DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23)

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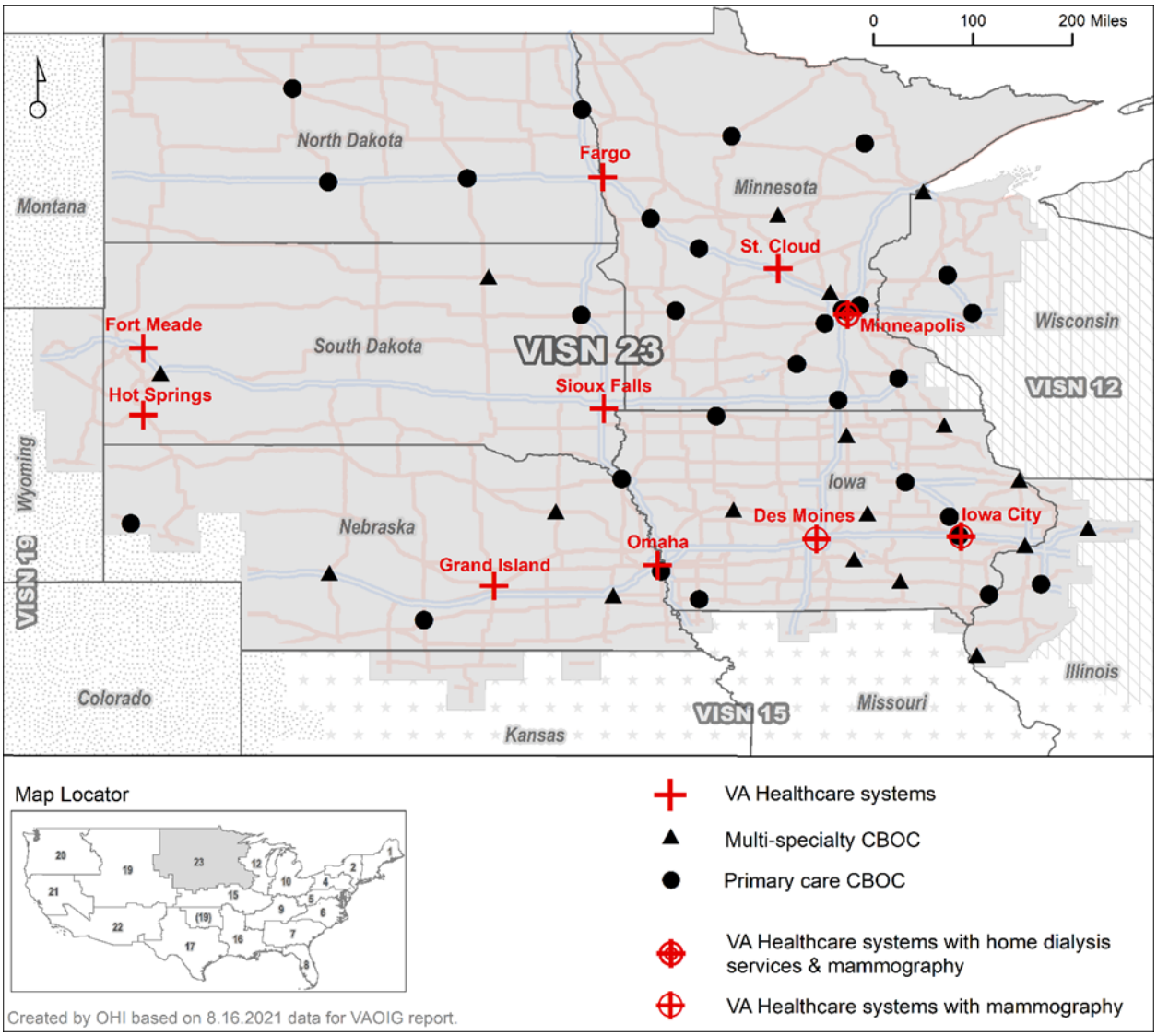

Figure 1. *Veterans Integrated Service Network 23: VA Midwest Health Care Network.*

Source: Veterans Health Administration Support Service Center, Capital Assets Data, accessed August 16, 2021.

Abbreviations

CBOC	community-based outpatient clinic
CHF	congestive heart failure
CITC	Care in the Community
CMS	Centers for Medicaid and Medicare Services
EHR	electronic health record
FDA	Food and Drug Administration
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
OCC	Office of Community Care
OIG	Office of Inspector General
PACT	Patient Aligned Care Team
PBM	Pharmacy Benefits Management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Integrated System Technology Architecture

Report Overview

The Office of Inspector General (OIG) Care in the Community (CITC) healthcare inspection program examines key clinical and administrative processes that are associated with providing quality VA and community (non-VA) care. CITC inspections are one element of the OIG's overall oversight efforts to ensure that veterans receive high-quality and timely healthcare services.

In 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated seven VA community care programs into one program, the Veterans Community Care Program.[1] According to the VA Fact Sheet, this program simplified the process for veterans to receive non-VA care by expanding eligibility criteria, creating a single non-VA care program, improving customer service, and providing a way for patients to access in-network walk-in care without requiring prior authorization.[2]

The OIG will be regularly overseeing the Veterans Health Administration's (VHA) clinical efforts with the implementation of the MISSION Act, by selecting and evaluating specific areas of focus on a cyclical basis. This report provides a focused evaluation of Veterans Integrated Service Network (VISN) 23 and its oversight of the quality of care delivered in its community-based outpatient clinics (CBOCs) and through community care referrals to non-VA providers.[3]

The OIG performed an unannounced virtual review of the Midwest Health Care Network (VISN 23) from April 26, 2021, through May 6, 2021, with the understanding that leaders provide oversight to ensure that care, treatment, or services are safe and effective.[4] When services are contracted, leaders must also provide oversight to ensure that care is safe and

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[1] U.S. Senate Committee on Veterans Affairs, *The VA Mission Act of 2018*, accessed July 8, 2021, https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf. The Mission Act consolidated "seven VA community care programs into one streamlined program."

[2] VA Fact Sheet, *Veteran Community Care General Information*.

[3] VA administers healthcare services through a network of 18 regional offices nationwide referred to as the Veterans Integrated Service Network.

[4] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," March 11, 2020, accessed February 22, 2022, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. Merriam-Webster.com Dictionary, "pandemic," accessed February 22, 2022, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, accessed February 22, 2022, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

effective. Patients should receive the same level of care regardless of whether it is delivered by VA or non-VA providers.[5] The OIG reviewed four clinical and administrative areas of focus:

- Care coordination—congestive heart failure management
- Primary care and mental health—diagnostic evaluations following positive screenings for depression or alcohol misuse
- Quality of care—home dialysis care
- Women's health—mammography care and communication of results

The findings presented in this report are a snapshot of VISN 23 care provided in community-based settings, which includes VA and non-VA care, within the identified focus areas at the time of the OIG review. Although it is difficult to measure the value of well-delivered and coordinated care between VA and non-VA providers, the findings in this report may help VISN leaders identify vulnerable areas of community care that, if properly addressed, should improve healthcare quality for veterans.

