



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Additional Actions Needed  
to Fully Implement and  
Assess the Impact of the  
Patient Referral  
Coordination Initiative

REVIEW

REPORT # 21-03924-234

OCTOBER 27, 2022



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## Executive Summary

Under the MISSION Act of 2018, veterans are eligible to receive community care under certain circumstances, such as when the veteran’s local VA medical facility does not provide the requested service or when a provider determines community care is in the veteran’s best medical interest. Consideration is also given to wait times for appointments and the times veterans spend driving to appointments.<sup>1</sup>

In 2019, the Veterans Health Administration (VHA) began implementing the Referral Coordination Initiative (RCI) at medical facilities across the country to facilitate consult scheduling for specialty care within VHA facilities and in the community for eligible veterans. The Office of Integrated Veteran Care (IVC), the program office responsible for overseeing the initiative, developed a guidebook to support facilities’ deployment of the RCI.<sup>2</sup> RCI tasks facility-based referral coordination teams (RCTs), rather than the referring healthcare providers (as was the practice), with triaging and scheduling consults for specialty care.<sup>3</sup> According to VHA, consults are used to request care or seek an opinion, advice, or expertise from other VA or community care providers regarding evaluation or management of patients.<sup>4</sup> All VA medical facilities across the country were to have created RCTs and implemented the initiative in all specialties by June 30, 2021.<sup>5</sup> The RCI was designed to improve veterans’ timely access to care, empower patients to make informed care decisions, and reduce providers’ administrative burden to spend more time on patient care.<sup>6</sup> The Office of Inspector General (OIG) conducted this

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<sup>1</sup> VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

<sup>2</sup> In July 2022, VHA reported it had integrated the Office of Veterans Access to Care and its Office of Community Care into one office called IVC to help VHA better coordinate care while also streamlining and simplifying access processes. While the Office of Veterans Access to Care was the program oversight office at the time of the review, the OIG refers to IVC throughout the document since the consolidation of the two offices occurred before publication of this report.

<sup>3</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, December 2021. The guidebook states that the RCT is a multidisciplinary team of clinical and administrative staff, which includes doctors, physician assistants, licensed nurse practitioners, registered nurses, and schedulers. Triaging involves reviewing a patient’s medical chart to determine how urgently the patient needs care and then assigning a corresponding priority level one through four, with level one indicating delays are likely to lead to patient harm.

<sup>4</sup> VHA Directive 1232 (3), *Consult Processes and Procedures*, amended April 5, 2021.

<sup>5</sup> “VHA Referral Coordination Initiative Implementation Checklist,” VHA Referral Coordination Initiative SharePoint site, accessed March 8, 2022. (This is an internal VA website not publicly accessible.) The checklist states “100% implementation required by June 30, 2021.”

<sup>6</sup> IVC has continually updated the RCI guidebook, including adding goals and benefits. The OIG team evaluated these three goals because they were the original ones in place from October 2021 to June 2022 (the review period). These goals are associated with measures that affect patient access to care and could be evaluated as the initiative was being implemented.

review to evaluate the RCI and identify challenges and potential obstacles affecting its implementation.

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

Under the RCI process, after a facility provider (usually a primary care physician) enters a consult for a patient requiring specialty services, the RCT determines the veteran's eligibility for community care. A clinical RCT member, typically a triage nurse, determines the available care options for the patient—in-house, in another VA facility, or in the community. The clinical RCT member then assigns the consult a priority level indicating how urgently the patient needs to be seen, determines whether any medical tests are needed, establishes whether the patient is eligible for community care, and contacts the patient to discuss care options.<sup>7</sup> A summary of differences between the two processes appears in appendix A.

## What the Review Found

Facility staff generally viewed the RCI as having the potential to improve how consults are triaged and scheduled, and how patients are educated on their care options. Facility staff reported that the initiative could result in (1) faster scheduling of patient appointments; (2) more informed decision-making by patients; and (3) reduced administrative burden for referring healthcare providers.

However, the OIG found that VHA should provide more support to facilities because they struggled to implement the RCI and develop mechanisms to measure its effectiveness. As described below, among the reported implementation challenges facilities faced were insufficient staffing and resources, the need to develop triage tools, unreliable wait time data, and the inability to get prompt responses to questions. Facility staff also did not always complete RCI-specific training. As a result of these challenges, no facilities had fully implemented the RCI

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<sup>7</sup> *Prioritization for Expanding Outpatient Consultations, Procedures, and Appointments*, ver. 4.0, VHA Referral Coordination Initiative SharePoint site, accessed March 8, 2022. The RCI guidebook refers clinical RCT members to this document, which provides guidance across a range of specialty areas for prioritizing consultations and assigning priority levels one through four. The guidebook states the RCT is responsible for determining community care eligibility except for wait time eligibility, because the VA wait time information is not current.

across all specialty services as of June 2022—about a year after the deadline.<sup>8</sup> In addition, IVC lacked reliable data to measure whether the initiative was meeting its goals to reduce the time to schedule appointments, and did not measure if it ensured staff provided patients with key information to make informed care decisions or enabled providers to spend more time with patients. The findings were based on extensive interviews, site visits, documentation review, and the examination of VA guidance. Details on the review scope and methodology appear in appendix B.

## Facilities Struggled with Implementation

Facility officials reported being unsure how to use existing resources to manage the initiative or which staffing model described in the RCI guidebook—centralized or decentralized—would be more appropriate for their facility.<sup>9</sup> Leaders and staff from the four facilities the team visited in person and virtually said they did not have enough staff to fully implement the initiative. Under the centralized model, there is a risk of services losing staff if no additional staff are hired to support the initiative. Under the decentralized model, staff assigned additional RCT duties had to juggle them with their existing responsibilities. Without clear direction on staffing models, some facilities tested different implementation methods. For example, officials at two facilities the team visited reported they completely changed their leadership and staffing model for the initiative after experiencing challenges. Given the staffing strain, initiative leaders from one facility said they were planning to roll out the initiative to only two services every month; at this rate, completion would take several years.

Facilities were also challenged by a lack of standardized triage tools tailored to their specialty services, no reliable community care wait time data in the tools provided, and difficulties with getting prompt answers from IVC to questions about the RCI.<sup>10</sup> Facility staff also did not always complete RCI-specific training courses. While IVC developed RCI training for VA’s Talent Management System, an online training platform, not all relevant RCT members completed this training, increasing the chances of them making errors or giving inaccurate information to veterans. The team identified instances during site visits at several facilities when staff did not consistently notify patients that they were eligible for community care based on drive times, as

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<sup>8</sup> For the RCI process to be “fully implemented” at a medical facility, it must be used for all specialty services that the facility or any VA facility in the same VISN is able to provide internally.

<sup>9</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*. As of March 2022, the guidebook had last been updated in January 2022. It describes the centralized staffing model as employing clinical and administrative RCT members who are dedicated to processing consults through the initiative and report to an RCT lead. A decentralized staffing model uses clinical and administrative RCT members who have other responsibilities and report to leaders in their service lines.

<sup>10</sup> According to the RCI guidebook, “a clinical triage tool is a guideline used by RCT for consult review, triage, documentation and scheduling. It is built collaboratively with specialty providers, referral coordination nurses and administrative team and provides a clinical algorithm for nurse decision making in determining appropriate care routing modalities.”

required by the RCI guidebook. In addition, Veterans Integrated Service Network (VISN) and facility leaders the review team interviewed said IVC did not generally address their questions or took a long time to do so.<sup>11</sup> For example, a facility RCI lead said IVC took a long time to respond or did not respond at all to concerns he raised via email, such as that he could not access various guides and training materials that were hyperlinked in the RCI checklist.

### **No Facility Had Fully Implemented the Initiative as of June 2022**

The June 30, 2021, deadline was for all facilities to implement the initiative in all service lines that the facility or any VA facility in the same VISN was able to provide internally. According to an IVC leader, no facility had fully implemented the RCI as of June 2022—about a year past the deadline. IVC did not know the status of RCI implementation across facilities because the office relied on implementation checklists to monitor the degree of completion.<sup>12</sup> However, the checklists given to facilities to complete did not detail how many specialty services had been implemented compared to how many services needed to be implemented. IVC did not provide the review team with alternative methods to evaluate progress across facilities.

### **IVC Was Unable to Assess Progress on Meeting Initiative Goals**

According to the guidebook at the time of the OIG review, the purpose of the initiative was to “improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.”<sup>13</sup> The RCI was also designed to reduce the administrative burden on VA healthcare providers and allow them to see more patients. However, IVC could not assess whether the initiative had improved timely access to care, due to incomplete and inaccurate data. For example, until October 2021, no mechanism existed to track RCI consults automatically, and VISN and facility leaders reported concerns about the completeness of hand-marked data. In October 2021, the Consult Toolbox 2.0 (a software update) was released and VHA staff were supposed to use it to document scheduling actions quickly and consistently. While the toolbox allowed staff to designate themselves as RCT members so that their consults are tracked as going through the RCI process, neither IVC nor facility leaders had a way of tracking whether all RCT members were doing so.

As of March 2022, IVC and RTC leaders from all four facilities the review team visited said they also had not determined whether the initiative had resulted in staff providing patients with key

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<sup>11</sup> VHA has 18 VISNs, regional systems of hospitals and other healthcare facilities.

<sup>12</sup> According to the RCI guidebook, the “RCI Implementation Checklist was created to assist VAMCs [VA medical centers] with effectively implementing RCTs in a standardized manner, while still allowing for VAMCs to adjust as needed based on their unique needs. . . . The RCI Implementation Checklist captures high level tasks and sub-tasks, which are broken down by implementation phases.” These phases include planning, execution, and oversight.

<sup>13</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, page 20.

information to make informed decisions. IVC had not developed a mechanism for facilities to evaluate whether staff were accomplishing this goal. The review team identified instances when facility staff did not provide patients with key information—for example, a provider who said he generally decides what is best for patients and does not usually give them an option. Similarly, IVC had not implemented a mechanism to evaluate if the initiative reduced the administrative burden on providers, and none of the four facilities the review team visited had conducted this type of analysis.

