survey included a question regarding the facility's process for resolving patients' disagreements when clinical reviewers make override decisions. Responses from about half of the VA medical facilities surveyed indicated that patients were involved in the resolution of disagreements regarding stat community care consults. Of the VA medical facilities surveyed, less than 5 percent responded that patients were not involved in the resolution of community care consult urgency status disagreements or clinical decisions. One VA medical facility reported having no formal resolution process.

Below are the responses from the VA medical facilities indicating no patient involvement in the resolution of community care consult urgency status disagreements:

[53] Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Access Standards in response to Coronavirus (COVID-19)*, Attachment, March 20, 2020. An updated memo, issued on March 30, 2020, offered additional instructions.

[54] VHA Directive 1041, *Appeal of VHA Clinical Decisions*, October 24, 2016 was in effect at the start of this review. The term 'clinical dispute' is defined as an impasse that occurs between a patient, or the patient's representative, and a VHA medical facility over the provision or denial of clinical care that potentially could result in a different and/or improved clinical outcome for the Veteran. This directive was replaced by VHA Directive 1041, *Appeal of Veterans Health Administration Clinical Decisions*, September 28, 2020 that contains similar language related to facility director responsibilities. The time frame for adjudication of an appeal in the 2020 directive is within three business days of receipt of an appeal by the VA medical facility for issues about eligibility for community care. All other clinical appeals will be adjudicated, and decisions communicated to the person(s) submitting the appeal within 45 business days of receipt except in instances where an external review is necessary.

[55] VHA Directive 1041, 2016; VHA Directive 1041, 2020.

- "We do not involve the patient in this discussion. It occurs between the [Office of Community Care] staff and the requesting provider."
- "Stat is a medical determination made by medical providers. It is not determined at the discretion of the patient."
- "Use of [stat] to direct health care is made by health care providers. It is not a term that is open to debate with patients who are not trained in health care."
- "Urgency levels are a clinical decision and should only be determined by trained clinicians. Patients do not have the ability to disagree with these decisions."
- "Patient cannot determine urgency. Clinical provider determines urgent. If Veteran disagrees and feels they have an emergent need, they are instructed to go to the nearest ER."

The OIG determined that the responses of these VA medical facilities may reflect a process that does not incorporate patient-centered care, nor VHA strategic goals.

When asked about patient involvement in resolving disagreements about overrides, 8 percent of the VA medical facilities surveyed responded in free text that patients were informed of the clinical appeal process. The OIG determined that VA medical facility staff who do not inform patients of the clinical appeal process, or the right to appeal, are not following VHA policy.[56] In addition, the 45-day time frame for adjudicating and communicating appeal decisions is not compatible with the 24-hour mandate for completing stat community care consults.[57]

Reporting of Adverse Events

The goal of VHA's patient safety program is to prevent harm by identifying and reporting adverse events.[58] VHA states that adverse event–reporting provides "valuable opportunities to evaluate the identified root causes and contributing factors, as well as associated actions and outcome measures to mitigate future events from reoccurring within that facility."[59] According to VHA Handbook 1050.01, VA medical facility staff are required to report unsafe conditions to the patient safety manager, even if the conditions have not resulted in an adverse event.[60]

According to the VHA Office of Community Care, a patient safety guidebook was developed after collaboration with numerous VHA program office to improve information sharing, reporting, and feedback to stakeholders for patient safety events that occur through the

[56] VHA Directive 1041, 2016; VHA Directive 1041, 2020.
[57] VHA Directive 1041, 2016; VHA Directive 1041, 2020. VHA Directive 1232(2), 2016, amended 2019.
[58] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
[59] VHA Handbook 1050.01.
[60] VHA Handbook 1050.01.

community care program (Patient Safety Guidebook).[61] The Patient Safety Guidebook recommends reporting community care patient safety events in accordance with VHA Handbook 1050.01.[62] While the VHA Handbook 1050.01 does not require notifications to community care network managers, the Patient Safety Guidebook recommends such notifications.[63]