Inspection Results

Care Coordination—Congestive Heart Failure Management

The OIG found that CBOC primary care providers managed congestive heart failure in accordance with existing VHA guidance for addressing elevated blood pressure, hospital admission follow-up, patient education, and medication reconciliation.

Primary Care and Mental Health—Diagnostic Evaluations

The OIG determined that patients, identified through screening to be at risk for depression or alcohol use disorder, received further diagnostic evaluations in compliance with VHA requirements. Referrals to specialty care were also processed in accordance with timeliness requirements.

Quality of Care—Home Dialysis Care

The OIG determined that patients in the VA home dialysis program generally received care in accordance with requirements. However, VISN 23 facility dialysis staff did not perform home visits to confirm environmental safety and gauge patient adjustment to home dialysis. Key VISN leaders expressed a lack of awareness of VHA requirements.

[5] The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021. "Care, treatment, and services provided through contractual agreement are provided safely and effectively."

Further, the OIG found that documentation of the care provided by non-VA dialysis providers was not available in patients' electronic health records. Therefore, to further evaluate care provided, the OIG interviewed those patients for reports of their experiences. The majority of patients (54 percent) in these programs described not receiving required home visits from non-VA providers.

VISN leaders are responsible for oversight of the dialysis program.[6] However, VHA does not require non-VA dialysis providers to report quality of care issues, such as infections or complications, back to referring VA providers. Instead, VISN leaders stated that non-VA providers are accountable to Centers for Medicaid and Medicare Services. Non-VA providers' reporting relationship with Centers for Medicaid and Medicare Services and the lack of documentation of care provided to VA complicates the reporting process and hinders VISN leaders from monitoring the quality of dialysis care.

Women's Health—Mammography Care and Communication of Results

The OIG team observed compliance with many elements of expected performance, including timely communication of mammography results to patients. However, the OIG found that some non-VA providers did not return written reports timely to VHA-ordering providers, which could lead to subsequent delays in follow-up with patients.

Conclusion

The OIG conducted a detailed review across four key clinical areas and issued three recommendations for improvement to the VISN 23 Director. The number of recommendations should not be used as a gauge for the overall quality of care provided in VISN 23. The intent is for the VISN Director and other leaders to use these recommendations to help guide improvements in their oversight of operations and clinical care.

[6] VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

VA Comments and OIG Response

The VISN Director agreed with the findings and recommendations and provided acceptable improvement plans (see appendix A, and the responses within the body of the report for the full text of the director's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The Office of Inspector General (OIG) Care in the Community (CITC) inspection program provides oversight in the provision of care delivered in Veterans Health Administration (VHA) community-based outpatient clinics (CBOCs) and through contracted non-VA care providers.

The OIG conducted this review of the VA Midwest Health Care Network, Veterans Integrated Service Network (VISN) 23, which is responsible for oversight of the care provided by its associated healthcare systems, CBOCs, and contracted providers.[7] Leaders make decisions that directly or indirectly affect every aspect of operations. They create policies and procedures and secure resources and services that support patient safety and quality care, treatment, and services.[8] This focused review was accomplished by examining key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so that informed decisions can be made to improve care (see appendix A for the OIG recommendations).

The findings presented in this report are a snapshot of VISN 23 compliance with VHA requirements and Joint Commission standards in identified focus areas during the time frame of July 1, 2019, through June 30, 2020. To examine the provision of care provided in community-based settings by VHA and contracted non-VA providers, the OIG focused on core processes in the following four areas of administrative and clinical operations:

- Care Coordination—congestive heart failure management
- Primary care and mental health—diagnostic evaluations of positive screenings for depression or alcohol misuse
- Quality of care—home dialysis care
- Women's health—mammography care and communication of results

[7] VHA administers healthcare services through 18 regional offices nationwide; these are referred to as the Veterans Integrated Service Networks.

[8] The Joint Commission, *Standards Manual*, LD.04.01.05, July 2021. "The organization effectively manages its programs, services, or sites."

Background

Veterans Integrated Service Networks

A VISN is a regional system of VHA healthcare facilities. VHA established 18 VISNs to meet local healthcare needs and provide greater access to care.[9] A VISN covers a geographic area, which is defined by patient referral patterns, numbers of veteran beneficiaries, and facilities needed to provide and support care, or boundaries such as state borders. Under the VISN model, care is provided at VA medical centers and CBOCs and through contractual or sharing agreements with non-VA providers. In VA's healthcare system, the VISN is the basic budgetary and planning entity.[10]

In general, a VISN director is responsible for ensuring implementation of VA policies; providing leadership that supports and promotes delivery of comprehensive, coordinated care; ensuring all facilities in the VISN are adequately staffed and resourced; and ensuring that facilities in the VISN achieve national and local performance and quality improvement goals.[11]

VA Midwest Health Care Network, VISN 23, includes sites in Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and portions of Illinois, Kansas, Missouri, Wisconsin, and Wyoming. VISN 23 serves over 440,000 enrolled veterans receiving care throughout nine hospitals, and 63 CBOCs or outreach clinics.[12] Additional details about the types of care provided by medical centers can be found in appendix B.

VA Community-Based Outpatient Clinic Care

VHA utilizes CBOCs to make VA health care more accessible to veterans. CBOCs provide common outpatient services without necessitating a visit to a larger medical center.[13] A CBOC is an outpatient site of healthcare services located geographically apart from a VHA medical facility and may be VA-owned or VA-leased. CBOCs provide healthcare services in primary care, specialty care, mental health care, or in any combination. CBOCs may operate from one to seven days per week.[14]

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[9] VHA, *About VHA*, accessed July 23, 2020, https://www.va.gov/health/aboutvha.asp.

[10] Statement of Carolyn Clancy, MD, VHA Executive in Charge, before the House Committee on Veterans' Affairs, May 22, 2018. accessed July 1, 2021, https://docs.house.gov/meetings/VR/VR00/20180522/108328/HHRG-115-VR00-Wstate-ClancyC-20180522.pdf.

[11] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017.

[12] VISN 23, About the VA Midwest Health Care Network.

[13] VHA, *About VHA*, accessed July 23, 2020, https://www.va.gov/health/aboutvha.asp.