Having reliable RCI data and mechanisms to evaluate the initiative would provide these leaders with preliminary information needed to determine whether improvements need to be made in oversight.

As the program office overseeing the RCI, IVC should follow federal guidance and help facilities meet the initiative’s goals by supporting staffing assessments and plans, providing standardized triage tools, improving access to reliable wait time data, and making its staff available to answer implementation questions as they arise. IVC should also develop mechanisms and processes to assess if the RCI is meeting its goals.

## **What the OIG Recommended**

VHA needs to ensure IVC takes appropriate steps to better assist VA medical facilities with initiative implementation, and to improve oversight of the initiative to make sure the process is working as intended. To help IVC in these areas, the OIG recommended that VHA assign specific RCI roles and responsibilities to IVC, ensure relevant staff complete RCI training, establish local processes for sharing available community care data at VA medical facilities to help facility staff communicate consistent wait times to patients, improve the tracking and monitoring of each facility’s progress toward full implementation, disseminate best practices and lessons learned, ensure facilities accurately track and monitor RCI consults, and develop measures and processes to assess whether facility staff are meeting the initiative’s intent.

## **VHA Comments and OIG Response**

The under secretary for health concurred with all seven recommendations and acknowledged that “while VHA has made great strides in the implementation of RCI, there remains more work to be done.” He provided corrective action plans that are responsive to the intent of the recommendations for recommendations 1 through 6, and that are partially responsive for recommendation 7. This includes IVC personnel assuring that RCI team members are appropriately assigned roles and responsibilities; training staff on tasks appropriate to their duties and assessing compliance with tools; establishing local processes and staff training for identifying and sharing community care wait time data; launching a dashboard to track facilities’ challenges and progress on implementing RCI in all relevant specialty services and using that information for field support; gathering and disseminating implementation best practices, lessons

learned, and updated reference materials to all relevant VA medical facilities; overseeing the use of and improvements to the Consult Toolbox to accurately track and monitor RCI consults; and helping VA medical facilities assess consult timeliness measures and manage consults. The under secretary stated that VHA considers recommendation 5 fully implemented and asked the OIG to consider closing it. The full text of the under secretary's comments appears in appendix C.

The OIG reviewed the responses and supporting documentation submitted for the recommendations and considers recommendation 5 closed. For recommendation 7, the under secretary addressed how VHA measures consult timeliness, but did not specifically address what measures and processes VHA will develop or use to assess if the RCI is meeting its three stated goals: (1) reducing scheduling times; (2) providing veterans with key information; and (3) minimizing facility providers' administrative burden of managing consults. The OIG will expect to see this information before closing this recommendation.

For recommendations 1 through 4 and 6 and 7, the OIG will monitor implementation of all planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



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## Abbreviations

DST	Decision Support Tool
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
RCI	Referral Coordination Initiative
RCT	referral coordination team
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The Veterans Health Administration’s (VHA) Referral Coordination Initiative (RCI), initiated in October 2019, shifted responsibility for handling specialty care consults from patients’ healthcare providers to facility-based referral coordination teams (RCTs).<sup>14</sup> All VA medical facilities across the country were required to have implemented the RCI in all specialties (such as cardiology or neurology) by June 30, 2021.<sup>15</sup> Prior to the RCI, care providers generally decided whether to refer a patient needing a specialty care consult to a VA specialty clinic or to the facility’s community care department for triaging and scheduling.<sup>16</sup> Providers based the referral decision, in part, on the patient’s eligibility for community care—that is, care delivered by a non-VA practitioner in the patient’s area. Through the initiative, VHA hoped to improve veterans’ timely access to care, empower patients to make informed care decisions, and reduce healthcare providers’ administrative burden. The Office of Inspector General (OIG) conducted this review to evaluate the RCI and identify challenges and potential obstacles affecting its implementation.

### Community Care Eligibility

Under the MISSION Act of 2018, veterans are eligible to receive community care under any of the following circumstances:<sup>17</sup>

- The veteran’s local VA medical facility does not provide the requested services.
- A provider determines community care is in the veteran’s best medical interest.

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<sup>14</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, December 2021. The guidebook states that the RCT is a multidisciplinary team of clinical and administrative staff, which includes doctors, physician assistants, licensed nurse practitioners, registered nurses, and schedulers. VHA Directive 1232(3), *Consult Processes and Procedures*, amended April 5, 2021. According to the directive, VHA providers use consults as the mechanism to request care for or seek an opinion, advice, or expertise regarding evaluation or management of patients from other VA or community providers.

<sup>15</sup> “VHA Referral Coordination Initiative Implementation Checklist,” VHA Referral Coordination Initiative SharePoint site, accessed March 8, 2022. (This is an internal VA website not publicly accessible.) The website states, “100% implementation required by June 30, 2021.” For the RCI process to be “fully implemented” at a medical facility, it must be used for all specialty services that the facility or any VA facility in the same VISN is able to provide internally. According to VISN RCT leads, 139 medical facilities were to have implemented the RCI process. For some large cities with more than one VA medical facility, the initiative was implemented at the facility that manages consults for the entire healthcare system.

<sup>16</sup> Triaging means reviewing a patient’s medical chart to determine how urgently the patient needs care and then assigning a corresponding priority level one through four, with one being appropriate when delays are likely to lead to patient harm.

<sup>17</sup> VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

- The veteran must drive an average of at least 30 minutes for mental health care or at least 60 minutes for specialty care to get to the nearest VA facility.
- Wait times at a local VA facility or clinic are more than 28 days for specialty care or 20 days for primary care, mental health care, and noninstitutional services.

To help determine whether a patient is eligible for community care, VHA staff use the Decision Support Tool (DST). The tool is meant to provide data such as drive-time projections based on the patient's home address and information on wait times:

- Drive-time standards and related eligibility for the requested service
- Average wait times for the requested service at VA facilities near the patient's home
- Average wait times for community care appointments<sup>18</sup>

## **The Non-RCI Consult Referral Process**

Under the non-RCI consult referral process (which continued for some services at all facilities after the June 2021 RCI implementation date), a facility provider determines a patient requires specialty services, then the provider assesses whether the patient is eligible for community care for the service based on the patient's best medical interest and on DST information.<sup>19</sup> If the patient is ineligible for community care, the provider submits a consult referral to the applicable VA service line (for example, cardiology or neurology), whose staff will call the patient to schedule a VA appointment. For eligible patients, the provider will generally transfer the consult to the community care department. The community care staff will confirm eligibility and then call the patient to discuss community care preferences (whether he or she wants community care, and if so which provider and location are desired), and then either help schedule the appointment or provide the patient with information to make the appointment.

## **The Development of the Referral Coordination Initiative**

After passage of the MISSION Act, former acting under secretary for health Dr. Richard Stone learned that patients were not being made aware of all their care options when facility staff were scheduling consults for specialty care. In response, Dr. Stone tasked staff from VHA's Office of Integrated Veteran Care (IVC) with reviewing and streamlining the general consult referral

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<sup>18</sup> Interviews revealed, however, that the DST does not always provide wait time averages for community care appointments. When it does, facility staff reported the wait times are generally inaccurate. This issue is discussed further in the finding.

<sup>19</sup> According to a VHA official, primary care does not use the RCI for referrals to it. The official said that patients can be assigned a primary care provider on or after enrollment in VHA without the use of the RCT.

process.<sup>20</sup> In October 2019, staff presented a proposed RCI process to Dr. Stone and VHA’s Governance Board Office.<sup>21</sup> Dr. Stone and the Governance Board Office approved the RCI in October 2019 (as shown in table 1) and designated IVC as the office responsible for implementing and overseeing it. IVC then developed an RCI guidebook.

**Table 1. Timeline of Events That Led to RCI Development and Rollout**

Date	Event
June 2018	The VA MISSION Act of 2018 was signed.
October 2019	IVC staff were tasked with streamlining the consult referral process.
November 2019	The new consult referral process was presented to the Governance Board Office, and then IVC was tasked with building tools and resources to support it.
January 2020	The first version of the RCI guidebook was completed.
February 2020	RCI implementation was paused due to the COVID-19 pandemic.
January 2021	Implementation resumed.
June 2021	IVC required that all facilities implement the initiative by June 30, 2021.

*Sources: VA MISSION Act of 2018; VHA IVC RCI SharePoint site dated August 20, 2021; and interviews with IVC officials on August 5, 2021.*

The guidebook states that “All VA Medical Centers (VAMCs) are required to implement RCI.” The guidebook also states that, “While each facility may develop strategies to address referral coordination, key minimum strategies include:” (1) implementing RCTs, (2) eliminating direct entry of community care referrals by referring providers, (3) working with VISNs to establish a network of interfacility consults between VAMCs [VA medical centers], (4) offering patients the ability to schedule an appointment at “check-out,” (5) identifying scheduling preferences for all patients who choose community care, and (6) using clinical and administrative RCI staff model recommendations to support a dedicated RCT.

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<sup>20</sup> Interview with IVC official (August 2021) and the team’s review of meeting notes between IVC and VHA’s Governance Board from October and November 2019. As noted in the summary, VHA reported in July 2022 it had integrated the Office of Veterans Access to Care and its Office of Community Care into one office called IVC to help VHA better coordinate care while also streamlining and simplifying access processes. While the Office of Veterans Access to Care was the program oversight office at the time of the review, the OIG refers to IVC throughout the document since the consolidation of the two offices occurred before publication of this report.

<sup>21</sup> VHA Directive 1217.01, *VHA Central Office Governance Board*, September 10, 2021. VHA’s Governance Board is “delegated authority from the Under Secretary for Health and is directly accountable to VHA’s Deputy Under Secretary for Health. The Governance Board has broad span of control to ensure outcomes are organized and aligned within a comprehensive strategy.” This directive also states, “It is VHA policy that the Governance Board drive decisions over matters within its span of control and make recommendations to the Under Secretary for Health on matters of national strategy, operations, and implementation.”