The OIG surveyed the 138 VA medical facilities regarding processes used for reporting community care clinical adverse events. Approximately 85 percent of the VA medical facilities reported adverse events to the patient safety manager as required by VHA Handbook 1050.01.[64] Of these, around 5 percent reported using the Patient Safety Guidebook.[65] While all VA medical facilities indicated a process was in place for reporting patient safety events, about 15 percent did not specifically include reporting to the facility patient safety manager as required.[66] The OIG determined the survey responses may reflect a gap in reporting adverse events, which could negatively affect VHA's ability to identify and address system vulnerabilities.

Barriers and Impact of Access Limitations on Stat Community Care Consults During COVID-19

VHA guidance indicated that, based on the severity or immediacy of a patient's medical need, care was to be scheduled within VA medical facilities or in the community as appropriate during COVID-19.[67]

Barriers

The OIG survey asked the 138 VA medical facilities to identify the barriers encountered when referring stat community care consults from a list of 14 options. The facilities could respond with other relevant information as well. Of the VA medical facilities surveyed, 20 percent reported not experiencing barriers. Listed below, in order of frequency, are the five barriers selected by the remaining VA medical facilities (reproduced verbatim from the OIG-provided options):[68]

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[61] VHA Handbook 1050.01; VHA Office of Community Care, *Patient Safety Guidebook*, August 2019 was in effect at the time of the events discussed in this report. The 2019 guidebook was replaced by VHA Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook, December 2020. A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as "near miss" incidents.

[62] VHA Office of Community Care, *Patient Safety Guidebook*, 2019.

[63] VHA Office of Community Care, *Patient Safety Guidebook*, 2019.

[64] VHA Handbook 1050.01.

[65] VHA Office of Community Care, *Patient Safety Guidebook*, 2019.

[66] VHA Handbook 1050.01.

[67] Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Access Standards in response to Coronavirus (COVID-19)*, Attachment, March 20, 2020.

[68] The response from three VA medical facilities reported barriers and also indicated not processing stat community care consults.

- Community providers have limited access/appointments available
- Delays in receiving postvisit medical documentation from CITC [care in the community] provider
- Community providers reduction in services
- Delayed response from community providers
- Stat consult process or procedures not followed by referring provider

The OIG's observations of missing EHR documentation from community providers and the number of discontinued consults may have resulted from these barriers. Despite the reported barriers, care was provided within 24 hours for the majority of stat community care consults reviewed.

Impact of Access Limitations

In a free-text survey question, VA medical facilities were asked about the impact of community provider access limitations when referring stat community care consults. More than one impact could be identified. No impact was reported from about 85 percent of the VA medical facilities surveyed.[69] Responses from the remaining surveyed VA medical facilities reported numerous impacts:

- Scheduling limitations
- Longer travel distances
- Use of different provider location
- Increased number of open consults
- Delays in community provider records
- Hindered coordination of care (communication or follow-up from community partners)
- Limited specialty service availability
- Retriaging of consults by community providers who determined urgency due to limited services

[69] For three VA medical facilities, responses could not be classified or were not specific to stat community care consults.

- Delayed appointment scheduling as a provider wanted to review medical records first
- Declined telehealth when offered to patients

The majority of VA medical facilities reported no observed impact due to community providers' access limitations when referring stat community care consults. As noted above, the OIG reviewed patients who did not receive care as requested by the referring providers during the inspection period and did not identify negative care outcomes.

Conclusion

At the outset of the pandemic, VHA providers were instructed to continue community care consults for emergent or urgent clinical needs.[70] In general, routine community care consults were placed on hold while stat community care consults continued. Consults changed from stat to routine during the pandemic could result in care not being scheduled in accordance with provider or patient expectations.