[14] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

VHA classifies these remotely located clinics as primary care or multi-specialty CBOCs or healthcare centers. The designations are based on the complexity and number of services utilized. Primary care CBOCs offer both medical and mental health care. Multi-specialty CBOCs deliver primary and mental health care as well as two or more specialty care services.[15]

Community Care

VHA leaders are responsible for providing oversight to ensure direct care, treatment, and services are safe and effective. When services are contracted, leaders must also provide oversight to ensure that care is safe and effective. Patients should receive the same level of care regardless of whether it is delivered by VA or non-VA providers.[16]

In 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated seven VA community care programs into one program, the Veterans Community Care Program."[17] This program simplified the process for veterans' non-VA care by expanding eligibility criteria, creating a single non-VA care program, improving customer service, and providing a way for patients to access walk-in care without requiring prior authorization.[18]

The goal of VHA's Office of Community Care (OCC) is to deliver a single, established program that is "easy to understand, simple to administer, and meets the needs of veterans, their families, community providers, and VA staff." VHA facilities may refer care to non-VA providers for eligible veterans who choose care in the community. Additionally, purchased care may also help VHA leaders ensure more timely procedures or provide access to procedures that may not be available locally through VHA providers.[19] VHA's *Office of Community Care Field Guidebook* (*Field Guidebook*) outlines the requirements, processes, and tools related to eligibility, referral, and care coordination. The *Field Guidebook* provides guidance for VA staff managing non-VA care consults, appointment scheduling, and communication between VA and non-VA providers.[20]

The ordering provider initiates the non-VA care referral process by placing a consult request for non-VA care. VA OCC staff determine if the care is available at VHA, or if the veteran is eligible for referral to an accessible non-VA provider. Appointment scheduling can occur in

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[15] VHA Handbook 1006.02.

[16] The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021. "Care, treatment, and services provided through contractual agreement are provided safely and effectively."

[17] U.S. Senate Committee on Veterans' Affairs, *The VA Mission Act of 2018*, accessed July 8, 2021, https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf.

[18] VA Fact Sheet, *Veteran Community Care General Information*.

[19] VHA Office of Community Care (OCC), Field Guidebook, Chapter 1: Introduction 1.0 Introduction to the Community Care Network, updated July 1, 2021.

[20] VHA OCC, *Field Guidebook, Landing Page,* updated July 1, 2021.

various ways, depending on VHA facility operations and patient preference, including scheduling by

- VHA OCC staff,
- the patient,
- the community provider,
- third-party administrator staff, or
- any combination of these ways.[21]

When patients schedule appointments for themselves directly with community providers, VHA instructs the patients to contact OCC staff with the date and time of the appointment. If a patient does not provide the appointment date, OCC staff are not required to contact patients to obtain the appointment information. In that event, OCC staff wait 30 days from the date the patient elected to self-schedule and contact the community provider for the appointment information. When they have the information, OCC staff record the date and time of the appointment.[22] Patients' self-scheduled appointments are excluded from certain VHA timeliness reporting requirements, for example, when consults are in an active status for greater than 30 days.[23]

Non-VA providers are responsible for sending medical record documentation to ordering providers within 30 days of completed appointments. The documentation can be returned to the referring provider through a variety of methods, including the fee-basis claim system, Health Share Referral Manager platform, third-party administrator's portal, electronic fax, other electronic means, or on paper. OCC staff review the multiple locations for the returned documentation, scan or import it, and then attach it to the relevant consult in a patient's electronic health record (EHR), which causes an alert notifying the ordering provider that the consult was completed.[24]

VHA does not require receipt of clinical documentation for claims payment or closure of the community care consult.[25] Although VHA expects that OCC staff work with community providers to ensure receipt of documentation for the patient's EHR, VHA allows OCC staff to

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[21] VHA OCC, *Field Guidebook, Chapter 3*: How to Perform Care Coordination.

[22] VHA OCC, *Field Guidebook, Chapter 3*.

[23] VHA OCC, *Field Guidebook, Chapter 3*.

[24] VHA OCC, *Field Guidebook, Chapter 3*.

[25] VHA OCC, *Field Guidebook, Chapter 4: Consult Completion and Medical Records Management*. In fiscal year 2018, VISN 23 (includes all facilities under VISN 23 oversight) had community care expenditures of $524,189,209. In fiscal year 2021, community care expenditures dropped to $182,980,356 (see appendix C). A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2018 began on October 1, 2017, and ended on September 30, 2018, and fiscal year 2021 began on October 1, 2020, and ended on September 30, 2021. VA/VHA Employee Health Promotion Disease Prevention Guidebook, *VA Finance Terms and Definitions*, July 2011, accessed February 10, 2022, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

close community care consults without documentation of care provided. After 14 days of the initial scheduled appointment, if no medical record documentation has been received from the non-VA provider, VHA OCC staff will contact the veteran to confirm attendance of the appointment and then attempt to retrieve the records of care provided.[26]

Attempts at retrieving the records from the community provider are noted in the referral documentation. VHA requires three documented attempts to obtain medical documentation; however, a consult may be closed after only one attempt is recorded in the EHR, with subsequent attempts made within 90 days. If the written evidence is not received, the consult is closed and noted as "Administratively closed without documentation." According to VHA, "Administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation [are] expected to ensure continuity of care." A referral must be closed within 90 days of the patient's appointment.[27]

[26] VHA OCC, *Field Guidebook, Chapter 4*; VHA OCC, Field Guidebook, Chapter 3.

[27] VHA OCC, *Field Guidebook, Chapter 4*.

Methodology

The OIG conducted an unannounced virtual review from April 26 through May 6, 2021.[28] The inspection team examined operations during the study period from July 1, 2019, through June 30, 2020. During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

To determine compliance with VHA requirements, the OIG inspection team sampled EHRs of patients receiving care provided by VHA clinicians or VA-contracted non-VA providers for each of the four areas of focus.[29] The OIG evaluated randomized EHRs and reviewed pertinent VISN administrative and performance measure data. The OIG team interviewed relevant VISN leaders and program managers and discussed oversight processes, validated EHR review findings, and inquired about reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat. 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.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow up until completion of corrective actions. The VISN 23 Director's responses to the report recommendations appear within each topic area.

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

[28] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," March 11, 2020, accessed February 22, 2022, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. *Merriam-Webster.com Dictionary*, "pandemic," accessed February 22, 2022, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, accessed February 22, 2022, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[29] For this inspection, the four areas of focus were care coordination (congestive heart failure management), primary care and mental health (diagnostic evaluations of positive screenings for depression or alcohol misuse), quality of care (home dialysis care), and women's health (mammography care by community providers and communication of results).

Results and Recommendations

Care Coordination—Congestive Heart Failure

Congestive heart failure (CHF) is a condition that results from the heart not pumping blood effectively to meet physiologic needs. When blood does not circulate as it should, fluid can accumulate throughout the body.[30]

As a chronic disease that is rarely cured but can be treated, CHF is projected to affect more than eight million people in the United States by 2030. With this condition noted as a leading cause of VHA hospital admissions, VA established evidence-based guidelines, which may allow veterans to experience longer lives with better quality of life.[31]

VHA primary care providers may refer veterans with CHF to VA or non-VA cardiologists or heart failure clinics for management of their conditions. Monitoring a veteran's daily weights, blood pressures, and heart function are important in managing the signs and symptoms of CHF.[32]

VHA requires clinicians to document essential and relevant information in the patient's EHR, including medication reconciliation.[33] The objective of medication reconciliation is to provide an accurate list of medications to the patient at points of treatment transitions and is a top patient safety priority.[34]

To determine whether VISN 23 CBOC clinicians complied with selected requirements for care coordination of CHF, the inspection team reviewed 100 randomly selected EHRs of patients who had at least two primary care visits at a VISN 23 CBOC during the study period and were diagnosed with CHF at least one year prior to the study period.