The RCI was developed to address identified deficiencies with the long-standing consult process. For example, IVC identified in the initiative guidebook the risks with the non-RCI consult referral process, including these:<sup>22</sup>

- “Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary.”
- “Veterans may not receive all the information needed to make decisions about their health care needs.”

The OIG focused its review on what challenges were encountered in rolling out the initiative, the status of the implementation effort across VHA facilities, and the extent to which VHA met the three original goals of the initiative:<sup>23</sup>

1. Reducing the average time to schedule appointments
2. Empowering patients to make more informed decisions about where to receive care
3. Reducing the administrative burden on clinicians, allowing them to spend more time on delivering patient care

## **RCI Implementation Guidebook and Consult Referral Process**

IVC created the RCI guidebook for VHA staff to use in implementing and managing the initiative.<sup>24</sup> Veterans Integrated Service Networks (VISNs) and VHA medical facilities are encouraged to use the guidebook and tailor strategies locally to improve consult scheduling timeliness and to standardize patient education on care options within VHA and in the community.<sup>25</sup> The guidebook lists roles and responsibilities of relevant VISN and facility staff, provides information on training options, and provides high-level information related to different initiative staffing models. It does not list specific IVC leadership or staff positions responsible for RCI oversight.

Under the initiative, the guidebook states that a provider submits a referral to the RCT for the patient to receive specialty services.<sup>26</sup> A clinical RCT member (medical practitioner), typically a

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<sup>22</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, pages 11 and 116.

<sup>23</sup> IVC has continually updated the RCI guidebook, including adding goals and benefits. The OIG team evaluated these three goals because they were the original ones in place from October 2021 to June 2022 (the review period). These goals are associated with measures that affect patient access to care and could be evaluated as the initiative was being implemented.

<sup>24</sup> As of March 2022, the last update to the *Referral Coordination Initiative Implementation Guidebook* was in December 2021.

<sup>25</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*. VHA is organized into 18 VISNs, which are regional systems of hospitals and other healthcare facilities.

<sup>26</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*.

triage nurse, determines the available care options for the patient—in-house, in another VA facility, or in the community. The clinical RCT member also assigns the consult a priority level (indicating how urgently the patient needs to be seen), determines whether any medical tests are needed before the appointment, and runs the DST to determine community care eligibility before contacting the patient to discuss care options. The RCI guidebook refers clinical RCT members to IVC’s SharePoint site, which contains a document describing the four priority levels. For example, the document directs clinical RCT members to designate patients as priority level one when “delays of care are likely to lead to harm to patients.”<sup>27</sup> According to the guidebook, the RCT is responsible for running the DST to determine community care eligibility, except for wait time eligibility because the DST tool estimates are not current. Although the DST provides information on VA wait times, the RCI guidebook states that they may not be used to determine eligibility. Instead, as stated in the DST user guide, the RCT member determines wait time eligibility for community care using specific VA clinic scheduling grids that display the most current available VA appointment slots for patients.

For a summary of the differences between the non-RCI consult referral process and the RCI process, see appendix A.

## **Scheduling Care for Patients**

Under the RCI, clinical RCT members triage consults by reviewing the patient’s medical chart to gather information and determine the most appropriate priority level. Clinical or administrative RCT members share with patients all their options for care. If the patient is eligible for community care, an RCT member calls the patient, explains the options of receiving care in VA or in the community, and shares key information (such as wait times) to help the patient decide which option to pursue. The guidebook also provides examples of scripts that both clinical and administrative RCT members can (but are not required to) use when discussing care options with their patients.

If the patient opts out of community care, the administrative RCT member schedules the patient’s appointment at a VA facility. If the patient opts in, the RCT member collects the patient’s community care preferences, such as specific providers, days, and times, and forwards the consult to the community care department for scheduling. If the patient is not eligible for community care, the administrative RCT member proceeds as if the patient had opted out. The administrative RCT member searches for the next available VA facility appointment and communicates that to the patient.

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<sup>27</sup> The RCI guidebook refers clinical RCT members to IVC’s SharePoint site, which contains the document titled *Prioritization for Expanding Outpatient Consultations, Procedures, and Appointments*, ver. 4.0, which describes the four priority levels.

According to the guidebook, VHA's goal is for the RCT to schedule patients for VA appointments within an average of three days from the time the referral is made to the RCT by the provider (file entry date).<sup>28</sup>

## RCT Staffing Models

While the guidebook states the RCT should be a multidisciplinary team, the guidebook also gives facilities the flexibility to develop their RCTs as they deem appropriate, using either a centralized or a decentralized RCT staffing model. The guidebook states that facilities should use workload analyses and current process flows to determine the most appropriate staffing model.

A centralized staffing model generally engages clinical and administrative RCT members who are dedicated to processing consults consistent with initiative guidance and all report to an RCT lead. The guidebook acknowledges that this staffing model may result in other services losing staff if no additional facility staff are hired to support the initiative.

A decentralized staffing model draws on clinical and administrative RCT members who have other responsibilities and report to leaders in their respective service lines. In this model, the RCT lead may not always have overall direct authority over the RCT members. The guidebook acknowledges that this staffing model may result in additional duties for existing staff and a lack of consistency in practice due to different levels of understanding of the initiative's goals. The guidebook also states this model presents the risk that RCT members under various service lines will use different processes to manage consults.

Regardless of the staffing model, the guidebook lists the following responsibilities for facility-level clinical RCT members:

- Conduct initial triage on all consults.
- Run the DST as an initial step to determining community care eligibility.
- Call the patient to discuss all available VA and community care options, when eligible.
- Document the conversation with the veteran using the Consult Toolbox.<sup>29</sup>
- Introduce the patient to the administrative RCT member who will schedule the VA appointment or forward the consult to the community care department.

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<sup>28</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, December 2021 update, page 12.

<sup>29</sup> The Consult Toolbox was designed for VHA staff to document scheduling actions quickly and uniformly. The toolbox uses consistent language to document scheduling steps, better track those steps, and improve analysis capabilities.



The guidebook lists the following responsibilities for administrative RCT members:

- Call patients to discuss care options and schedule appointments as indicated by the clinical RCT member.
- Use the DST to determine community care eligibility, as appropriate.
- Document scheduling efforts using the Consult Toolbox.
- Document the discussion of VA wait times versus community wait times, when appropriate.
- Record a patient's community preferences, such as which provider the patient wants to see and when.
- Ensure a warm and seamless handoff to the community care department, when appropriate.

## Results and Recommendations

### **Finding: VHA Should Provide More Support to Facilities as They Implement the Referral Coordination Initiative and Develop Mechanisms to Measure Its Effectiveness**

As detailed in the following section, the OIG review team conducted extensive interviews, administered two questionnaires, and completed four site visits. The determinations that support the OIG finding are based on staff and leader responses and an analysis of related guidance and documentation. Facility staff that the team interviewed generally viewed the RCI as having the potential to positively transform consult management. Staff envisioned improvements such as faster scheduling, more informed decision-making by patients, and a reduced administrative burden for providers. However,

- facilities expressed the need for greater RCI support,
- no facility had fully implemented the initiative as of June 2022, and
- IVC is unable to assess progress on meeting RCI goals.<sup>30</sup>

Specifically, the OIG found facilities struggled and were unprepared and ill-equipped to undertake the RCI. Facilities had difficulty implementing the initiative with existing staff and resources, and deciding which staffing model to use. Facilities were also challenged by the lack of standardized triage tools, reliable community care wait time data, and prompt answers from IVC on RCI-related questions. Facility staff also did not always complete RCI-specific training courses. Facilities could benefit from additional support in these areas from IVC. As a result, no facility had fully implemented the process as of June 2022, despite the June 30, 2021, deadline.

The OIG also found that IVC was unable to determine whether the initiative was meeting its goals. The review team learned that facility staff were not completely and accurately capturing data needed to gauge whether the initiative was expediting appointment scheduling. Similarly, IVC was not tracking progress on providing patients with all options to make informed decisions on their care, or assessing whether care providers no longer managing these specialty consults were able to spend more time with patients.

### **What the OIG Did**

The review team conducted more than 75 interviews with leaders in VHA's IVC, in VA's Office of Regulatory Policy and Management, and at three VISNs and seven medical facilities.

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<sup>30</sup> For the RCI process to be considered "fully implemented" at a medical facility, it must be implemented for all specialty services provided by the facility or any VA facility in the same VISN.

Of these seven facilities, the team conducted site visits to the following four VA healthcare systems: Eastern Colorado (Aurora), Central Western Massachusetts (Leeds), Sierra Nevada (Reno), and Puget Sound (Seattle).<sup>31</sup> Team members analyzed various planning documents and guidebooks for the RCI to help evaluate whether the initiative met the intent of IVC's three initial goals.

In addition, the team sent two questionnaires to 18 VISN RCT leads, who distributed them to RCI leaders at the 139 medical facilities that were supposed to have implemented the initiative.<sup>32</sup> The team received a 100 percent response rate. The questionnaires solicited information on how facilities implemented the initiative, whether they received funding to support it, and whether they experienced any challenges during or after implementation.<sup>33</sup> Using the responses to the initial questionnaire, the team selected sites to reflect differences in facility-reported RCI implementation status, initiative staffing model, and challenges. The team also considered facility location (urban, rural, west coast, and east coast) and complexity during the site selection process.<sup>34</sup> Appendix B provides additional information about the team's scope and methodology.

The OIG finding is based on the following deficiencies:

- **Facility leaders found support for RCI insufficient.** Facilities struggled to implement the initiative with existing staff and funding and expressed the need for more guidance to decide which staffing model to use. They developed their own triage tools, potentially delaying RCI implementation. Facility staff were not always completing RCI-specific training, lacked access to reliable community care wait time data, and did not receive prompt answers to implementation questions.
- **No facilities had fully implemented the initiative as of June 2022.** Leaders and staff from all four facilities the team visited said they did not have enough staff to fully implement the RCI initiative.