Overall, of the EHRs reviewed, the OIG identified 81.8 percent of care ordered through stat community care consults was provided within 24 hours during the time frame under review, but only 28.4 percent of these consults were changed in the patients' EHR to a completed status within 24 hours. For the 71.6 percent that were not changed to a completed status within 24 hours, the most frequently documented reasons provided were awaiting medical documentation or attempting to obtain records. Delays in receiving community provider medical documentation could negatively affect VA provider care coordination.

The OIG identified that, during the time frame under review, 91.6 percent of the care requested through stat community care consults was provided regardless of the 24-hour time frames. Three other patients did not receive community care as requested; no negative patient care outcomes were identified.

Of the stat community care consults that needed follow-up care, 84 percent received the care within the time frame requested. No negative patient care outcomes were identified for the remaining consults that were associated with care delivered but not within the time frame requested.

Of the 138 surveyed VA medical facilities, approximately 10 percent responded that stat community care consults were not processed from submission to completion. These VA medical facilities reported using alternate processes to request stat care in the community, which is not in

[70] Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Access Standards in response to Coronavirus (COVID-19)*, Attachment, March 20, 2020. While the memo discusses emergent and urgent care, VHA policy related to consults does not use that terminology, but categorizes consults as routine or stat. The policy defines stat as an immediate need to be addressed within 24 hours. VHA Directive 1232(2), 2016, amended 2019.

alignment with VHA policy. Creating alternate processes may result in provider uncertainty when requesting care.

The Special Advisor described actions to be taken when a clinical reviewer determines that stat community care consult does not warrant a stat urgency. Steps included collaboration between designees and referring providers to clarify questions and come up with alternate means of care, if appropriate. However, of the 138 VA medical facilities, almost one-fourth responded that the designees changed the urgency status of consults from stat to routine without collaborating with the referring providers. Lack of collaboration between the designees and referring providers when considering changes in consult urgency status from stat to routine could result in delays of care that may affect patient care outcomes.

The OIG surveyed VA medical facilities regarding the process used when a patient disagrees with a consult initially entered as stat but changed to routine upon clinical review. Responses from about half of the VA medical facilities described a process that involved patients in the resolution of community care consult urgency status disagreements. Less than 5 percent of the VA medical facilities described a process that did not involve the patient in the resolution of community care consult urgency status disagreements, and one VA medical facility reported having no formal resolution process. Responses from the VA medical facilities that did not involve patients were indicative of processes that did not incorporate patient-centered care or VHA strategic goals.

Of the VA medical facilities surveyed, about 85 percent described reporting adverse events to the patient safety manager as required. While all VA medical facilities reported a process, about 15 percent did not specifically include reporting to the facility patient safety manager. These responses may reflect a gap in reporting adverse events to the patient safety manager that may negatively affect VHA's ability to identify and address system vulnerabilities.

Recommendations 1–6

1. The Under Secretary for Health evaluates community care resources, facility practices, and Veterans Health Administration requirements related to stat community care consult processes and takes action as warranted to ensure that patients receive clinically indicated care in the appropriate time frame.
2. The Under Secretary for Health clarifies guidance to VA medical facilities for stat community care consults including the timeliness of clinical review and approval, retrieval of medical records, and administrative closure.
3. The Under Secretary for Health issues guidance to VA medical facilities regarding the override process for stat community care consults to include collaboration expected between the referring provider and the designee.
4. The Under Secretary for Health evaluates patient involvement in decision-making regarding clinical reviewers' modification of the urgency status of stat community care consults to determine if the process is in alignment with Veterans Health Administration patient-centered care goals and takes action as warranted.
5. The Under Secretary for Health evaluates the time frame for adjudicating and communicating clinical appeals, determines applicability to the 24-hour requirement for completing stat community care consults, and takes action as warranted.
6. The Under Secretary for Health evaluates adverse event reporting processes in community care, including a review of guidance provided in the *VHA National Patient Safety Improvement Handbook,* 1050.01 and the *VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook* for inconsistencies and takes action as warranted.

