



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

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Care in the Community  
Healthcare Inspection of VA  
Heartland Network (VISN 15)



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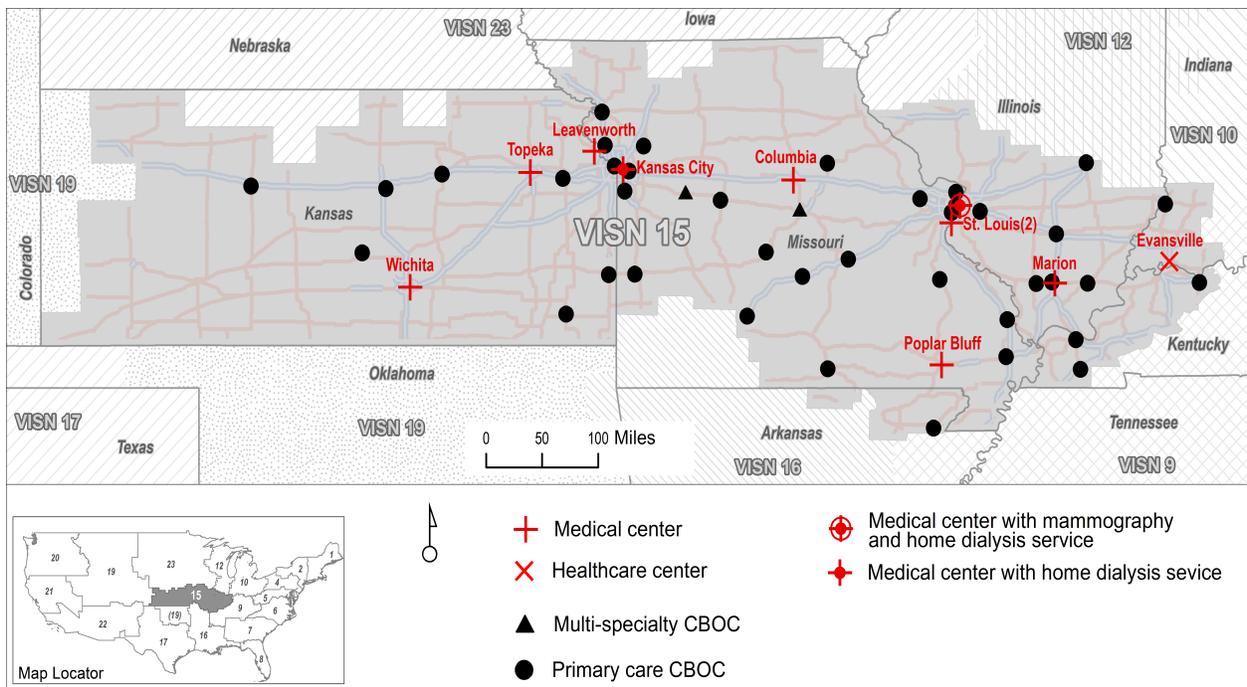
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**Figure 1.** Veterans Integrated Service Network 15: VA Heartland Network.

Source: Veterans Health Administration Support Service Center, accessed March 15, 2022.

## Abbreviations

CBOC	community-based outpatient clinic
CHF	congestive heart failure
CITC	Care in the Community
COVID-19	coronavirus disease
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Report Overview

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

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

The OIG oversees the Veterans Health Administration's (VHA's) clinical efforts with the implementation of the MISSION Act by selecting and evaluating specific areas of focus on a rotating basis. This report provides a focused evaluation of Veterans Integrated Service Network (VISN) 15: VA Heartland Network and its oversight of the quality of care delivered in its community-based outpatient clinics and through community care referrals to non-VA providers.<sup>3</sup> VISN leaders are responsible for ensuring that care, treatment, and services are provided safely and effectively regardless of whether they are delivered by VA or non-VA providers.<sup>4</sup>

The OIG performed a virtual review of VISN 15 from June 22 through June 30, 2021, and reviewed four clinical and administrative areas of focus:

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

The findings presented in this report are a snapshot of VISN 15 care provided in community-based settings, which includes VA and non-VA care, within the identified focus areas at the time of the OIG review. Although it is difficult to measure the value of well-delivered and

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<sup>1</sup> The VA MISSION Act of 2018, Pub. L. No. 115-182 (2018).

<sup>2</sup> VHA Office of Community Care, "Veteran Community Care General Information," September 9, 2019.