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<sup>31</sup> The team conducted a virtual site visit of the Eastern Colorado facility. The other three site visits were conducted in person.

<sup>32</sup> The team did not identify specific staff from each of the 139 facilities who contributed to answering the questionnaires. The team relied on the VISN RCI leads to contact the appropriate staff at each facility, and to provide the team with a facility point of contact who could answer any facility-specific questions.

<sup>33</sup> The purpose of the review team's first questionnaire was to identify facilities for the team to visit or interview. The purpose of the second questionnaire was to determine the extent to which facilities received funding to support the RCI, and whether they believed the funding was sufficient to implement the initiative.

<sup>34</sup> "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing website, accessed May 16, 2022, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (This is an internal website not publicly accessible.) "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." Facility groupings are used for operational reporting, performance measurement, and research studies.

- **IVC was unable to assess progress on meeting initiative goals.** Its inability was due to inaccurate or unreliable data and a lack of assessment mechanisms.

## Facility Leaders and Staff Projected Positive Outcomes of the Initiative

Before detailing the deficiencies found, it is important to recognize the potential benefits of the initiative according to facility staff. Facility staff generally viewed the RCI as having the potential to improve how consults are triaged and scheduled, and how patients are educated on their care options.

Facility staff reported these potential benefits related to RCI goals:

- **Reducing the time facility staff take to schedule patient appointments.** Facility staff from 29 of 139 VA medical facilities reported to the OIG that they envisioned that the initiative could help streamline the consult review and scheduling processes. This was particularly the case under a centralized staffing model in which clinical RCT members are dedicated to triaging and administrative staff are focused on scheduling.
- **Allowing more informed decision-making by patients.** Staff from 52 of 139 facilities understood that under the RCI process, patients would be presented with estimates of VA and community care wait times—positioning patients to make more knowledgeable choices on where to receive their care. They would then be asked whether they prefer being seen at a VA facility or in the community.
- **Reducing the administrative burden of providers.** Staff from five of 139 facilities reported to the OIG that with clinical RCT members triaging consults, the process should allow clinicians more time for patient care.

## Facility Leaders Found Support for RCI Insufficient

Facilities reported struggles with fully implementing the RCI and could benefit from additional guidance and resources from IVC. The RCI guidebook provides flexibility to facilities on how to implement the RCI, including how to staff and organize the RCT using a centralized or decentralized model. However, this flexibility also left facilities to figure out which model would work best with little direction or the benefit of lessons learned. Facilities were also left to develop their own consult triage tools and ensure RCI-specific training was provided to RCT members. The DST also was not a reliable source of community care wait time data because RCT members said the tool did not always provide wait time information, and when it did, it was

not always accurate. This left RCT members to rely on other, sometimes inadequate sources.<sup>35</sup> In addition, facility leaders told the OIG that IVC did not always provide prompt responses to RCI implementation questions. In sum, facilities experienced challenges in the following areas:

- Implementing the RCI with existing staff and funding, and deciding which staffing model to use
- Developing consult triage tools
- Making sure RCT members completed RCI-specific training
- Accessing reliable community care wait time data
- Obtaining prompt responses from IVC to implementation questions

The Government Accountability Office's *Standards for Internal Controls in the Federal Government* requires managers to design appropriate control activities related to their objectives. Accordingly, IVC (as the program office overseeing the RCI) could better support facilities to fully implement the initiative by

- working with each facility to help determine sufficient staffing levels and the appropriate models, and whether additional resources are needed to support the initiative;
- providing employees with the right tools, such as standardized triage tools for specialty services;
- making sure facility staff have the knowledge, skills, and abilities to carry out their RCI-related responsibilities;
- maintaining reliable data needed for eligibility determinations, such as VA and community care wait times, that can also be communicated to veterans who are deciding their best care options; and
- developing processes to promptly respond to facility staffs' implementation questions and addressing identified concerns.<sup>36</sup>

In July 2022, after an interim briefing with the OIG on the review team's findings, an IVC leader sent the team a document that showed IVC had taken steps to evaluate the strengths and weaknesses related to RCI implementation and processes at 12 VA medical facilities. According to the document, IVC also made recommendations to these facilities to improve the process, such

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<sup>35</sup> RCT members have two options for determining community wait time data—the DST and VHA's community care wait time report. RCT members from all four facilities the team visited said neither option was reliable.

<sup>36</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 4, section 4.02; Principle 10, section 10.03; Principle 13, section 13.06; and Principle 14, section 14.03.

as completing RCI training, implementing consult management tools, conducting workload analyses, and clarifying RCI roles and responsibilities. As facilities continue to implement the RCI, IVC should continue to identify challenges and make recommendations to facilities to help them manage the RCI process.

## **Facilities Struggled to Implement the Initiative with Existing Staff and Funding, and to Decide Which Model to Use**

Implementing the initiative with existing staff was a significant challenge. Prior to the December 2021 guidebook update, facilities did not have detailed strategies or examples of how to use existing staff to create RCTs. For example, staff at 67 of the 139 facilities that responded to the review team's questionnaire (about 48 percent) stated they had not received guidance on the appropriate size of the RCT. Implementation was made more challenging because facilities did not have sufficient staff. For example, a VISN RCI leader told the team of having to use staff with collateral duties to process RCI consults, and most facilities did not receive additional funding from VA to hire more staff for the initiative. Finally, facility staff reported not having enough information to know whether to use centralized or decentralized staffing models for the RCI, making it difficult for facilities to efficiently implement the RCI within the prescribed timelines.

### ***Staffing Levels***

Leaders and staff from all four facilities the team visited in person and virtually said they did not have enough staff to fully implement the RCI initiative, as illustrated in the following examples.

#### ***Example 1***

*During the team's site visit in November 2021, an RCI leader from the Sierra Nevada (Reno) facility said that due to staffing levels, the facility was planning to roll out the initiative to two services every month. At this rate, reaching every [specialty] service would take several years.*

#### ***Example 2***

*The Sierra Nevada facility RCT lead told the team that the facility had a significant shortage of schedulers, but also needed additional clinical RCT members to successfully implement the initiative. He also said the initiative had not alleviated staffing challenges for the facility.*

#### ***Example 3***

*In January 2022, the Washington, DC, facility RCT lead said in an email the facility did not have enough nurses even before the initiative. He said the initiative exacerbated this staffing shortage because many specialty service lines*

*do not have nurses to act as the dedicated clinical RCT members to perform the responsibilities of the initiative. The RCT lead also said the facility was short about 50 schedulers.*

#### **Example 4**

*The Puget Sound facility deputy chief of staff also said that staffing shortages were the biggest challenges to implementing the initiative. However, she said the facility was planning to develop a rapid process improvement workgroup to evaluate current and future staffing levels and identify opportunities to reallocate staff to manage the initiative process. In January 2022, the deputy reported that this analysis was postponed until February 2022 due to challenges with the COVID-19 pandemic. In June 2022, the deputy chief of staff said that the rapid process improvement workgroup had completed its evaluation, and the facility was in the process of hiring a nurse manager and four nurses to be part of the RCT.*

Questionnaire respondents provided similar feedback. Of the 139 facilities that provided responses, 73 facilities (about 53 percent) reported they did not have enough staff at the time of the questionnaire to support the initiative as currently implemented for the specific specialty services using an RCT. In addition, 95 facilities (about 68 percent) reported they did not have enough staff to fully implement the initiative for all specialty services the facility provides. Furthermore, 16 of the 17 VISN officials responded to the questionnaire and validated the views of facility staff, reporting that they did not believe their facilities had enough staff to support the initiative (one VISN official provided no response to this question). For example, one VISN RCT leader said his facilities had assigned staff collateral duties instead of using dedicated staff to process RCI consults because the facilities did not have sufficient resources.

#### **Funding**

Staffing challenges were exacerbated by funding shortages. Facilities had to implement the initiative using their own funds or by requesting more through their VISN. Of the 139 facilities that responded to the review team's questionnaire, 115 facilities (over 82 percent) reported they had not received funding to support the RCI.<sup>37</sup> Whether they received funding or not, 61 of the 139 facilities (over 43 percent) reported that they did not believe they had the funds needed to carry out the initiative.

In response to the team's questionnaire, 16 of the 17 VISN officials (over 94 percent) reported that they did not believe the facilities within their VISN had enough staff to support the RCI

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<sup>37</sup> Of the four facilities the review team visited, two (Aurora, Colorado, and Reno, Nevada) reported receiving funding from the VISN to support the initiative. The other two facilities (Seattle, Washington, and Leeds, Massachusetts) reported they did not.

(one VISN official provided no response to this question). The team also determined from questionnaire responses that only four of 18 VISNs provided funding to some of the facilities in their region in support of the initiative. One VISN did so after conducting a VISN-wide staffing analysis and determining that about \$6 million was needed to fill about 50 clinical positions across its facilities. Based on this analysis, the VISN distributed these funds to all eight facilities that implemented the initiative. A facility official from each of two other VISNs asked their respective VISN leaders for funding to hire additional clinical and administrative staff to process RCI consults with varying success. They used the RCI guidebook—which suggests clinical RCT members could process 25 to 45 consults per day—to estimate the funding needed. One of the facilities did not receive funding from the VISN but used its own funds to hire additional administrative staff, while the other facility received funding from the VISN for additional staff.

### *Choice of Staffing Model*

Facilities had to decide whether to use a centralized or decentralized model, without detailed examples or guidance on which model might better fit different types of facilities.<sup>38</sup> One VISN RCT leader said VHA's IVC let facilities choose their staffing model and experiment without providing clear, evidence-based strategies or guidance on what those options might entail. The experimentation likely led to further delays in implementation, as seen in the following examples as well.