Appendix A: VA Medical Facilities Included in Review

Table A.1. List of 139 VA Medical Facilities Included in Review

VISN	Station Number	Facility*	Type
1	402	*VA Maine Healthcare System – Togus	VA Medical Center
1	405	*White River Junction VA Medical Center	VA Medical Center
1	523	VA Boston Healthcare System	VA Health Care System
1	608	*Manchester VA Medical Center	VA Medical Center
1	631	VA Central Western Massachusetts Healthcare System	VA Medical Center
1	650	Providence VA Medical Center	VA Medical Center
2	526	James J. Peters VA Medical Center (Bronx, NY)	VA Medical Center
2	528	*VA Western New York Healthcare System	VA Health Care System
2	528A5	*Canandaigua VA Medical Center	VA Medical Center
2	528A6	*Bath VA Medical Center	VA Medical Center
2	528A7	Syracuse VA Medical Center	VA Medical Center
2	528A8	*Albany VA Medical Center: Samuel S. Stratton	VA Medical Center
2	561	VA New Jersey Health Care System	VA Health Care System
2	620	VA Hudson Valley Health Care System	VA Health Care System
2	630	VA NY Harbor Healthcare System	VA Health Care System
2	632	Northport VA Medical Center	VA Medical Center
4	460	*Wilmington VA Medical Center	VA Medical Center
4	503	*Altoona - James E. Van Zandt VA Medical Center	VA Medical Center
4	529	Butler VA Health Care System	VA Medical Center
4	542	*Coatesville VA Medical Center	VA Medical Center
4	562	*Erie VA Medical Center	VA Medical Center
4	595	*Lebanon VA Medical Center	VA Medical Center
4	642	Corporal Michael J. Crescenz VA Medical Center	VA Medical Center
4	646	*VA Pittsburgh Healthcare System	VA Health Care System
4	693	*Wilkes-Barre VA Medical Center	VA Medical Center
5	512	VA Maryland Health Care System	VA Health Care System
5	517	Beckley VA Medical Center	VA Medical Center
5	540	*Clarksburg - Louis A. Johnson VA Medical Center	VA Medical Center
5	581	Hershel "Woody" Williams VA Medical Center	VA Medical Center
5	613	*Martinsburg VA Medical Center	VA Medical Center

VISN	Station Number	Facility*	Type
5	688	Washington DC VA Medical Center	VA Medical Center
6	558	*Durham VA Medical Center	VA Medical Center
6	565	*Fayetteville VA Medical Center	VA Medical Center
6	590	*Hampton VA Medical Center	VA Medical Center
6	637	*Asheville VA Medical Center	VA Medical Center
6	652	Hunter Holmes McGuire VA Medical Center	VA Medical Center
6	658	Salem VA Medical Center	VA Medical Center
6	659	*Salisbury - W.G. (Bill) Hefner VA Medical Center	VA Medical Center
7	508	Atlanta VA Health Care System	VA Medical Center
7	509	Charlie Norwood VA Medical Center	VA Medical Center
7	521	*Birmingham VA Medical Center	VA Medical Center
7	534	*Ralph H. Johnson VA Medical Center	VA Medical Center
7	544	*Columbia VA Health Care System	VA Health Care System
7	557	Carl Vinson VA Medical Center	VA Medical Center
7	619	*Central Alabama Veterans Health Care System West Campus	VA Medical Center
7	679	*Tuscaloosa VA Medical Center	VA Medical Center
8	516	Bay Pines VA Healthcare System	VA Health Care System
8	546	Miami VA Healthcare System	VA Medical Center
8	548	*West Palm Beach VAMC	VA Medical Center
8	573	North Florida/South Georgia Veterans Health System	VA Health Care System
8	672	*VA Caribbean Healthcare System	VA Health Care System
8	673	*James A. Haley Veterans' Hospital	VA Medical Center
8	675	*Orlando VA Medical Center	VA Medical Center
9	596	Lexington VA Health Care System	VA Health Care System
9	603	Robley Rex VA Medical Center	VA Medical Center
9	621	James H. Quillen Veterans Affairs Medical Center	VA Medical Center
9	626	Tennessee Valley Healthcare System	VA Health Care System
10	506	VA Ann Arbor Healthcare System	VA Medical Center
10	515	*Battle Creek VA Medical Center	VA Medical Center
10	538	*Chillicothe VA Medical Center	VA Medical Center
10	539	*Cincinnati VA Medical Center	VA Medical Center
10	541	*Louis Stokes Cleveland VA Medical Center	VA Medical Center