<sup>3</sup> VHA administers healthcare services through a network of 18 regional offices referred to as Veterans Integrated Service Networks.

<sup>4</sup> "Care, treatment, and services provided through contractual agreement are provided safely and effectively." The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021.

coordinated care between VA and non-VA providers, the findings may help VISN leaders identify vulnerable areas of community care that, if properly addressed, could improve healthcare quality for veterans.

## **Inspection Results**

### **Care Coordination: Congestive Heart Failure Management**

The OIG found that community-based outpatient clinic primary care providers managed patients with congestive heart failure in accordance with existing VHA guidance, including addressing elevated blood pressure, post-discharge follow-up, patient education, and medication reconciliation.

### **Primary and Mental Health Care: Diagnostic Evaluations**

The OIG determined that patients identified through screening to be at risk for depression or alcohol use disorder received further diagnostic evaluations in compliance with VHA requirements. The OIG also found that staff processed patients' referrals to specialty or mental health care in accordance with timeliness requirements.

### **Quality of Care: Home Dialysis Care**

The OIG determined that patients in the VA home dialysis program generally received care in accordance with requirements. However, VISN 15 facility dialysis clinicians who provided end-stage renal disease care did not consistently ensure that all outpatient dialysis patients had monthly visits. Additionally, VISN 15 facilities' dialysis staff did not ensure home visits were conducted to evaluate environmental safety and gauge patient adjustment to home dialysis. Key VISN leaders expressed a lack of awareness of VHA requirements.

Further, the OIG found that VISN leaders did not monitor the quality of home dialysis care and attributed this deficiency to a lack of communication between VA and non-VA providers and VA's national dialysis contract.

### **Women's Health: Mammography Care and Communication of Results**

The OIG team observed compliance with the required elements of performance including timely communication of mammography results to patients.

## **Conclusion**

The OIG conducted a review across four key clinical and administrative areas and issued three recommendations for improvement to the VISN 15 Network Director. The number of recommendations should not be used as a gauge for the overall quality of care provided in

VISN 15. The intent is for the Network Director and other leaders to use these recommendations to help guide improvements in their oversight of operations and clinical care.

### **VA Comments and OIG Response**

The VISN 15 Network Director agreed with the findings and recommendations and provided acceptable improvement plans (see appendix D, page 29, and the responses within the body of the report for the full text of the Network Director's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



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## Purpose and Scope

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

The OIG conducted this review of Veterans Integrated Service Network (VISN) 15: VA Heartland Network, which is responsible for oversight of the care provided by its associated medical facilities, CBOCs, and contracted providers.<sup>1</sup> This includes ensuring that care, treatment, and services are provided safely and effectively regardless of whether they are delivered by VA or non-VA providers.<sup>2</sup> Leaders make decisions that directly or indirectly affect every aspect of operations. They create policies and procedures and secure resources that support patient safety and the quality of care, treatment, and services.<sup>3</sup>

To examine the provision of care provided in community-based settings by VHA and contracted non-VA providers, the OIG focused on core processes in the following four areas of clinical and administrative operations:

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

The findings presented in this report are a snapshot of VISN 15 compliance with VHA requirements and The Joint Commission standards in identified focus areas from July 1, 2019, through June 30, 2020. The OIG reports these findings to VISN leaders so they can make informed decisions to improve care (see appendix A for OIG recommendations).

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<sup>1</sup> VHA administers healthcare services through a nationwide network of 18 regional offices referred to as Veterans Integrated Service Networks. Statement of Carolyn Clancy, MD, VHA Executive in Charge, before the House Committee on Veterans' Affairs, May 22, 2018, accessed July 1, 2021, <https://docs.house.gov/meetings/VR/VR00/20180522/108328/HHRG-115-VR00-Wstate-ClancyC-20180522.pdf>.

VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020. VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

<sup>2</sup> "Care, treatment, and services provided through contractual agreement are provided safely and effectively." The Joint Commission, *Standards Manual*, LD.04.03.09, July 2021.

<sup>3</sup> "The organization effectively manages its programs, services, or sites." The Joint Commission, *Standards Manual*, LD.04.01.05, July 2021.