#### *Example 5*

*The Sierra Nevada facility group practice manager said the facility started off using a decentralized staffing model but decided to switch to a centralized model. The facility's community care manager said leaders realized the decentralized model was not going to work well because the specialty services did not have enough staff to take on the additional RCI responsibilities. With the switch to a centralized model, the RCI oversight responsibilities changed from the group practice manager to the community care manager.*

#### *Example 6*

*The Eastern Colorado facility's RCT lead said the facility originally had the community care department overseeing the initiative in a mostly decentralized model. However, the facility changed the oversight structure to have the facility's chief nurse oversee the initiative instead, since the RCI process occurs outside the community care department because the training, education, and meetings remain*

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<sup>38</sup> As noted earlier, the centralized staffing model is generally made up of clinical and administrative RCT members who are dedicated to processing consults through the RCI and report to an RCT lead. A decentralized staffing model is generally made up of clinical and administrative RCT members who have other responsibilities and report to leaders in their service lines.



*with the services implementing the RCI. To comply with federal internal control standards and better assist facilities, IVC should provide additional guidance on developing implementation strategies using existing staff and funding (or direction on what to do if using current staff is insufficient), including examples of when centralized or decentralized models might work best.<sup>39</sup> Facilities would also benefit from IVC broadly disseminating best practices or lessons learned.*

## **Facilities Developed Their Own Triage Tools, Potentially Delaying Implementation of RCI**

According to the RCI guidebook, specialty service staff within each facility were responsible for developing an RCT triage tool for that service.<sup>40</sup> A triage tool is a step-by-step procedure for nurses to use in determining appropriate care. It (1) allows nurses to triage consults (referrals) based on an approved medical algorithm, (2) increases consistency in the referral and scheduling process, and (3) provides a system to document in the record a summary of the referral triage, plan, and scheduling. All facilities had to create their own triage tools.

While facility leaders and RCT members indicated that developing these tools was an important first step in the RCI process, they said it was very time-consuming and they would have benefited from being given standardized triage tools prior to implementation. For example, a VISN RCI leader said that facilities' staff felt discouraged when trying to implement the initiative, in part because they had to develop their own triage tools. This RCI leader also said nationally developed triage tools would still be helpful as facilities continue to implement the initiative.

A Sierra Nevada facility RCT lead said developing and finalizing triage tools was time-consuming, but because the facility could not process consults for some specialty services without them, implementation may have been delayed. VHA has an opportunity to make triage tools available for all specialty services while facilities continue implementation, so that they can roll out the process more efficiently to more services.

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<sup>39</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 10, section 10.03. Principle 10 states that "effective management of an entity's workforce, its human capital, is essential to achieving results and an important part of internal control. Only when the right personnel for the job are on board and are provided the right training, tools, structure, incentives, and responsibilities is operational success possible."

<sup>40</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*. According to the RCI guidebook, "a clinical triage tool is a... guideline used by RCT for consult review, triage, documentation and scheduling. It is built collaboratively with specialty providers, referral coordination nurses and administrative team and provides a clinical algorithm for nurse decision making in determining appropriate care routing modalities."

## **Facility Staff Did Not Always Complete Referral Coordination Initiative Training**

While IVC developed six RCI-related training courses available through the Talent Management System (VA's online training platform), not all relevant RCT members completed the training. Some RCT members from all four facilities the review team visited said they had not completed any formal RCI training. For example, an RCT lead from one facility the team visited reported that only five of the facility's 11 RCT members had completed the RCI training available through VA's Talent Management System. A clinical RCT lead at another facility the team visited was only able to provide documentation that two of the facility's five RCT members had completed that training. Facility staff said they either figured the RCI process out for themselves or obtained on-the-job instruction from colleagues instead of through formal training.

Although the OIG team did not assess whether errors or misinformation were provided to patients due to lack of training, IVC developed the courses to help ensure consistent, quality referrals and scheduling. The review team identified instances during site visits at several facilities when staff did not generally notify patients that they were eligible for community care based on drive times, as required by the RCI guidebook, a step that could have been reinforced through comprehensive training. This may have led to staff not completely and accurately informing patients of all their care options so that they can make informed care decisions, a goal of the RCI.

As the program office responsible for the initiative, IVC could do more to ensure relevant facility staff have the knowledge, skills, and abilities to carry out their RCI-related responsibilities.<sup>41</sup> IVC could hold facilities' leaders accountable for ensuring staff complete RCI-specific training courses to prepare them to manage consults under the RCI process.

## **Facilities Did Not Have Access to Reliable Community Care Wait Time Data**

The guidebook states that if a patient is eligible for community care, staff must inform the patient of the expected wait times in the community. However, facility staff did not have access to reliable reports to provide patients with that key information.<sup>42</sup>

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<sup>41</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 4, section 4.02. Principle 4 states that "management establishes expectations of competence for key roles, and other roles at management's discretion, to help the entity achieve its objectives. Competence is the qualification to carry out assigned responsibilities. It requires relevant knowledge, skills, and abilities, which are gained largely from professional experience, training, and certifications."

<sup>42</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 13, sections 13.01 and 13.05. Principle 13 states that "management should use quality information to achieve the entity's objectives." It also states that "management uses quality information to make informed decisions and evaluate the entity's performance in achieving key objectives and assessing risks."

RCT members have two options for determining community wait time data—the DST and VHA’s community care wait time report. RCT members from all four facilities visited said neither option was reliable. One RCT member reported relying on the DST to inform patients of wait times in the community but acknowledged that information was not always available or accurate. The RCT member said that in practice, staff relied on the DST because they did not have a better source for community care wait time data. When the DST did not provide an average for community care wait times, the RCT member said staff simply told patients they did not know how long the wait time in the community would be.<sup>43</sup> At that point, patients had to decide to obtain their care in the VA based on the VA wait times or take a chance that the facility’s community care department could arrange for them to be seen sooner in the community.

VHA staff also have access to a community care report that provides wait times for various services. However, this report does not include all types of consults. Additionally, RCT members said the report did not reflect current or accurate wait time data. This report calculates wait times based on a prior 90-day average.<sup>44</sup>

The DST and the community care wait time report use the same source to calculate average wait times for community care. Therefore, the review team determined that both reports were unreliable. One facility employee related deciding to call community providers to determine current wait times before contacting patients to discuss their options.

The absence of reliable community care wait time data presents the risk that patients will make decisions based on misleading or incomplete information, which may lead to them waiting longer for care. As of March 2022, an IVC leader said the office was brainstorming ways to improve the accuracy of community care wait time reports, including potentially obtaining access to community providers’ schedules. In June 2022, the same IVC leader stated in an email that this effort was still in process.

## **Facilities Did Not Receive Prompt Answers to Implementation Questions**

VISN and facility leaders interviewed by the review team between November 2021 and March 2022 said IVC did not generally address their questions or took a long time to do so. For example, an RCI lead said IVC took a long time to respond or did not respond at all to concerns

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<sup>43</sup> The average community care wait times, when available, calculated the average days between when the appointment was made and the appointment date itself. The DST does not account for how long it might also take for community care department staff to schedule patient appointments after they receive the consults.

<sup>44</sup> VHA Support Service Center, *Community Care Community Wait Times Report*, August 24, 2021. According to this document, data come from a compiled referrals dataset with appointments made within the last 90 days. The report “excludes the following categories of care: administrative use only; contract nursing home; ER visit/urgent care; nic [nursing interventions classification] bowel and bladder. Additionally, referrals missing values in the provider state field, or missing the provider’s name, are excluded.”

he raised via email, including not having access to various guides and hyperlinked training materials in the RCI checklist. He also told the review team that staff had a lot of questions, and it would have been helpful if someone from IVC had joined facility meetings to answer questions. However, the lead said that IVC officials said that they would not do this, and that the only guidance and support they could give was during the national calls that were set to discuss the RCI. This lead said his VISN director was also frustrated with the lack of support from IVC.

In addition, two VISN leaders said they previously gave feedback and shared concerns with IVC but never received a response. One of these VISN leaders also said IVC was not well positioned to help facilities implement the initiative and respond to questions, and that those in the field knew about the challenges with the initiative before IVC did. This could have contributed to the overall frustration among facility leaders and staff, and delayed the implementation process.

In January 2022, about three months after the OIG met with IVC staff at the start of this review, a VISN RCT lead and facility leaders said IVC had begun to be more responsive to their questions and had reached out to ask for feedback. This change was reported by facility staff to the OIG after the team's discussion with IVC staff and during the OIG's fieldwork. IVC officials should continue to assess whether they could develop additional processes and controls to help facilitate prompt and effective communications with facility staff that address implementation questions and concerns.<sup>45</sup>

## **No Facility Had Fully Implemented the Initiative as of June 2022**

According to an IVC leader, no facility had fully implemented the RCI as of June 2022—about a year after the deadline. According to an internal VA website that stores the RCI implementation checklist, “100% implementation [was] required by June 30, 2021.” Based on the guidebook and the RCI implementation checklist, the review team determined that full implementation means implementing the RCI process across all specialties provided by the facility or any VA facility in the same VISN.<sup>46</sup> A VISN RCT leader said IVC was firm on facilities implementing the initiative by June 30, 2021, but that facilities were not ready.<sup>47</sup>

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<sup>45</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 14, section 14.03. Principle 14 states that “management communicates quality information down and across reporting lines to enable personnel to perform key roles in achieving objectives, addressing risks, and supporting the internal control system.”

<sup>46</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*.

<sup>47</sup> According to the RCI guidebook, VISN RCI leaders oversee initiative implementation across all VISN facilities. Their responsibilities include ensuring consistency of RCT functions and the use of RCT tools across facilities, and disseminating appropriate initiative materials.

To monitor implementation status across facilities, IVC had facilities self-report their progress on a checklist of tasks related to planning, execution, and oversight.<sup>48</sup> IVC required facilities to update their checklist biweekly on the RCI SharePoint site. The checklist included over 90 tasks that fell under 15 categories, such as determining the RCI staffing model and implementation strategy for each specialty service line, and establishing RCT facility-level oversight responsibility.