VISN	Station Number	Facility*	Type
10	552	Dayton VA Medical Center	VA Medical Center
10	553	*John D. Dingell VA Medical Center	VA Medical Center
10	583	*Richard L. Roudebush VA Medical Center	VA Medical Center
10	610	*VA Northern Indiana Health Care System	VA Health Care System
10	655	*Aleda E. Lutz VA Medical Center	VA Medical Center
10	757	Chalmers P. Wylie Ambulatory Care Center	VA Medical Center
12	537	Jesse Brown VA Medical Center	VA Medical Center
12	550	*VA Illiana Health Care System	VA Medical Center
12	556	Captain James A. Lovell Federal Health Care Center	VA Medical Center
12	578	*Edward Hines Jr. VA Hospital	VA Medical Center
12	585	*Oscar G. Johnson VA Medical Center	VA Medical Center
12	607	*William S. Middleton Memorial Veterans Hospital	VA Medical Center
12	676	*Tomah VA Medical Center	VA Medical Center
12	695	*Clement J. Zablocki Veterans Affairs Medical Center	VA Medical Center
15	589	*Kansas City VA Medical Center	VA Medical Center
15	589A4	*Harry S. Truman Memorial	VA Medical Center
15	589A5	*VA Eastern Kansas Health Care System - Colmery-O'Neil VA Medical Center	VA Medical Center
15	589A7	*Robert J. Dole VA Medical Center	VA Medical Center
15	657	*VA St. Louis Health Care System	VA Health Care System
15	657A4	*John J. Pershing VA Medical Center	VA Medical Center
15	657A5	*Marion VA Medical Center	VA Medical Center
16	502	*Alexandria VA Health Care System	VA Medical Center
16	520	*Gulf Coast Veterans Health Care System	VA Medical Center
16	564	*Veterans Health Care System of the Ozarks	VA Medical Center
16	580	Michael E. DeBakey VA Medical Center	VA Medical Center
16	586	G.V. (Sonny) Montgomery VA Medical Center	VA Medical Center
16	598	Central Arkansas Veterans Healthcare System Eugene J. Towbin Healthcare Center	VA Medical Center
16	629	Southeast Louisiana Veterans Health Care System	VA Medical Center
16	667	Overton Brooks VA Medical Center	VA Medical Center
17	504	*Amarillo VA Health Care System	VA Health Care System
17	519	*West Texas VA Health Care System	VA Health Care System
17	549	VA North Texas Health Care System	VA Health Care System