[30] NIH, National Heart Lung and Blood Institute, "Heart Failure," accessed on September 23, 2020, https://www.nhlbi.nih.gov/health-topics/heart-failure.

[31] VHA Pharmacy Benefits Management (PBM) Academic Detailing Service, "Managing Heart Failure in Primary Care," accessed on July 07, 2021, https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/HeartFailure_Provider_ProviderGuide_IB101161.pdf. NIH, National Heart Lung and Blood Institute, "Heart Failure," accessed on September 23, 2020, https://www.nhlbi.nih.gov/health-topics/heart-failure.

[32] VHA PBM Academic Detailing Service, "Managing Heart Failure in Primary Care," accessed on July 07, 2021, https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/HeartFailure_Provider_ProviderGuide_IB101161.pdf.

[33] VHA Directive 1164.

[34] Institute for Healthcare Improvement. *Medication Reconciliation to Prevent Adverse Drug Events.* accessed on September 23, 2020, https://www.ihi.org/topics/ADEsMedicationReconciliation/Pages/default.aspx.

The OIG evaluated selected components of care coordination for patients with CHF:

1. Post-discharge contact following a VHA inpatient stay
2. Use of alternative care modalities[35]
3. Medication reconciliation
4. Patient education on home care and monitoring[36]
5. Monitoring and interventions for hypertension
6. Referrals to non-VA providers for specialty care
7. Communication of results to the ordering provider

Care Coordination Findings and Recommendations

VISN 23 CBOC providers delivered care that generally met the requirements listed above. The OIG made no recommendations.

Primary Care and Mental Health Care—Diagnostic Evaluations

Patient Aligned Care Team (PACT) staff screen veterans for various conditions such as cancer, tobacco usage, immunizations, alcohol use disorder, suicide risk, and depression.[37] They conduct health education and refer patients to specialty care when clinically indicated.[38] Comprehensive primary care ensures veterans have access to the health care they need to promote and improve their quality of life.[39] Clinical preventive services are part of comprehensive primary care and are used for early recognition of disease in persons with no symptoms of a condition, with the goal of preventing or reducing risks for future morbidity or death.[40]

Diagnostic Evaluation of Patients at Risk for Depression

Depression can cause sadness, loss of energy or interest in activities, and withdrawal from interactions with other people. Depression can also cause feelings of hopelessness and thoughts of suicide and is one of the most common mental disorders in the United States.[41]

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[35] Alternative care modalities include coordinated care, home telehealth, and home-based primary care.

[36] Examples of home care and monitoring include measuring daily weights, avoiding fluid overload, and restricting fluid and sodium intake.

[37] VHA Handbook 1101.10(1).

[38] VHA Handbook 1101.10(1).

[39] VHA Handbook 1101.10(1).

[40] VHA Handbook 1101.10(1).

[41] VA Office of Research & Development, "Depression Fact Sheet," September 2016, accessed September 1, 2021, https://www.research.va.gov/pubs/docs/va_factsheets/Depression.pdf.

VHA requires annual screenings for patients receiving primary or mental health care.[42] During this OIG review, VHA had also required a suicide risk screening when a patient's depression screen was positive.[43] If either screening was positive, VHA required a provider to follow up with a diagnostic evaluation and determine whether referral to specialty or mental health care providers was warranted.[44]

To determine if VISN 23 CBOC clinicians complied with selected requirements for diagnostic evaluations for positive depression screenings, the OIG team reviewed 98 randomly selected EHRs of VISN 23 CBOC patients identified as being at risk for depression. These patients did not have a positive screening for at least three years prior to the study period.

The OIG evaluated selected components required for positive depression screenings:

- The primary care provider conducted a diagnostic evaluation in response to the positive depression screening.
- The primary care provider conducted a suicide risk evaluation if a suicide risk screening was positive.
- Referrals made to specialty providers were scheduled and completed within 30 days as required.[45]

The OIG found that CBOC primary care providers provided diagnostic evaluations of patients at risk for depression or suicide, and referrals for care by VA or non-VA specialty providers were scheduled within the required time frame. The team interviewed key VISN 23 leaders and discussed results of the review. The OIG had no findings or recommendations regarding follow-up care for positive depression screening.

Diagnostic Evaluation of Patients at Risk for Alcohol Use Disorder

Excessive drinking is associated with multiple health problems including chronic diseases, unintentional injuries, homicide, suicide, and various other disorders.[46] VHA requires alcohol use disorder screening for new patients and annual screenings for established patients.[47] If a

[42] VA/DoD Clinical Practice Guideline, "Management of Major Depressive Disorder, Version 3.0." April 2016.

[43] Veterans Integrated System Technology Architecture (VistA) Clinical Reminders, "MH Reminder Updates, Installation and Setup Guide," February 2017.

[44] VA/DoD Clinical Practice Guideline, "Management of Major Depressive Disorder, Version 3.0." April 2016. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. Amended November 16, 2015.

[45] VHA Directive 1230(2), *Outpatient Scheduling Processes And Procedures*, July 15, 2016.

[46] Centers for Disease Control and Prevention, "Alcohol Questions and Answers," accessed August 26, 2020, https://www.cdc.gov/alcohol/faqs.htm.

[47] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. Amended November 16, 2015.

patient is screened positive and identified at risk for alcohol use disorder, VHA requires the provider to conduct a diagnostic evaluation and education or counseling.[48]

To determine whether VISN 23 CBOC clinicians complied with selected requirements for diagnostic evaluations related to positive alcohol use disorder screenings, the OIG team reviewed 98 randomly selected EHRs of patients who screened positive for risk of alcohol misuse. These patients did not have a positive screening for at least three years prior to the study period.

The OIG evaluated selected components required for positive alcohol use disorder screenings:

1. The primary care provider completed a diagnostic evaluation in response to the positive screening.
2. The evaluation included education and counseling regarding drinking limits and the adverse consequences of heavy drinking.
3. Referrals made to specialty providers were scheduled and completed within 30 days as required.[49]

VISN 23 CBOC clinicians performed diagnostic evaluations of patients at risk for alcohol use disorder and generally met the requirements listed above. The OIG made no recommendations.

Quality of Care—Home Dialysis Care

Home dialysis provided by VHA offers advantages over in-center (VA and non-VA) dialysis including increased ability to deliver care to veterans with end-stage renal disease, especially when patients live distant from VA medical centers. In addition, cost may be lower as compared to contracted dialysis service, and patients may experience improved quality of life with greater survival and fewer hospitalizations.[50] All VHA dialysis programs must offer home dialysis to medically qualified patients with end-stage renal disease.[51]

[48] VHA Handbook 1160.01.