According to officials from three facilities the team visited, the checklist served as a helpful guide as they started implementing certain services. For example, the Eastern Colorado RCT lead said staff understood how to complete the checklist, and the Central Western Massachusetts RCT lead said the checklist was clear and precise.

A VA internal document, however, requires facilities to implement the initiative across all necessary specialties and services.<sup>49</sup> Consequently, VISN and facility staff reported the following concerns related to the checklist:

- The Sierra Nevada RCT lead said the RCI checklist is not service-specific, so it would not tell IVC how many or which of the relevant specialty services the facility had implemented. Thus, the review team determined that the checklist was not a good status indicator of implementation progress.
- A VISN RCI leader said it would have been helpful if separate checklists had been created for complexity level 1, 2, and 3 facilities.<sup>50</sup>

Because checklists do not detail the extent to which facilities have implemented the initiative in all relevant specialty services, neither IVC nor the OIG could rely on them to assess implementation status across all facilities. IVC did not provide the review team with alternative methods to evaluate progress across facilities. As a result, IVC should develop mechanisms to improve its oversight of each facility's advancement.

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<sup>48</sup> The RCI guidebook states that the "RCI Implementation Checklist was created to assist VAMCs [VA medical centers] with effectively implementing RCTs in a standardized manner, while still allowing for VAMCs to adjust as needed based on their unique needs. ... The RCI Implementation Checklist captures high level tasks and sub-tasks, which are broken down by implementation phases." These phases include planning, execution, and oversight.

<sup>49</sup> "VHA Referral Coordination Initiative Implementation Checklist," VHA Referral Coordination Initiative SharePoint site, accessed August 20, 2021. (This is an internal VA website not publicly accessible.) For the RCI process to be "fully implemented" at a medical facility, it must be used for all specialty services that the facility or any VA facilities in the same VISN are able to provide internally.

<sup>50</sup> Level 1a facilities are the most complex. "VHA Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing website, accessed May 16, 2022, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (This is an internal website not publicly accessible.)

## **IVC Was Unable to Assess Progress on Meeting Initiative Goals**

According to the RCI guidebook at the time of the OIG review, the initiative's purpose was to

- reduce the average time to schedule appointments,
- empower patients to make more informed decisions about where to receive care, and
- reduce the administrative burden on clinicians, allowing them to spend more time on delivering patient care.<sup>51</sup>

The review team learned through interviews and site visits that IVC, VISN, and facility leaders had not fully assessed whether the initiative was meeting these goals. The assessment gaps impede oversight efforts to identify needed improvements to RCI processes and effects.

The review team briefed IVC leaders in March 2022 on the issues discussed in the following sections. An IVC leader said the office did not have any updates or additional information to provide at that time.

### **Data Were Unreliable, Preventing IVC from Evaluating Whether the Initiative Reduced Scheduling Time**

The review team determined that VHA's RCI data were unreliable for two reasons: First, prior to October 2021, facility staff were required to make manual entries in the files of patients for consults that were managed under the initiative, but staff did not always make these entries. Second, an update to an existing tool in October 2021 that was designed to automatically track consults managed under the initiative did not allow for accurate identification of RCT members, and any consults processed by team members who did not assign themselves as such were not tracked. The unreliability of the data prevented IVC from accurately evaluating the timeliness with which RCI consults were scheduled.<sup>52</sup>

From March until October 2021, IVC required facility staff to manually record #RCT# in the patient's medical file to document consults reviewed through the RCI process because no mechanism in the Consult Toolbox software tracked these RCI consults automatically. However, VISN and facility leaders reported concerns related to the reliability of the RCI data. For example, a VISN RCI lead reported not being confident the RCI data were complete because staff were not consistently marking patients' files. As a result, the lead could not be sure how many consults had been managed under the RCI process. At the Dallas VA Medical Center, the

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<sup>51</sup> VHA, *Referral Coordination Initiative Implementation Guidebook*, page 20.

<sup>52</sup> GAO, *Standards for Internal Control in the Federal Government*, Principle 13, section 13.01 and 13.05. Principle 13 states that "management should use quality information to achieve the entity's objectives." It also states that "management uses the quality information to make informed decisions and evaluate the entity's performance in achieving key objectives and addressing risks."

RCT lead said staff did not record #RCT# for any consults because it would have been cumbersome to train everyone on doing so, since the recording process would be changing. As a result, RCI data for this facility would be incomplete.

In October 2021, after the Consult Toolbox 2.0 software update was released, staff were supposed to use it to document scheduling actions quickly and consistently.<sup>53</sup> The toolbox uses consistent language to document scheduling steps, allowing for better tracking and analysis. Specific to the initiative, the updated toolbox allows staff to designate themselves as RCT members so their consults are automatically tracked as having gone through the RCI process. In fact, the RCI guidebook states that “use of the RCT User Role within CTB [Consult Toolbox] is mandatory for all members of Referral Coordination Teams (RCTs) and its utilization will be incorporated in RCI outcome metrics.” This designation was meant to allow VHA and facility leaders to differentiate between consults, enabling them to determine how many consults were managed through the RCI process and whether timeliness of consult scheduling has improved.

However, facility leaders said they did not have a way to check which, or if, RCT staff assigned themselves as RCT members. For example, one facility’s RCT leader said they did not know who had been designated as RCT members and questioned the reliability of the RCI data for their facility. This leader said she was sure relevant staff had assigned themselves as RCT members in the toolbox but could not verify this; in fact, an RCT member from that facility admitted they had not indicated that assignment in the toolbox, making the RCI data at that facility incomplete and inaccurate.

The team determined that as of March 2022, IVC, VISN, and facility leaders still relied on incomplete and inaccurate data to evaluate the timeliness of consults scheduled through the RCI process.<sup>54</sup> The inability to effectively evaluate consults managed through the RCI process presents the risk that leaders may not identify delays in consult scheduling or processing errors. IVC, VISN, and facility leaders cannot determine whether the RCI process is working as intended to accelerate consult scheduling. Until VHA completely and accurately tracks and monitors RCI consult data, IVC, VISN, and facility leaders may miss opportunities to identify challenges with consults processed through the initiative and make needed improvements.

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<sup>53</sup> The RCI guidebook states that members of the RCT should use the Consult Toolbox 2.0 for the following actions: (1) capturing the consult triage/review process; (2) documenting if the clinical pre-work provided was complete; (3) capturing if the community care appointment was scheduled at the RCT level; (4) capturing that all available care modality options were discussed with the Veteran; and (5) forwarding consults to community care.

<sup>54</sup> As previously mentioned, VHA’s RCI guidebook states that VHA’s goal is for the RCT to schedule patients for VA and community care appointments within an average of three days from the time the referral is made to the RCT by the provider (file entry date).

## **IVC Lacked Measures to Evaluate Whether Key Information Was Provided to Patients to Inform Care Decisions**

IVC and RCT leaders said they had not determined whether the RCI process resulted in staff providing patients with information needed to make informed decisions. IVC had not developed a process to evaluate whether staff were accomplishing this goal as of March 2022. An IVC leader also reported that the office was still identifying best practices so it could share them with facilities and make recommendations to help them implement and oversee the RCI process.

Leaders from all four facilities the review team visited stated they did not ensure staff identified or appropriately communicated all care options to patients or that the information was accurate, nor did they have an effective way to evaluate staff communications. Additionally, a VISN RCI leader said he was not aware of any reports that outlined how to assess staff compliance with this RCI goal.

During site visits, the team identified instances when facility staff did not provide patients with key information on their care options.

### ***Example 7***

*A clinical RCT member from the Eastern Colorado facility in Aurora said staff cannot run the DST to determine community care eligibility because they get over 40 consults per day. Therefore, unless the clinical note says the patient wants community care, staff send the consult to a scheduler to make a VA appointment.*

### ***Example 8***

*Two Puget Sound (Seattle, Washington,) facility RCT schedulers said they did not generally notify patients when they were eligible for community care based on driving distance unless patients complained about drive times. In most cases, the schedulers called the patients to explain they could be seen by a VA physician within 28 days and scheduled a VA appointment.*

### ***Example 9***

*Two providers from the VA Central Western Massachusetts facility who triaged all consults for their specialty service line did not generally call patients to provide them with their care options, even when patients were eligible for community care. When asked whether they evaluated community care eligibility, one provider said he determined whether patients should be sent to community care based on his review of the patients' medical records. Furthermore, the same provider said he did not consider drive time when determining whether to send patients to community care because he thought VHA would provide transportation if necessary. This provider said he sent only about 1 percent of all*



*cardiology consults to the community. He also said he was the only full-time cardiologist in the area.*

Under the initiative, patients are supposed to be given all their care options and allowed to make the decision that works best for them. Patients at these facilities were not completely and appropriately informed of all their care options, contrary to the RCI guidebook. Some of these patients might have received more convenient care in the community had they been notified of their eligibility and given the option. According to an internal VHA document that the team accessed from IVC's SharePoint site on June 2022, IVC was still developing measures to track veteran satisfaction with the initiative.

### **IVC Had No Mechanism to Evaluate Whether the Initiative Reduced Healthcare Providers' Administrative Burden**

None of the four facilities the review team visited had conducted their own analyses to determine whether providers in service lines that had implemented the initiative had been able to see more patients or spend more time with patients since clinical RCT members started triaging their consults. In addition, while the results from one case study conducted by IVC to examine the potential impacts of a patient-centered approach to specialty care for sleep medicine at one VA medical facility suggest that this approach could save providers time on consults, IVC did not provide facilities with a mechanism to assess whether the RCI was actually doing so, or if it was allowing providers to spend more time with patients.<sup>55</sup> This would be an important analysis to determine the effect of the RCI process on providers.

Facility leaders and staff reported care providers' hesitancy to relinquish triage duties as an obstacle to implementing the initiative for certain specialty services, regardless of staffing model. For example, RCT members stated that some providers were reluctant to trust clinical RCT members to triage their consults appropriately.