## Background

### Veterans Integrated Service Networks

A VISN is a regional system of VHA healthcare facilities. VHA established 18 VISNs to meet local healthcare needs and provide greater access to care.<sup>4</sup> A VISN covers a geographic area defined by patient referral patterns, numbers of veteran beneficiaries and facilities needed to provide and support care, and boundaries such as state borders. Under the VISN model, care is provided at VA medical centers and CBOCs and through contractual or sharing agreements with non-VA providers. In VA’s healthcare system, the VISN is “the basic budgetary and planning” entity.<sup>5</sup>

In general, a VISN director is responsible for ensuring implementation of VA policies; providing leadership that supports and promotes delivery of comprehensive, coordinated care; and “ensuring all facilities in the VISN are adequately staffed and resourced” to “achieve national and local...performance and quality improvement goals.”<sup>6</sup>

VISN 15, the VA Heartland Network, includes sites in Arkansas, Illinois, Indiana, Kansas, Kentucky, and Missouri. This VISN serves over 209,000 enrolled veterans receiving care throughout seven medical facilities and 63 CBOCs or outreach clinics.<sup>7</sup> Prior to the COVID pandemic, the VISN spent over \$477M on non-VA care in FY 2019.

### Community-Based Outpatient Clinics

A CBOC is an outpatient site of healthcare services geographically located apart from a VHA medical facility and may be leased or owned by the VA. VHA uses CBOCs to make health care more accessible to veterans and reduce their need to visit a larger medical center for outpatient care.<sup>8</sup> CBOCs provide primary, specialty, and mental health care, or any combination of these, and operate from one to seven days per week.<sup>9</sup>

VHA classifies these remotely located clinics as primary care or multi-specialty CBOCs depending on the complexity, number, and types of services provided. Primary care CBOCs

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<sup>4</sup> “About VHA,” VHA, accessed July 23, 2020, <https://www.va.gov/health/aboutvha.asp>.

<sup>5</sup> Statement of Carolyn Clancy, MD, VHA Executive in Charge, before the House Committee on Veterans’ Affairs, May 22, 2018, accessed July 1, 2021, <https://docs.house.gov/meetings/VR/VR00/20180522/108328/HHRG-115-VR00-Wstate-ClancyC-20180522.pdf>.

<sup>6</sup> VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

<sup>7</sup> “About VA Heartland Network – VISN 15,” accessed March 24, 2022, <https://www.visn15.va.gov/about/index.asp>.

<sup>8</sup> “About VHA,” VHA; VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

<sup>9</sup> VHA Handbook 1006.02.

offer both medical and mental health care. Multi-specialty CBOCs deliver primary and mental health care as well as two or more specialty care services.<sup>10</sup> Additional details about the CBOCs within VISN 15 can be found in appendix B.

## Community Care

VHA leaders are responsible for providing oversight to ensure direct care, treatment, and services, including contracted services, are safe and effective. Patients should receive the same level of care regardless of whether it is delivered by VA or non-VA providers.<sup>11</sup>

In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated VA community care programs into the Veterans Community Care Program.<sup>12</sup> This program simplified veterans' access to non-VA care by expanding eligibility criteria, creating a single non-VA care program, improving customer service, and providing a way for patients to receive walk-in care without prior authorization.<sup>13</sup>

The goal of VHA's Office of Community Care (OCC) is to deliver a single, established program that is "easy to understand, simple to administer, and meets the needs of veterans, their families, community providers, and VA staff."<sup>14</sup> VHA facility providers may refer care to non-VA providers for eligible veterans who choose care in the community. This option may also help VHA leaders ensure timely treatment or allow access to procedures that may not be available through VHA providers.<sup>15</sup> VHA's OCC's *Field Guidebook* outlines the requirements, processes, and tools related to eligibility, referral, and care coordination and provides guidance for VA staff managing non-VA care consults, appointment scheduling, and communication between VA and non-VA providers.<sup>16</sup>

The ordering provider initiates the non-VA care referral process by placing a consult request for care. OCC staff then determine if the care is available at VHA or the veteran is eligible for referral to an accessible non-VA provider.<sup>17</sup> Depending on VHA facility operations and patient preference, appointments may be scheduled by

- OCC staff,
- the patient,

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<sup>10</sup> VHA Handbook 1006.02.

<sup>11</sup> *Standards Manual*, LD.04.03.09.

<sup>12</sup> The VA MISSION Act of 2018, Pub. L. No. 115-182 (2018).

<sup>13</sup> VHA OCC, "Veteran Community Care General Information," September 9, 2019.