[49] VHA Directive 1230(2).

[50] Ishani A, Slinin Y, Greer N, MacDonald R, Messana J, Rutks I, Wilt TJ. "Comparative Effectiveness of Home-based Kidney Dialysis versus In-center or Other Outpatient Kidney Dialysis Locations - A Systematic Review." VA ESP Project #09-009; 2015.

[51] VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

VHA requires VISN directors to convene a VISN dialysis council with representation from each of its medical facilities for the purpose of

> promoting efficient, high quality dialysis care within the VISN, coordinating the VISN operations of dialysis initiatives, harmonizing dialysis care within VISNs, and enhancing communication related to dialysis to/from VA facilities, non-VA dialysis facilities, VISN leadership, and the VHA National Kidney Program.[52]

VHA requires all dialysis outpatients to be seen at least monthly by a clinician providing end-stage renal disease care, evidenced by a monthly progress note "endorsed by the responsible independent renal practitioner."[53]

A VHA home dialysis program must provide the following:

1. Patient training performed in the dialysis center by a qualified dialysis registered nurse.
2. Patient monitoring performed in the dialysis center, including a review of the patient's self-monitoring data and a clinical exam on a periodic basis (at least every two months).
3. Support services including
    - ongoing medical, nursing, dietician, and social work support services,
    - initial and periodic (at least annual) home visits,[54]
    - provision of all necessary disposable supplies and U.S Food and Drug Administration (FDA) approved dialysis devices, and
    - regular monitoring of water quality in the case of home hemodialysis.[55]

VHA facilities not capable of furnishing the care due to geographic inaccessibility or lack of a VHA home dialysis program must offer veterans access to home dialysis through the Non-VA Medical Care Program (now Veterans Community Care Program).[56] The non-VA provider is then responsible for patient training and monitoring and support services as noted above. VA is then responsible for monitoring the contracted clinical services.[57]

[52] VHA Handbook 1042.01.

[53] VHA Handbook 1042.01; The clinician should be "a physician, nurse practitioner, clinical nurse specialist, or physician's assistant."

[54] VHA requires home visits prior to a patient's acceptance into the home dialysis program (initial) and then at least annually, to assess the environmental safety in patients' homes and their adjustment to home dialysis.

[55] VHA Handbook 1042.01.

[56] VHA Handbook 1042.01.

[57] VHA Handbook 1042.01.

VHA does not require non-VA dialysis providers to submit documentation of ongoing care. The VHA National Program Director for Kidney Disease explained that the Centers for Medicare and Medicaid Services (CMS) monitors non-VA dialysis providers who must maintain CMS accreditation to meet federal requirements.

To determine if the VISN 23 home dialysis program complied with requirements, the OIG team reviewed EHRs of all five patients performing home dialysis managed by VHA providers. Specific to the requirement for annual home visits, the OIG reviewed EHR documentation during the prior 27-month period for evidence of periodic reassessments of the patients' environment and adjustment to home dialysis. Four of the five patients were accepted into the VISN 23 home dialysis program during the study period and their care required an initial home visit. The fifth patient had been in the program multiple years and required annual home visits.

The OIG also reviewed all 49 VISN 23 patients managed by non-VA dialysis providers during the study period. In determining the quality of non-VA dialysis care, the OIG was unable to evaluate for compliance based on the review of patients' EHRs because of the lack of non-VA dialysis providers' documentation. As a result, the OIG team interviewed 28 of the 49 home dialysis patients managed by non-VA providers to assess for patients' perception of quality of care.[58]

Quality of Care Findings and Recommendations

The OIG determined that patient training, monitoring, and most support services for home dialysis generally met requirements when provided through the VISN 23 home dialysis program or by non-VA providers. However, VISN 23's home dialysis program lacked an essential required element of support services—home visits for patients prior to acceptance to the program and on an annual basis thereafter. Table 1 presents the OIG's determinations of the quality of home dialysis provided within VISN 23 and by non-VA providers.

[58] The OIG made two attempts to contact patients by telephone. Seven of the 49 patients were deceased, and 14 patients did not respond to calls or voice messages by OIG inspectors or declined to provide information.

Table 1. Comparison of VISN 23 and Non-VA Compliance with Home Dialysis Requirements

Requirement	VA*	Non-VA†
Training by a Registered Nurse	Four of five patients initiated home dialysis during the study period and all four (100 percent) received training by a Registered Nurse	27 of 28 patients (96 percent) confirmed training by a Registered Nurse
Review of patient's self-monitoring data at least every two months	Five of five patients (100 percent) had their self-monitoring data reviewed at least every two months	25 of 28 patients (89 percent) reported their self-monitoring data were reviewed at least every two months
Clinical support when needed	Five of five patients (100 percent) had clinical support documented in their EHRs	28 of 28 patients (100 percent) reported receiving clinical support when they needed it
Home visit–prior to acceptance into the home dialysis program	None of four patients (zero percent) received an initial home visit**	24 of 28 patients (86 percent) reported receiving an initial home visit
Home visit–annual	None of one patient (zero percent) received an annual home visit‡	13 of 28 patients (46 percent) reported receiving an annual home visit
Provision of supplies and equipment	Five of five patients' EHRs (100 percent) had documented provision of supplies and equipment by the VISN 23 home dialysis program	27 of 28 patients (96 percent) reported provision of supplies and equipment by the non-VA home dialysis program

Source: OIG determination of quality elements of a home dialysis program.
** These results were determined by OIG review of EHR documentation.*
† Because there was no non-VA documentation available in the VHA EHR, these results were determined by OIG interview of patients who reported their remembered experiences.
*** The OIG evaluated this visit for patients accepted into the VISN home dialysis program during the study period.*
‡ The OIG evaluated this visit for patients accepted into the VISN home dialysis program for a time period long enough to require an annual visit.

VHA requires initial and annual home visits as components of support services in a home dialysis program.[59] The OIG found that in the VISN 23 home dialysis program, none of the five patients received home visits as required. The majority (54 percent) of patients in non-VA home dialysis programs reported not receiving home visits that may have provided information about possible patient safety needs. Home visits are essential to assuring environmental safety and a patient's adjustment to home dialysis. The VISN 23 Lead Dialysis Nurse reported a lack of awareness of VHA's requirements for home visits performed prior to

[59] VHA Handbook 1042.0; VHA requires home visits prior to a patient's acceptance into the home dialysis program (initial) and then at least annually, to assess the environmental safety in patients' homes and their adjustment to home dialysis.

a patient's acceptance into the program and annually thereafter. The Lead Dialysis Nurse's understanding was that criteria for home visits in a VHA handbook cannot be made mandatory. However, the National Kidney Program Director stated that home visits are made to ensure alignment with CMS requirements and to verify that patients are not homeless, ensure a place where patients can safely perform dialysis, and assess that patients have adequate storage space for supplies and equipment. The OIG determined that by not ensuring home visits were made, home dialysis leaders could not monitor these aspects of quality of care for patients across VISN 23.