VISN	Station Number	Facility*	Type
17	671	South Texas Veterans Health Care System	VA Health Care System
17	674	*Central Texas Veterans Health Care System	VA Health Care System
17	740	*VA Texas Valley Coastal Bend Health Care System	VA Health Care System
17	756	El Paso VA Health Care System	VA Health Care System
19	436	*Fort Harrison VA Medical Center	VA Health Care System
19	442	*Cheyenne VA Medical Center	VA Medical Center
19	554	VA Eastern Colorado Health Care System (ECHCS)	VA Health Care System
19	575	*VA Western Colorado Health Care System	VA Medical Center
19	623	*Eastern Oklahoma VA Health Care System (Jack C. Montgomery VAMC)	VA Health Care System
19	635	Oklahoma City VA Health Care System	VA Health Care System
19	660	*VA Salt Lake City Health Care System	VA Health Care System
19	666	*Sheridan VA Medical Center	VA Medical Center
20	463	*Alaska VA Healthcare System	VA Health Care System
20	531	*Boise VA Medical Center	VA Medical Center
20	648	*VA Portland Health Care System	VA Health Care System
20	653	Roseburg VA Health Care System	VA Medical Center
20	663	*VA Puget Sound Health Care System	VA Health Care System
20	668	*Mann-Grandstaff VA Medical Center	VA Medical Center
20	687	*Jonathan M. Wainwright Memorial VA Medical Center	VA Medical Center
20	692	*White City or VA Southern Oregon Rehabilitation Center	VA Medical Center
21	459	VA Pacific Islands Health Care Center	VA Medical Center
21	459GE	VA Guam Community Based Outpatient Clinic	Multi-Specialty CBOC
21	459GH	VA Saipan Outreach Clinic	Other Outpatient Services
21	570	Central California VA Health Care System	VA Medical Center
21	593	VA Southern Nevada Healthcare System	VA Medical Center
21	612	*VA Northern California Health Care System	VA Medical Center
21	640	*VA Palo Alto Health Care System	VA Medical Center
21	654	VA Sierra Nevada Health Care System	VA Medical Center
21	662	*San Francisco VA Health Care System	VA Health Care System
22	501	*New Mexico VA Health Care System	VA Health Care System
22	600	*VA Long Beach Healthcare System	VA Medical Center
22	605	VA Loma Linda Healthcare System	VA Medical Center

VISN	Station Number	Facility*	Type
22	644	Phoenix VA Health Care System	VA Health Care System
22	649	*Northern Arizona VA Health Care System	VA Health Care System
22	664	*VA San Diego Healthcare System	VA Medical Center
22	678	*Southern Arizona VA Health Care System	VA Health Care System
22	691	*VA Greater Los Angeles Healthcare System (GLA)	VA Medical Center
23	437	*Fargo VA Health Care System	VA Health Care System
23	438	*Sioux Falls VA Health Care System	VA Health Care System
23	568	VA Black Hills Health Care System - Fort Meade Campus	VA Health Care System
23	618	Minneapolis VA Health Care System	VA Health Care System
23	636	Omaha VA Medical Center--VA Nebraska-Western Iowa HCS	VA Health Care System
23	636A6	*VA Central Iowa Health Care System	VA Health Care System
23	636A8	*Iowa City VA Health Care System	VA Health Care System
23	656	*St. Cloud VA Health Care System	VA Health Care System

Source: Created by the OIG from http://vaww.va.gov/directory/guide/rpt_fac_list.cfm*, accessed on September 16, 2020. (This is an internal website not accessible by the public.)*
**Facilities with patients who received community care within 24 hours but did not complete 50 percent or more of the consults within 24 hours.*

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 24, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report: Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic (VIEWS 5776776)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic*. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.
2. VHA has one technical comment to improve accuracy and completeness of the draft report.
    a. Page 9: The current language in the third paragraph, "The VHA Office of Community Care is responsible for planning and oversight as well as managing all programs used to facilitate care and services provided by community providers. Established in 2015, all programs that allow veterans to receive care and services through providers outside of VA are managed by the Delivery Operations business line," is inaccurate. VHA suggests replacing the first two sentences with the following: "The Veterans Health Administration Office of Community Care (OCC) administers multiple community care programs that enable eligible Veterans and beneficiaries to receive health care services from providers outside of a VA medical facility. Community care eligibility is based on specific requirements, availability of VA care, and the needs and circumstances of individual Veterans."