<sup>14</sup> VHA OCC, *Field Guidebook*, chap. 1: "Introduction to the Community Care Network," updated July 1, 2021.

<sup>15</sup> VHA OCC, *Field Guidebook*, chap. 1; The VA MISSION Act of 2018, Pub. L. No. 115-182 (2018).

<sup>16</sup> VHA OCC, *Field Guidebook*.

<sup>17</sup> VHA OCC, *Field Guidebook*, chap. 2: "Eligibility, Referral, and Scheduling," updated July 12, 2021.

- the community provider,
- third-party administrator staff, or
- any combination of these.<sup>18</sup>

When patients schedule appointments for themselves directly with community providers, OCC staff instruct the patients to contact them with the date and time of the appointment. If a patient does not provide the appointment date, OCC staff are not required to contact the patient to obtain the appointment information. In that event, OCC staff wait 30 days from the date the patient elected to self-schedule, and then contact the community provider to obtain and record the appointment information.<sup>19</sup> Patients' self-scheduled appointments are excluded from certain VHA timeliness reporting requirements; for example, when consults are in an active status for longer than 30 days.<sup>20</sup>

Non-VA providers are responsible for sending medical record documentation to ordering providers within 30 days of completed appointments. Non-VA providers can return the documentation through a variety of methods, including the fee-basis claim system, the Health Share Referral Manager platform, a third-party administrator's portal, electronic fax or other electronic means, or through the mail. OCC staff review the multiple locations for the returned documentation and attach it to the relevant consult in a patient's electronic health record, which creates an alert notifying the ordering provider that the consult was completed.<sup>21</sup>

VHA does not require receipt of clinical documentation for closure of the community care consult.<sup>22</sup> Although VHA expects OCC staff to work with community providers to ensure documentation is received for the patient's electronic health record, it allows OCC staff to close community care consults without documentation of care provided. If OCC staff have not received medical record documentation from the non-VA provider after 14 days of the initial scheduled appointment, they will contact the patient to confirm attendance of the appointment and then attempt to retrieve the records of care provided.<sup>23</sup>

VHA requires OCC staff to make three attempts to obtain medical documentation from the community provider and document this in the electronic health record. They may close a consult after making only one attempt but must make the subsequent attempts within 90 days. If OCC staff are unable to obtain the medical documentation, they close the consult and note it as "administratively closed without documentation." According to VHA OCC leaders,

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<sup>18</sup> VHA OCC, *Field Guidebook*, chap 3: "How to Perform Care Coordination."

<sup>19</sup> VHA OCC, *Field Guidebook*, chap 3.

<sup>20</sup> VHA OCC, *Field Guidebook*, chap 3.

<sup>21</sup> VHA OCC, *Field Guidebook*, chap 3.

<sup>22</sup> VHA OCC, *Field Guidebook*, chap 4: "Consult Completion and Medical Records Management."

<sup>23</sup> VHA OCC, *Field Guidebook*, chap 4.

“administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation [are] expected to ensure continuity of care” even though OCC staff must close the consult within 90 days of the patient’s appointment.<sup>24</sup>

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<sup>24</sup> VHA OCC, *Field Guidebook*, chap 4.

## Methodology

The OIG conducted a virtual review of VISN 15 from June 22 through June 30, 2021.<sup>25</sup> The inspection team examined operations during the study period of July 1, 2019, through June 30, 2020. During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

To determine compliance with VHA requirements, the OIG inspection team sampled electronic health records of patients receiving care provided by VA and non-VA clinicians in the community for each of the four focus areas of clinical care reviewed. The OIG evaluated electronic health records and reviewed pertinent VISN administrative and performance measure data. The OIG team interviewed relevant VISN leaders and program staff and discussed oversight processes, validated electronic health record review findings, and inquired about reasons for noncompliance. In determining the quality of non-VA dialysis care, the OIG was unable to evaluate patients' electronic health records because they lacked documentation from non-VA clinicians. As a result, the OIG team interviewed available patients accepted by non-VA home dialysis programs to assess for their perceptions of the quality of their care.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>26</sup> The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the VISN leader completes corrective actions. The VISN 15 Network Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the Network Director developed based on the reasons for noncompliance.

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

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<sup>25</sup> The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. COVID-19 is caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)." "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," WHO, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it).