Recommendation 1

The VISN 23 Director ensures implementation and sustainment of initial and annual home visits for patients accepted into the VISN 23 home dialysis program.

VISN 23 concurred.

Status: In progress

Target date for completion: January 31, 2023

VISN 23 response: The VISN 23 Home Peritoneal Dialysis Program exists at the Minneapolis VA Health Care System. Since April 2021, the program has developed and implemented a Standard Operating Procedure (SOP) and an accompanying checklist for home visits for those patients who are enrolled in the program. The SOP specifies the requirement that all new enrollees within the program have an initial home visit, and thereafter, an annual home visit by a program team member. Currently there are 11 Veterans enrolled in this program and all have received a home visit between September 2021 – December 2021 from the program's clinical team. The home visits have been documented within the Veterans electronic health care records and will continue to be documented there. The program staff will collect data on compliance with conducting initial and annual home visits. The target will be that 100% of new enrollees will receive an initial home visit prior to initiation of home PD [peritoneal dialysis] services for 2 or more consecutive quarters. A second target will be that, as of January 31, 2023, 100% of established Veterans within the program will receive an annual visit within 12 months of the prior visit. The data will be reported to the VISN 23 Dialysis Community of Practice monthly, and to the VISN 23 Specialty Care Integrated Clinical Community on a quarterly basis.

Potential complications associated with peritoneal dialysis include peritonitis (an infection of the patient's body fluid) or hernia (an area of weakness in the abdominal muscle); potential problems associated with hemodialysis include infection or accidental blood loss.[60]

During the EHR review, the OIG team identified potential medical complications in the setting of home dialysis for patients managed by non-VA dialysis providers. The OIG team inquired whether VISN 23 leaders were aware of these complications and if these raised concerns about the quality of care by non-VA dialysis providers. VISN 23 leaders were not aware of the complications and that selected clinical data on individual cases would not be as useful as selected aggregated data. The leaders also stated that there was no contact with community dialysis providers for information; instead, they would rely on community dialysis providers to track their own infections and report to CMS, and CMS would monitor non-VA dialysis providers' services.[61] They also stated that without more detailed information, such as the ability to calculate infection rates, they would have difficulty establishing criteria to use in taking action to reduce patient safety risks.

VHA Handbook 1042.01 states that "VA is responsible for monitoring the contracted clinical services."[62] The OIG determined that clinicians at VISN 23 facilities referred patients to non-VA home dialysis programs without internal processes to monitor the quality of clinical services.

In addition to documentation from community providers, ongoing care from other VHA providers (primary care or specialists) can provide information to referring providers about patients' needs. The OIG noted periodic renewals of home dialysis referrals; however, EHR documentation did not indicate that referring providers had awareness of current healthcare needs of their patients or had evaluated the quality of home dialysis services received by patients, which might influence continued home dialysis care.

The OIG is concerned that when VHA's referring providers are unaware of complication events, they are unable to effectively coordinate care or reassess the continued appropriateness of home dialysis. Without the ability to monitor and reassess a patient's care through community care documentation, the ordering provider cannot be assured that the patient is receiving adequate, safe, and timely care. Non-VA providers' reporting relationship

[60] National Institute of Diabetes and Digestive and Kidney Diseases, "Peritoneal Dialysis is a treatment for kidney failure that uses the lining of the abdomen, or belly, to filter blood inside the body. Health care providers call this lining the peritoneum," accessed April 29, 2021, https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/peritoneal-dialysis#problems. National Institute of Diabetes and Digestive and Kidney Diseases, "Hemodialysis is a treatment to filter wastes and water from blood," accessed May 10, 2021, https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis#problems.

[61] CMS is part of the Department of Health and Human Services (HHS), accessed October 21, 2021, https://www.cms.gov/About-CMS/About-CMS.

[62] VHA Handbook 1042.01.

with CMS and the lack of documentation of care provided to VA complicates the reporting process and hinders VISN leaders from monitoring the quality of dialysis care.

Recommendation 2

The VISN 23 Director ensures the implementation and sustainment of quality monitoring of contracted clinical services for home dialysis.

VISN 23 concurred.

Status: In progress

Target date for completion: March 31, 2023

VISN 23 response: VISN 23 will initiate an ongoing audit the medical records of all Veterans who are new, as of July 2021 to home peritoneal dialysis (PD) that was provided by non-VA community providers (vendors). The audit will assess if those Veterans received/are receiving an initial home visit from the vendor prior to initiation of home PD services (target = 100% compliance with this requirement). Initially, a sample (20%) of Veterans who have been receiving home peritoneal dialysis from non-VA community providers for greater than two years (as of March 31, 2022) will have their medical records audited to ensure that they have received an annual home visit from the vendor in the prior 12-16 months (target for compliance = 100%). Auditing for compliance with the requirement of initial and home visits by the vendors will occur as an ongoing performance monitor conducted by VISN 23. Data will be reported at the monthly meetings of the VISN 23 Dialysis Community of Practice and the VISN 23 Specialty Care Integrated Clinical Community (ICC). The Health Systems Specialist for the VISN 23 Specialty Care ICC will communicate audit results to the appropriate contracting officials within VISN 23 and VHA.

Women's Health—Mammography Services by Non-VA Providers

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment in all VA medical facilities. Every site of care in the VA healthcare system must provide women's health services; however, not every site provides mammography services.[63] For these sites, patients are referred to non-VA mammography providers.

VHA established timeliness requirements applicable to VA and non-VA providers regarding notification of mammography results to ordering providers and patients. Specifically, when a mammogram result is negative (normal), a report must be communicated to the ordering provider *in writing within 30 days* of the procedure.[64] VHA then requires the ordering provider (or designee) to "communicate the results of normal mammograms completed in-

[63] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017, amended July 24, 2018, and further amended on June 29, 2020. This directive was in effect during the period for documents reviewed in this report (July 1, 2019, through June 30, 2020).

[64] VHA Directive 1330.01(2).

house or through contract or non-VA care to the patient within 14-calendar days of receiving a normal result."[65]

Reports of positive (abnormal) mammography results should include a recommended course of action and must be communicated to the ordering provider *as soon as possible* (defined by VHA as being no more than seven calendar days), and this is followed by a written report within 30 days of the procedure date. The ordering provider must then communicate abnormal results to the patient within seven calendar days from the date of receipt.[66] VHA requires that the ordering provider document the communication about mammography results to the patient in the EHR.[67]

To determine compliance with VHA requirements, the OIG reviewed a random sample of 80 patients who received non-VA mammography referrals with the procedures performed within the study period. The OIG evaluated selected requirements:

- Completeness of mammography reports including
  - patient name and identifier,
  - non-VA provider name with signature,
  - date of procedure, and
  - recommendations for further action and follow-up if indicated.
- Linking of mammography reports into the EHR.[68]
- Communication of normal or abnormal results within required time frames.[69]

[65] VHA Directive 1330.01(2); For this report, a negative result is a normal result.