An unintended consequence the team discovered was that the initiative increased some providers' administrative burden.<sup>56</sup> For example, one gastrointestinal provider said he had triaged almost every consult since the initiative was implemented because the facility chief of staff designated him as the only person who could forward gastrointestinal consults to the community care department. The chief of staff at this facility said other specialties are also using providers to triage consults until they have enough clinical RCT members to relieve providers of

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<sup>55</sup> According to a case study of one specialty service at one facility from February 2021, *The Referral Coordination Team: A Redesign of Specialty Care to Enhance Service Delivery and Value in Sleep Medicine*, IVC found, "The referral coordination team could allow VA Puget Sound to accommodate 4,800 additional visits/year for sleep medicine consults." However, this case study was completed about four months before facilities were required to implement the RCI, and is the only one that has been completed.

<sup>56</sup> Under the non-RCI process, staff within the facility's community care department performed triage of community care referrals. Under the RCI process, all consults should be sent to the RCT to be triaged.

this duty. Heightened administrative burdens increase the risks of providers having less time for patient care and delaying scheduling.

## Conclusion

While facility staff generally viewed the RCI as having the potential to improve consult management and how patients are informed of their care options, no facilities had fully implemented it by June 2022, despite the June 2021 deadline. Facilities struggled to implement the initiative with existing staffing and funding. They reported that more information on which staffing model to use would also have been of significant benefit. In addition, facilities had to develop their own triage tools, which was time-consuming. The OIG review team also determined that key personnel were not completing available training on the RCI process, which could help diminish errors and misinformation. RCT members lacked reliable community care wait time data and experienced difficulties getting prompt answers to questions about RCI implementation. As a result, facilities had implemented the initiative in only some service lines.

The OIG also found that IVC did not have reliable performance data to know if the initiative was reducing the time to schedule appointments and had no way to determine whether staff provided patients with key information to make informed decisions about their care options. There were also insufficient measures to help determine whether providers were able to spend more time on patient care when triaging was done by RCT clinicians. The recommendations that follow are meant to help VHA take corrective actions to address the deficiencies outlined in this report.

## Recommendations 1–7

The OIG made the following recommendations to the under secretary for health:

1. Assign specific roles and responsibilities to the Office of Integrated Veteran Care to ensure effective oversight of the Referral Coordination Initiative.
2. Make certain that staff with Referral Coordination Initiative responsibilities are sufficiently trained on how to triage, communicate key information on options to veterans, schedule, or document consults, according to their respective duties.
3. Direct relevant VA medical facilities to establish local processes by which VA medical facility staff identify and share available community care wait time data with referral coordination team members within each facility, and then establish controls to help ensure that this information is consistently communicated to patients.
4. Establish a mechanism or update the Referral Coordination Initiative checklist to effectively track and monitor each facility's challenges with implementation and progress toward implementing the initiative for all relevant specialty services.

5. Develop and then disseminate to all relevant VA medical facilities best practices and lessons learned for implementing the Referral Coordination Initiative.
6. Make sure that VA medical facility staff are completely and accurately tracking and monitoring consults processed through the Referral Coordination Initiative using the Consult Toolbox 2.0 or the most current system and version.
7. Develop measures and processes to assess whether facility staff are meeting the Referral Coordination Initiative's intent of reducing scheduling times, providing veterans with key information, and minimizing facility providers' administrative burden of managing consults.

## VHA Management Comments

The under secretary for health concurred with all seven recommendations and provided an action plan detailing steps for implementation. Appendix C includes the full text of the under secretary's comments, which are summarized below.

**Recommendation 1.** IVC will ensure the roles and responsibilities of core RCI team members “are appropriately assigned for optimal oversight of RCI implementation.”

**Recommendation 2.** IVC and the assistant under secretary for health for operations will develop a compliance and oversight plan to make certain that RCI staff receive training appropriate to their respective duties. IVC will also monitor and analyze Consult Toolbox 2.0 usage to assess process compliance.

**Recommendation 3.** IVC and the assistant under secretary for health for operations will also see that VA medical centers develop referral management processes to better incorporate community care wait time data so that RCT staff communicate that information to veterans, along with their options for care. Appropriate training on this communication process will be developed for all RCT staff.

**Recommendation 4.** IVC recently developed and launched an enhanced information dashboard to gather facilities' RCI implementation information meant to enhance oversight of each facility's implementation progress for all relevant specialty services. A field support team also helps identify sites experiencing RCI implementation challenges and metrics will be monitored. Sites will have opportunities to discuss issues and provide feedback.

**Recommendation 5.** Following interviews with RCI staff to gather best practices, these were compiled and posted to an RCI SharePoint site as of May 2022, and supplemented with RCI national office hours. The enhanced information dashboard is also meant “to foster a community of practice and enable sites to find RCI implementation information and points of contact for all [medical centers].” IVC also developed and released revised RCI reference materials for VA medical facilities, including an updated guidebook, RCI scheduling learners guide, RCI scripts,

and training courses to standardize RCI execution. In view of all these actions, the OIG was asked to close this recommendation as completed.

**Recommendation 6.** IVC and the assistant under secretary for health for operations will support VISNs and facilities in developing “local processes to track and monitor consults processed by RCT members.” IVC will also partner with VHA Operations to oversee that the process and tools are being used as directed and will enhance the toolbox so that consults can be accurately tracked and monitored more easily.

**Recommendation 7.** Consult timeliness measures are outlined in standard operating procedures, and some are included in the RCI key performance indicators. These measures include scheduling timeliness for VA facility and community care consults, which can be tracked using the RCI VHA Support Service Center Dashboard. Support will be provided to sites having difficulty.

## OIG Response

The OIG acknowledges the steps VHA has taken to smooth implementation of the RCI and finds the planned actions responsive to recommendations 1 through 4, and 6. For recommendation 5, the OIG reviewed the supporting documentation submitted and considers this recommendation closed. For recommendation 7, the response is partially responsive to the recommendation and provides an example of an existing measure: consult scheduling timeliness. However, it does not specify what measures VHA will develop or use to assess whether facility staff are meeting the RCI’s intent: reducing scheduling times, providing veterans with key information, and minimizing facility providers’ administrative burden of managing consults. The OIG will expect to see this information before closing this recommendation.

The OIG will monitor implementation of the remaining planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

## Appendix A: Summary of Differences between the Non-RCI and RCI Consult Referral Processes

Table A.1 highlights the key differences between the non-RCI consult referral process and the RCI consult referral process for patients who *are not* eligible for community care.

**Table A.1. Differences between the Non-RCI and RCI Consult Referral Processes  
When Patient Is Not Eligible for Community Care**

Process step	Non-RCI process	RCI process
Submit referral for patient to receive specialty care service	Referring provider	Referring provider
Determine whether the patient is eligible for community care	Referring provider*	RCT member (clinical or administrative)**
Triage the patient's consult	Specialty service provider	RCT member (clinical)
Schedule the patient's appointment	Specialty service administrative staff*	RCT member (administrative)**

*Note: This table does not represent every step in the consult management process. It is intended to provide a high-level explanation of key differences between the consult referral processes.*

*\* Under the non-RCI process, specialty service staff generally processed fewer consults because the referring provider would send a portion of consults directly to the community care department.*

*\*\* Under the RCI process and in a decentralized staffing model, specialty service staff were likely to be responsible for processing more consults because some are tasked with managing RCI consults in addition to their other duties. Under a centralized model, the RCT staff would generally be dedicated to managing RCI consults.*

Table A.2 highlights the key differences between the non-RCI consult referral process and the RCI consult referral process for patients who *are* eligible for community care.

**Table A.2. Differences between the Non-RCI and RCI Consult Referral Processes  
When Patient Is Eligible for Community Care**

Process step	Non-RCI process	RCI process
Submit referral for patient to receive specialty care service	Referring provider	Referring provider
Determine whether the patient is eligible for community care	Referring provider*	RCT member (clinical or administrative)**
Triage the patient's consult (before forwarding the consult to community care)	Not applicable. Referring provider sends consult directly to the community care department.	RCT member (clinical)
Contact eligible patient to discuss care options and determine whether the patient wants to opt in or out of community care	Not applicable. Referring provider sends consult directly to the community care department for scheduling.	Clinical or administrative RCT member provides patients with key information, such as wait times, on VA facility and community care options.
Forward consult to community care department	Referring provider*	An administrative RCT member conveys the patient's community care preferences collected before forwarding the consult to the community care department.**
Schedules the patient's appointment	Community care scheduler	Community care scheduler

*Note: This table does not represent every step in the consult management process. It is intended to provide a high-level explanation of key differences between the consult referral processes.*

*\* Under the non-RCI process, specialty service staff generally processed fewer consults because the referring provider would send a portion of consults directly to the community care department.*

*\*\* Under the RCI process and in a decentralized staffing model, specialty service staff were likely to be responsible for processing more consults because some are tasked with managing RCI consults in addition to their other duties. Under a centralized model, the RCT staff would generally be dedicated to managing RCI consults.*

## Appendix B: Scope and Methodology

### Scope

The review team performed its work from October 2021 through July 2022. This review evaluated the RCI to identify challenges and potential obstacles affecting its implementation. The scope of the review included whether IVC (as the program oversight office) effectively planned for the initiative by providing adequate guidance, such as identifying best practices for implementation and ensuring staff were properly trained on the RCI process. The team also examined IVC's oversight to ensure the intent of the initiative was being met, including speeding up consult scheduling, providing veterans with key information to make informed care decisions, and reducing the administrative burden on providers so that they can spend more time with patients.