<sup>26</sup> Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

## Results and Recommendations

### Care Coordination: Congestive Heart Failure Management

Congestive heart failure (CHF) is a condition that results when the heart is unable to effectively pump blood to meet physiologic needs. When blood does not circulate as it should, fluid can accumulate throughout the body.<sup>27</sup> As a chronic disease, CHF is projected to affect more than 8 million people in the United States by 2030. Because CHF is a leading cause of VA hospital admissions, VA has established evidence-based guidelines for its treatment with the goal of veterans living a longer and better quality of life.<sup>28</sup>

VHA primary care providers may refer patients with CHF to cardiologists or heart failure clinics for management of their conditions. Monitoring a patient's daily weight, blood pressure, and heart function is important in managing the signs and symptoms of CHF.<sup>29</sup> VHA requires providers to document essential and relevant information, including their medication review and reconciliation, in the patient's electronic health record.<sup>30</sup> Additionally, medication reconciliation is a top patient safety priority and ensures patients and healthcare teams have an accurate list of medications at treatment transition points.<sup>31</sup>

To determine whether providers complied with selected requirements for care coordination for patients with CHF, the inspection team reviewed 88 randomly selected electronic health records of patients who had at least two primary care visits at a VISN 15 CBOC during the study period and were diagnosed with CHF at least one year prior to the study period.

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

- Post-discharge contact following a VHA inpatient stay
- Use of alternative care modalities<sup>32</sup>
- Medication reconciliation

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<sup>27</sup> "Heart Failure," National Heart Lung and Blood Institute, accessed September 23, 2020, <https://www.nhlbi.nih.gov/health-topics/heart-failure>.

<sup>28</sup> "Managing Heart Failure in Primary Care," VHA Pharmacy Benefits Management (PBM) Academic Detailing Service, accessed July 7, 2021, [https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic\\_Detailing\\_Educational\\_Material\\_Catalog/HeartFailure\\_Provider\\_ProviderGuide\\_IB101161.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/HeartFailure_Provider_ProviderGuide_IB101161.pdf); "Heart Failure," National Heart Lung and Blood Institute.

<sup>29</sup> "Managing Heart Failure in Primary Care," VHA PBM Academic Detailing Service.

<sup>30</sup> VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

<sup>31</sup> "Medication Reconciliation to Prevent Adverse Drug Events," Institute for Healthcare Improvement, accessed September 23, 2020, <https://www.ihl.org/topics/ADEsMedicationReconciliation/Pages/default.aspx>.

<sup>32</sup> Alternative care modalities include coordinated care home telehealth and home-based primary care.

- Patient education on home care and monitoring<sup>33</sup>
- Monitoring and interventions for hypertension
- Referrals to non-VA providers for specialty care
- Communication of results to the ordering provider<sup>34</sup>

### **Care Coordination Findings and Recommendations**

VISN 15 CBOC providers delivered care that generally met the requirements listed above. The OIG made no recommendations.

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<sup>33</sup> Examples of home care and monitoring include measuring daily weights, avoiding fluid overload, and restricting fluid and sodium intake.

<sup>34</sup> “Managing Heart Failure in Primary Care,” VHA Pharmacy Benefits Management (PBM) Academic Detailing Service.

## Primary and Mental Health Care: Diagnostic Evaluations

Patient Aligned Care Team (primary care) staff screen veterans for various “conditions or risky health behaviors” such as cancer, tobacco and alcohol use, immunizations, suicide risk, and depression.<sup>35</sup> They conduct health education and refer veterans to specialty care when clinically indicated.<sup>36</sup> Comprehensive primary care ensures veterans have access to the health care they need to maintain or improve their quality of life.<sup>37</sup> Clinical preventive services are part of comprehensive primary care and are used for early recognition of disease in persons without symptoms to prevent or reduce risks of illness or death.<sup>38</sup>

### Diagnostic Evaluation of Patients at Risk for Depression

Depression is “one of the most common mental disorders in the United States” and can cause sadness, loss of energy or interest in activities, withdrawal from interactions with other people, feelings of hopelessness, and thoughts of suicide.<sup>39</sup> VHA requires annual depression screenings for patients receiving primary or mental health care.<sup>40</sup> At the time of this OIG review, VHA required staff to complete a suicide risk screening when a patient’s depression screen was positive.<sup>41</sup> If either screening was positive, VHA required a provider to perform a diagnostic evaluation and refer the patient to a specialty or mental health care provider if warranted.<sup>42</sup>

To determine if providers complied with selected requirements for diagnostic evaluations for positive depression screenings, the OIG team reviewed 99 randomly selected electronic health records of VISN 15 CBOC patients who screened positive for depression.<sup>43</sup>

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<sup>35</sup> VHA Handbook 1101.10(1); VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 3.0, April 2016.