[66] VHA Directive 1105.03, *Mammography Program Procedures and Standards,* May 21, 2018. VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. FDA, "Mammography Quality Standards Act Regulations," accessed July 6, 2021, https://www.fda.gov/radiation-emitting-products/regulations-mqsa/mammography-quality-standards-act-regulations. According to the FDA, a "positive mammogram" refers to a mammogram with an overall assessment of findings that are either "suspicious" or "highly suggestive of malignancy." In this report, a *positive result* is considered an *abnormal result*.

[67] VHA Directive 1105.03.

[68] VHA Directive 1105.03; "If reports are received on paper, they must be scanned into VistA Imaging and linked to an administrative report in VistA/CPRS [Computerized Patient Record System]. Patient reports must be incorporated into VistA either by software modifications or by scanning a copy of the paper report into VistA Imaging and associating it with an order for an outside radiology procedure in CPRS." For this report, the OIG considered the term *linking* to be associating the report with an order for an outside radiology procedure and incorporating the report into the patient's VHA EHR, and that *linking* was achieved by scanning a hard copy or using software modifications.

[69] VHA Directive 1105.03; VHA Directive 1330.01(2).

Women's Health Findings and Recommendations

VHA requires that a mammography report must be communicated to the ordering provider in writing within 30 days of the procedure.[70] The OIG estimated that for 19 percent of mammogram referrals to non-VA providers, VISN 23 ordering providers did not receive results *in writing* within 30 calendar days from the date of the procedure.[71] Time of receipt of these written results ranged from 31 to 133 days. Without timely results, VA providers could not fulfill their obligation to communicate and plan with the patient in follow-up to potentially serious examination findings.

The VISN 23 Women's Health Coordinator reported difficulties obtaining records from non-VA providers during the study period, stating that when VHA switched to the (then current) third-party administrator, it became more challenging to get results timely. Also, the Women's Health Coordinator and the VISN 23 Chief Business Officer described understanding that each facility's Office of Community Care staff were responsible for getting records at that time. The Chief Business Officer acknowledged past challenges in obtaining records and reported that the new third-party administrator, at the time of the OIG inspection, had contractual responsibility for obtaining non-VA records.

[70] VHA Directive 1330.01(2).

[71] The OIG estimated that 81 percent of mammogram referrals to non-VA providers had results reported to the VHA ordering provider within 30 calendar days from the date of the procedure; 95 percent of the time, the true compliance rate was between 72.29 and 89.28 percent, which was statistically significant and below VHA's 90-percent benchmark.

Recommendation 3

The VISN 23 Director ensures that VA providers receive mammography reports from non-VA providers within the established acceptable timeframe.

VISN 23 concurred.

Status: In progress

Target date for completion: March 31, 2023

VISN 23 response: VISN 23 will implement a report for facility staff to identify community care mammography consults where the appointment occurred 3 or more days in the past and mammography reports have not been received. This will provide the appropriate facility staff an additional tool to monitor community mammography consults and act as needed to ensure reports are received and communicated to VA providers within 30 days. The VISN 23 Community Care Nurse Program Manager and Women Veteran Program Manager will add an element to an existing monitor to identify mammography consults that did not have reports available for VA providers within the established acceptable time frame (30 days or less). Target will be that the VISN 23 facilities receive 90% of mammogram reports within 30 days (for 2 consecutive quarters) from non-VA providers. Results of the monitor will be communicated with the appropriate facility staff and reported to the VISN 23 Health Care Delivery Committee on a quarterly basis. Facility Community Care and Women's Health staff will report any challenges in obtaining mammography reports timely from community providers to the TPA [third party administrator] for them to educate providers on the contractual requirements. The VISN 23 Diagnostics Integrated Clinical Community (ICC) will purchase and implement Medicom which will provide VA staff direct, real-time access to images and reports from many community providers.

Report Conclusion

The OIG conducted this review of the VA Midwest Health Care Network, which is responsible for oversight of the care provided by its associated healthcare systems, CBOCs, and contracted providers. This focused review was accomplished by examining key clinical and administrative processes associated with quality care and positive patient outcomes.

The OIG acknowledges the inherent challenges of operating VA medical facilities and simultaneously providing contracted care in the community, especially during times of unprecedented stress on the U.S. healthcare system. To assist VISN leaders in evaluating the quality of care provided to veterans in the community within their jurisdiction, the OIG conducted a detailed review of four clinical areas and provided three recommendations on systemic issues that may adversely affect patients.

While the OIG's recommendations are not intended to serve as a comprehensive assessment of the caliber of services delivered in the community by VHA and non-VA providers, the intent is to illuminate areas of concern and provide a road map for improvement. A summary of OIG recommendations is presented in appendix A.

Appendix A: Care in the Community Recommendations

The intent is for VISN leaders to use OIG recommendations as a road map to help improve operations and clinical care. The recommendations address systems' issues as well as other less-critical findings that, if left unattended, may interfere with the delivery of quality health care (see table A.1).

Table A.1. Summary Table of OIG Recommendations

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination—Congestive Heart Failure	• Post-discharge contact following a VHA inpatient stay • Alternative care modalities • Medication reconciliation • Patient education on home care and monitoring • Hypertension monitoring and interventions • Referrals to non-VA specialty care providers • Communication of results to the ordering provider	• None	• None
Primary Care and Mental Health—Diagnostic Evaluations	• Diagnostic evaluations in response to positive depression or alcohol use disorder screenings • Diagnostic evaluations include all required elements • Timeliness of referrals to specialty providers	• None	• None
Quality of Care—Home Dialysis	• Patient training • Periodic patient monitoring • Support services included required elements • Monitoring of contracted home dialysis service	• Staff (VA or non-VA) conduct initial and annual home visits for patients accepted into the VISN 23 home dialysis program. • VA staff monitor quality of contracted clinical services for home dialysis.	• None

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health—Mammography by Non-VA Providers	• Completeness of mammography reports • Linking of community mammography reports to orders in the EHR • Communication of normal or abnormal results within required timeframes	• Non-VA providers communicate results in writing within 30 days of the procedure.	• None

Source: OIG analysis of findings and resulting determination of recommendations.