### Methodology

The review team identified and reviewed VHA and IVC assessments, training materials, applicable laws and regulations, VA policies and procedures, and guidebooks related to RCI implementation. The team conducted three interviews with IVC leaders who were responsible for implementing and overseeing the initiative. The team also conducted more than 70 interviews of leaders and staff from three VISNs and six medical facilities who were involved with the initiative. This included leaders and staff from the four sites the team visited in person and virtually: the Eastern Colorado facility in Aurora; the Central Western Massachusetts facility in Leeds; the Sierra Nevada facility in Reno; the North Texas facility in Dallas; and the Puget Sound facility in Seattle. The team conducted site visits not only to interview staff, but to better evaluate implementation status and observe how staff processed consults under the initiative. The site visits and other interviews provided the team with an understanding of the processes, challenges, internal controls, and general governance structure used to implement and oversee the initiative.

The team also developed and disseminated two questionnaires to VISN RCI leaders. The 18 VISN leaders disseminated both questionnaires to 139 medical facilities at which the RCI was supposed to have been implemented.<sup>57</sup> The team received a 100 percent response rate to both questionnaires. The first questionnaire was developed and disseminated in August 2021 before the team conducted the entrance conference with VHA. The purpose of this questionnaire was to gain a better understanding of the implementation status across facilities and challenges with

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<sup>57</sup> The review team determined, and VISN RCT leads confirmed, that 139 medical facilities were to have implemented the RCI process. For some large cities with more than one VA medical facility, the initiative was implemented at the facility that manages consults for the entire system. For example, while Boston, Massachusetts, has three large VA medical facilities, the initiative was being managed by only one.

implementation. The team also used this questionnaire to help identify facilities to visit and interview. In November 2021, the team developed the second questionnaire after the entrance conference to help determine the extent to which facilities received funding to support the initiative.

Using responses to the initial questionnaire, the team selected facilities based on facility-reported RCI implementation status, staffing models, and challenges. The team also considered facility location (e.g., urban, rural, west coast, and east coast) and complexity during the selection process.<sup>58</sup> However, based on questionnaire responses and the site visits, the team determined some facility personnel believed that they had fully implemented the initiative even when they had not done so for all services, or responded that they were using a centralized model when they were actually using a hybrid centralized and decentralized model.

## Internal Controls

The review team determined that internal controls relevant to control environment, control activities, information and communication, and monitoring components were significant to this review.<sup>59</sup> Based on the work performed, the team identified deficiencies related to (1) accountability for and oversight of the RCI, (2) data used to monitor consults processed under the RCI, (3) ensuring relevant facility staff took RCI training, and (4) ensuring the stated benefits of the RCI were being met.<sup>60</sup>

## Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators during the course and scope of their review. The OIG did not identify any instances of fraud or potential fraud during this review.

## Data Reliability

The review team did not use computer-processed data to support any findings, conclusions, or recommendations. The team did determine that the data IVC used to assess the timeliness and

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<sup>58</sup> “Facility Complexity Model,” VHA Office of Productivity, Efficiency & Staffing website, accessed May 16, 2022, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (This is an internal website not publicly accessible.) “The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex.” Facility groupings are used for operational reporting, performance measurement, and research studies.

<sup>59</sup> Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

<sup>60</sup> Since the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this review.



number of consults scheduled under the RCI process were unreliable because facilities did not have an effective method to separate consults processed under the RCI from consults processed using the previous method. Therefore, the team did not analyze or evaluate RCI consult data for this report.

## **Government Standards**

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

## Appendix C: VA Management Comments

### Department of Veterans Affairs Memorandum

Date: September 23, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative (Project No. 2022-03924-AE-0192) (VIEWS #6194164)

To: Division Director, Community Care Division (52A02), OIG Office of Audits and Evaluations

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.
2. Veterans' access to care is central to our mission and a top priority, whether Veterans receive that care in the Department of Veterans Affairs or in the community. With teams comprised of both clinical and administrative staff, Referral Coordination Initiative (RCI)'s goals are to communicate all available care options and to connect Veterans more seamlessly to needed health care.
3. While VHA has made great strides in the implementation of RCI, there remains more work to be done. We will continue to focus our efforts on optimizing models of RCI structure and strategies to deliver care to Veterans most efficiently and effectively. We also will improve VHA's oversight to monitor and support each facility's progress towards successful implementation.

*The OIG removed point of contact information prior to publication.*

(Original signed by)

Shereef Elnahal, M.D., MBA

Attachment

## VETERANS HEALTH ADMINISTRATION (VHA)

### Action Plan

The OIG made the following recommendations to the Under Secretary for Health:

**Recommendation 1: Assign specific roles and responsibilities to the Office of Integrated Veteran Care (IVC) to ensure effective oversight of the Referral Coordination Initiative (RCI).**

**VHA Comments:** Concur. In June 2022, VHA's Office of Community Care and Office of Veterans Access to Care merged to become IVC. As part of the transition to IVC, the RCI is undergoing program management review and realignment. IVC will assure that the roles and responsibilities of core RCI team members are appropriately assigned for optimal oversight of implementation of RCI.

Status: In Progress

Target Completion Date: November 2022

**Recommendation 2: Make certain staff with Referral Coordination Initiative responsibilities are sufficiently trained on how to use standardized triage tools, communicate key information on options to veterans, schedule, or document consults, according to their respective duties.**

**VHA Comments:** Concur. IVC will work with the Assistant Under Secretary for Health for Operations to develop a robust compliance and oversight plan to ensure that staff with RCI responsibilities are sufficiently trained on how to use standardized triage tools, communicate key information on options to veterans, schedule, or document consults, according to their respective duties. Additionally, IVC will also develop more robust data monitoring and analysis of Consult Toolbox 2.0 usage to assess compliance with processes.

Status: In Progress

Target Completion Date: February 2023

**Recommendation 3: Direct relevant VA medical facilities to establish local processes by which VA medical facility staff identify and share available community care wait time data with Referral Coordination Team members within each facility, and then establish controls to help ensure that this information is consistently communicated to patients.**

**VHA Comments:** Concur. VHA continues to enhance and improve its ability to accurately measure and monitor the timeliness of care delivered in the community based on the process data we can capture internally. VHA also currently has a task force of experts reviewing our processes to identify opportunities for significant system improvements of both direct and community care scheduling. IVC will work with the Assistant Under Secretary for Health for Operations to ensure that VAMCs develop referral management processes that better incorporate this data and that staff assigned to Referral Coordination Team (RCT) roles communicate this information to Veterans, along with their options for care, as part of the referral management processes. IVC will develop the appropriate training on this process for all RCT staff.

Status: In Progress

Target Completion Date: February 2023

**Recommendation 4: Establish a mechanism or update the Referral Coordination Initiative checklist to effectively track and monitor each facility's challenges with implementation and progress toward implementing the initiative for all relevant specialty services.**

**VHA Comments:** Concur. VHA IVC recently developed and launched an enhanced information dashboard to gather facilities' RCI implementation information. This dashboard will improve VHA IVC's

oversight to monitor and support each facility's progress towards successful implementation for all relevant specialty services.

VHA IVC currently has a process in place to identify sites that need support. This is done through the VHA IVC Field Support Team which regularly monitors site-specific performance and engages with sites based on needs and findings. VHA IVC will integrate review of RCT metrics as part of standard support and engagement with the field. RCI implementation will also be discussed as part of VHA IVC site visits, including opportunities to provide feedback about implementation challenges.

Status: In Progress

Target Completion Date: February 2023

**Recommendation 5: Develop and then disseminate to all relevant VA medical facilities best practices and lessons learned for implementing the Referral Coordination Initiative.**

**VHA Comments:** Concur. VHA IVC conducted interviews with RCI staff to identify promising practices/lessons learned that demonstrated consistency and improvements in the ability to sustain RCI successfully. Promising practices were captured from VAMCs with positive outcomes that achieved the mission of successfully empowering Veterans to make informed health care decisions, improved scheduling timeliness, and offered additional assistance to Veterans when needed. Promising practices were compiled and posted to the RCI SharePoint (SP), and an announcement was made in May 2022 on the RCI Office Hours call about new resources that are available for the field on the RCI SP.

VHA IVC also performs outreach to have VAMCs share promising practices and lessons learned via monthly RCI national office hours which are also posted on the RCI SP. The RCI POC and VAMC Information Dashboard was also recently developed to foster a community of practice and enable sites to find RCI implementation information and points of contact for all VAMCs. Additionally, VHA IVC developed and released revised reference material beginning in May 2022 which includes: the RCI guidebook, RCI scheduling learners guide, RCI scripts, role-specific learning paths, and TMS courses to standardize RCI implementation across the field. VHA IVC has met the intent of this recommendation as evidenced by the below documentation and asks OIG to consider closure of this recommendation.

Status: Complete, requesting closure

**Recommendation 6: Make sure that VA medical facility staff are completely and accurately tracking and monitoring consults processed through the Referral Coordination Initiative using the Consult Toolbox 2.0 or the most current system and version.**

**VHA Comments:** Concur. IVC will work with the Assistant Under Secretary for Health for Operations to support VISNs/VAMCs with implementation and to develop local processes to track and monitor consults processed by RCT members. This will include oversight in partnership with VHA Operations to ensure that the process and tools are being utilized as directed. VHA IVC will work to enhance care pathways and Consult Toolbox 2.0 (CTB) to make it easier for consults to be accurately tracked and monitored.

Status: In Progress

Target Completion Date: February 2023

**Recommendation 7: Develop measures and processes to assess whether facility staff are meeting the Referral Coordination Initiative's intent of reducing scheduling times, providing veterans with key information, and minimizing facility providers' administrative burden of managing consults.**

**VHA Comments:** Concur. Consult timeliness measures, as outlined in the Consult Timeliness Standard Operating Procedures, exist to assess whether facility staff are meeting consult timeliness metrics, some of which are included in the RCI key performance indicators. These consult timeliness measures include scheduling timeliness for internal and community care consults, which can be tracked using the RCI VHA

VSSC Dashboard. Support from IVC is provided to sites that are experiencing challenges, including review of consult management processes to identify and address opportunities for improvement.

Status: In Progress

Target Completion Date: June 2023

*For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.*

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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