<sup>36</sup> VHA Handbook 1101.10(1).

<sup>37</sup> VHA Handbook 1101.10(1).

<sup>38</sup> VHA Handbook 1101.10(1).

<sup>39</sup> “VA Research on Depression,” VA Office of Research & Development, September 2016, accessed September 1, 2021, [https://www.research.va.gov/pubs/docs/va\\_factsheets/Depression.pdf](https://www.research.va.gov/pubs/docs/va_factsheets/Depression.pdf).

<sup>40</sup> *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 3.0, April 2016.

<sup>41</sup> VA Product Development, *Veterans Health Information Systems and Technology Architecture (VistA) Clinical Reminders, MH Reminder Updates, Installation and Setup Guide*, February 2017.

<sup>42</sup> *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 3.0; VHA Handbook 1160.01.

<sup>43</sup> These patients had screened positive (score of  $\geq 3$ ) on PHQ2 at any CBOC in VISN 15 during a primary care visit occurring between July 1, 2019, through June 30, 2020, and did not have a positive depression screening in the prior 3 years from the positive screen date. In this study, primary care visits are those with stop codes of 323 or 338. If a patient had more than one positive screen during the study period, the first occurrence was used for the review.

The OIG evaluated the following components required for positive depression screenings:

- Primary care providers conducted diagnostic evaluations in response to positive depression screenings.
- Primary care providers conducted suicide risk evaluations if suicide risk screenings were positive.
- Patients referred to specialty or mental health providers had appointments scheduled within 30 days.<sup>44</sup>

### **Diagnostic Evaluation of Patients at Risk for Alcohol Use Disorder**

Excessive drinking is associated with multiple health problems including chronic diseases and unintentional injuries, as well as homicide, suicide, and various other disorders.<sup>45</sup> VHA requires alcohol use disorder screening for new patients and annual screenings for established patients.<sup>46</sup> If a patient's screening is positive, and they are identified as being at risk for alcohol use disorder, VHA requires the provider to conduct a diagnostic evaluation and ensure the provision of education or counseling.<sup>47</sup>

To determine whether VISN 15 CBOC providers complied with selected requirements for diagnostic evaluations for positive alcohol use disorder screenings, the OIG team reviewed 94 randomly selected electronic health records of patients who screened positive for alcohol use disorder.<sup>48</sup>

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

- Primary care providers completed diagnostic evaluations in response to positive screenings.
- Diagnostic evaluations included education and counseling regarding drinking limits and adverse consequences of heavy drinking.

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<sup>44</sup> VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020; VHA Handbook 1160.01; VA Product Development, *Veterans Health Information Systems and Technology Architecture (Vista) Clinical Reminders, MH Reminder Updates, Installation and Setup Guide; VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, version 3.0.

<sup>45</sup> "Alcohol Questions and Answers," Centers for Disease Control and Prevention, accessed August 26, 2020, <https://www.cdc.gov/alcohol/faqs.htm>.

<sup>46</sup> VHA Handbook 1160.01.

<sup>47</sup> VHA Handbook 1160.01.

<sup>48</sup> These patients had screened positive (score of  $\geq 5$ ) on AUDIT-C at any CBOC in VISN 15 during a primary care visit occurring between July 1, 2019, through June 30, 2020, and did not have a positive alcohol use disorder screening in the prior 3 years from the positive screen date. In this study, primary care visits are those with stop codes of 323 or 338. If a patient had more than one positive screen during the study period, the first occurrence was used for the review.

- Patients referred to specialty or mental health providers had appointments scheduled within 30 days.<sup>49</sup>

## **Primary and Mental Health Care: Diagnostic Evaluations Findings and Recommendations**

The OIG found that CBOC primary care providers provided diagnostic evaluations of patients at risk for depression or suicide, and patients referred for care by VA or non-VA specialty or mental health providers had appointments scheduled within the required time frame. The OIG did not identify deficiencies or issue recommendations regarding follow-up care for positive depression screenings.