Appendix B: VA Outpatient Clinic Profiles

VA outpatient clinics in communities within the catchment area of VISN 23 provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.1 provides information relative to each of the clinics.[72]

Table B.1. VA Outpatient Clinic Workload/Encounters and Community Care Referrals (July 1, 2019, through June 30, 2020)

Location	Station No.	VAST Classification	Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Bismarck, ND	437GB	Primary Care CBOC	Urban	23,803	5,707
Fergus Falls, MN	437GC	Primary Care CBOC	Rural	6,697	1,150
Minot, ND	437GD	Primary Care CBOC	Rural	13,213	4,389
Bemidji, MN	437GE	Primary Care CBOC	Rural	15,359	2,787
Williston, ND	437GF	Primary Care CBOC	Rural	6,704	3,068
Grand Forks, ND	437GI	Primary Care CBOC	Rural	13,812	2,913
Dickinson, ND	437GJ	Primary Care CBOC	Rural	6,227	2,294
Jamestown, ND	437GK	Primary Care CBOC	Rural	5,765	1,505
Spirit Lake, IA	438GA	Primary Care CBOC	Rural	15,038	2,117
Dakota Dunes, SD	438GC	Primary Care CBOC	Urban	30,904	3,006
Aberdeen, SD	438GD	Multi-Specialty CBOC	Rural	13,816	2,585
Watertown, SD	438GF	Primary Care CBOC	Rural	12,674	1,716
Rapid City, SD	568GA	Primary Care CBOC	Urban	36,999	4,415

[72] Table B.1 includes all outpatient clinics in the community that were in operation as of July 1, 2019. VHA Directive 1230(2), *Outpatient Scheduling Processes And Procedures*, July 15, 2016. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

Location	Station No.	VAST Classification	Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Scottsbluff, NE	568HH	Primary Care CBOC	Rural	5,612	3,531
Superior, WI	618BY	Multi-Specialty CBOC	Urban	49,736	6,070
Hibbing, MN	618GB	Primary Care CBOC	Rural	11,710	2,608
Maplewood, MN	618GD	Primary Care CBOC	Urban	25,675	1,213
Chippewa Falls, WI	618GE	Primary Care CBOC	Urban	20,710	2,837
Rochester, MN	618GG	Primary Care CBOC	Urban	16,811	1,422
Hayward, WI	618GH	Primary Care CBOC	Rural	3,181	1,429
Ramsey, MN	618GI	Multi-Specialty CBOC	Urban	36,231	1,807
Shakopee, MN	618GJ	Primary Care CBOC	Urban	13,833	694
Albert Lea, MN	618GK	Primary Care CBOC	Rural	7,321	1,053
Minneapolis, MN	618GL	Primary Care CBOC	Urban	17,588	44
Rice Lake, WI	618GM	Primary Care CBOC	Rural	8,580	3,686
Mankato, MN	618GN	Primary Care CBOC	Urban	14,012	1,974
Lincoln, NE	636A5	Multi-Specialty CBOC	Urban	130,034	6,072
Norfolk, NE	636GA	Primary Care CBOC	Rural	11,864	2,939
North Platte, NE	636GB	Primary Care CBOC	Rural	13,717	2,368
Mason City, IA	636GC	Multi-Specialty CBOC	Rural	23,127	2,580
Marshalltown, IA	636GD	Multi-Specialty CBOC	Rural	8,396	459
Davenport, IA	636GF	Primary Care CBOC	Urban	56,624	4,092
Quincy, IL	636GG	Primary Care CBOC	Rural	14,687	3,476

Location	Station No.	VAST Classification	Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Waterloo, IA	636GH	Primary Care CBOC	Urban	21,830	1,631
Galesburg, IL	636GI	Primary Care CBOC	Rural	24,795	2,899
Dubuque, IA	636GJ	Primary Care CBOC	Urban	17,217	1,124
Fort Dodge, IA	636GK	Primary Care CBOC	Rural	12,040	1,810
Bellevue, NE	636GL	Primary Care CBOC	Urban	22,715	1,555
Carroll, IA	636GM	Primary Care CBOC	Rural	9,127	403
Cedar Rapids, IA	636GN	Multi-Specialty CBOC	Urban	27,231	1,284
Shenandoah, IA	636GP	Primary Care CBOC	Rural	9,103	976
Holdrege, NE	636GQ	Primary Care CBOC	Rural	5,805	908
Knoxville, IA	636GR	Multi-Specialty CBOC	Rural	15,977	537
Ottumwa, IA	636GS	Multi-Specialty CBOC	Rural	12,566	1,211
Sterling, IL	636GT	Multi-Specialty CBOC	Rural	13,076	1,237
Decorah, IA	636GU	Primary care CBOC	Rural	9,466	572
Coralville, IA	636GW	Primary Care CBOC	Urban	41,374	1,650
Brainerd, MN	656GA	Multi-Specialty CBOC	Rural	35,900	4,478
Montevideo, MN	656GB	Primary Care CBOC	Rural	15,683	2,180
Alexandria, MN	656GC	Primary Care CBOC	Rural	16,617	2,201

Source: VHA Support Service Center and VA Corporate Data Warehouse.
Note: The OIG did not assess VA's data for accuracy or completeness.

Appendix C: Expenditures for Community Care

Table C.1. Community Care Disbursement Expenditures by Fiscal Year for VHA, VISN 23, and VISN 23 Facilities

Location	FY 2018*	FY 2019	FY 2020	FY 2021
VHA	$7,864,960,844	$11,337,791,664	$4,181,333,650	$4,186,519,218
VISN 23**	$524,189,209	$635,922,908	$271,481,395	$182,980,356
Black Hills, SD† (568/00)	$49,290,895	$54,778,305	$10,816,744	$14,066,944
Des Moines, IA (636/A6)	$47,916,240	$52,075,476	$15,440,273	$15,604,387
Fargo, ND (437/00)	$66,968,611	$93,739,022	$36,303,228	$31,099,613
Iowa City, IA (636/A8)	$56,981,608	$67,586,253	$23,049,357	$14,225,055
Minneapolis, MN (618/00)	$119,927,349	$141,315,561	$93,811,159	$60,672,143
NE-Western IA‡ (636/00)	$72,211,186	$87,398,431	$51,037,366	$23,190,245
Sioux Falls, SD (438/00)	$38,724,985	$53,937,079	$19,372,844	$13,634,061
St. Cloud, MN (656/00)	$72,168,336	$85,092,782	$21,650,424	$10,487,909

Source: VHA community care expenditure data.
Note: The OIG did not verify the accuracy of this VHA disbursement information.
** FY is fiscal year. Disbursement amounts have been rounded up to the nearest dollar.*
*** Expenditures include CBOCs and outpatient clinics associated with VA medical facilities.*
† Black Hills includes the Hot Springs and Fort Meade campuses in South Dakota.
‡ Nebraska-Western Iowa includes the Omaha and Grand Island campuses in Nebraska.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 11, 2022

From: Executive Director, VA Midwest Health Care Network (10N23)

Subj: Draft Report: Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23)

To: Director, Office of Healthcare Inspections (54CC00)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

I have reviewed the draft report for Care in the Community Healthcare Inspection of VISN 23: VA Midwest Health Care Network. I concur with the action plans and submitted documentation.

(Original signed by:)

Robert P. McDivitt, FACHE
Executive Director
VA Midwest Health Care Network (VISN 23)
Minneapolis, MN

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