OIG OCC Consult (Stat) Processes During the COVID-19 (VIEWS #5776776)

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.
Attachment

OIG Response to VHA Technical Comment

The OIG reviewed the technical comment, reviewed the VA Community Care website, and clarified information provided that was relevant to the report.[71]

[71] "Community Care-About Us," VA, accessed August 30, 2021, https://www.va.gov/COMMUNITYCARE/programs/overview.asp.

Under Secretary for Health Response

VETERANS HEALTH
Action Plan
OIG Draft Report: Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic

Recommendation 1. The Under Secretary for Health evaluates community care resources, facility practices, and VHA requirements related to stat community care consult processes and takes action as warranted to ensure that patients receive clinically indicated care in the appropriate time frame.

VHA Comments: Concur

The VHA Office of Community Care (OCC) will evaluate the reported staffing levels in the facility community care offices in all Veterans Integrated Service Networks (VISN), create clear guidance and assess the practices for managing stat community care consults. OCC will ensure clear guidance on the process for managing stat community care consults and work with the VISNs and local VA Medical Centers (VAMC) who have direct oversight in ensuring Veterans receive clinically indicated care in the appropriate timeframe and guide them in taking appropriate action when necessary.

Status: In progress Target Completion Date: March 2022

Recommendation 2. The Under Secretary for Health clarifies guidance to VA medical facilities for stat community care consults including the timeliness of clinical review and approval, retrieval of medical records, and administrative closure.

VHA Comments: Concur

OCC will assemble a team to clarify guidance regarding the comprehensive management of stat community care consults. This guidance will address the timeliness of clinical review and approval, the expectations regarding retrieval of medical records and the appropriate use of the administrative closure policy. Any additional guidance will be communicated and updated in policy and field guidance. Oversight will remain at the VISN level with OCC support.

Status: In progress Target Completion Date: March 2022

Recommendation 3. The Under Secretary for Health issues guidance to VA medical facilities regarding the override process for stat community care consults to include collaboration expected between the referring provider and the designee.

VHA Comments: Concur

OCC will assess processes for the override process for stat community consults to ensure the expected collaboration between the referring provider and the designee.

Oversight will be put in place by Medical Centers and VISNs. OCC will ensure appropriate policy changes and trainings.

Status: In progress Target Completion Date: March 2022

Recommendation 4. The Under Secretary for Health evaluates patient involvement in decision-making regarding clinical reviewers' modification of the urgency status of stat community care consults to determine if the process is in alignment with VHA patient-centered care goals and takes action as warranted.

VHA Comments: Concur

OCC will evaluate patient involvement in decision-making regarding clinical reviewers' modification of the urgency status of stat community consults to determine if the process is in alignment with VHA patient-centered care goals and takes action as warranted. This will be communicated to VAMCs and VISNs. Requisite training, policy changes and communications will be implemented.

Status: In progress Target Completion Date: March 2022

Recommendation 5. The Under Secretary for Health evaluates the time frame for adjudicating and communicating clinical appeals, determines applicability to the 24-hour requirement for completing stat community care consults, and takes action as warranted.

VHA Comments: Concur

OCC will work with the Office of the Assistant Under Secretary for Health for Clinical Services to evaluate the time frame for adjudicating and communicating clinical appeals. Current work is underway to change the completion of stat community care consults to 48 hours. OCC will determine the applicability to the newly updated 48-hour requirement for completing stat community care consults and take action as warranted.

Status: In progress Target Completion Date: March 2022

Recommendation 6. The Under Secretary for Health evaluates adverse event reporting processes in community care, including a review of guidance provided in the *VHA National Patient Safety Improvement Handbook*, 1050.01 and the *VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook* for inconsistencies and takes action as warranted.

VHA Comments: Concur

OCC will collaborate with the VHA National Center for Patient Safety (NCPS) office to develop standard processes for reviewing adverse events and develop standard actions to align with NCPS policies. VAMCs and VISNs will share lessons learned in any adverse event. OCC will track all reported adverse events.

Status: In progress Target Completion Date: March 2022

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