The OIG also found that VISN 15 CBOC providers completed diagnostic evaluations of patients who were at risk for alcohol use disorder and generally met the remaining requirements listed above. The OIG made no recommendations.

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<sup>49</sup> VHA Handbook 1160.01.

## Quality of Care: Home Dialysis Care

Home dialysis provided by VHA offers advantages over in-center (VA and non-VA) dialysis, which include increased ability to deliver care to veterans with end-stage renal disease, especially when patients live far from VA medical centers. Costs may also be lower than contracted dialysis service, and patients may experience improved quality of life with “greater survival and fewer hospitalizations.”<sup>50</sup> All VHA dialysis programs must offer home dialysis to medically qualified patients with end-stage renal disease.<sup>51</sup> Additionally, VHA requires

VISN directors [to] convene a VISN Dialysis Council...with Dialysis Program representation from each VA medical facility in the VISN for the purpose of promoting efficient, high quality dialysis care within the VISN, coordinating the VISN operations of dialysis initiatives, harmonizing dialysis care within VISNs, and enhancing communication related to dialysis to/from VA facilities, non-VA dialysis facilities, VISN leadership, and the VHA National Kidney Program.<sup>52</sup>

VHA also requires all dialysis outpatients to be seen at least monthly by a clinician who provides end-stage renal disease care, evidenced by a monthly progress note “endorsed by the responsible independent renal practitioner.”<sup>53</sup> Additionally, a VHA home dialysis program must provide the following services:

- Patient training by a dialysis registered nurse
- Patient monitoring (patient’s self-monitoring data and a clinical exam) at least every two months
- Ongoing medical, nursing, nutritional, and social work support services, as needed
- Initial and periodic (at least annual) home visits<sup>54</sup>
- Provision of all necessary disposable supplies and dialysis devices approved by the U.S. Food and Drug Administration
- Regular monitoring of water quality in the case of home hemodialysis<sup>55</sup>

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<sup>50</sup> Areef Ishani et al., *Comparative Effectiveness of Home-based Kidney Dialysis versus In-center or Other Outpatient Kidney Dialysis Locations - A Systematic Review*, Department of Veterans Affairs Health Services Research & Development Service, Evidence-based Synthesis Program, April 2015.

<sup>51</sup> VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs*, May 23, 2016.

<sup>52</sup> VHA Handbook 1042.01.

<sup>53</sup> The clinician should be “a physician, nurse practitioner, clinical nurse specialist, or physician’s assistant.” VHA Handbook 1042.01.

<sup>54</sup> VHA requires staff to conduct home visits prior to accepting patients into the home dialysis program (initial) and then at least annually to assess the environmental safety in patients’ homes and their adjustment to home dialysis. VHA Handbook 1042.01.

<sup>55</sup> VHA Handbook 1042.01.

When VHA facilities are incapable of furnishing the above care and services due to geographic inaccessibility or lack of a VHA home dialysis program, staff must offer veterans access to home dialysis through the Veterans Community Care Program.<sup>56</sup> The non-VA provider is then responsible for patient training, monitoring, and support services, and “VA is responsible for monitoring the contracted clinical services.”<sup>57</sup>

VHA does not require non-VA dialysis providers to submit documentation of ongoing care. The VHA National Program Director for Kidney Disease and Dialysis described that the Centers for Medicare & Medicaid Services established the requirements for non-VA dialysis care, and VHA does not require non-VA dialysis providers to send their medical documentation to VA. However, the National Program Director also stated that VHA providers can request it, for example, in response to a patient’s complaint about non-VA dialysis care.

To determine if the VISN 15 home dialysis program complied with requirements, the OIG team reviewed electronic health records of all 27 home dialysis patients who were managed by VHA providers. Specific to the requirement for annual home visits, the OIG reviewed electronic health record documentation during the prior 27-month period for evidence of periodic reassessments of the patients’ environment and adjustment to home dialysis.<sup>58</sup> Six of the 27 patients were accepted into the VISN 15 home dialysis program during the study period, and their care required an initial home visit. Of the remaining 21 patients, 13 had been in the program multiple years and required annual home visits.<sup>59</sup>

The OIG also reviewed electronic health records for all 15 patients managed by non-VA dialysis providers during the study period and was unable to determine the quality of non-VA dialysis care because the records lacked the non-VA providers’ documentation. As a result, the OIG team interviewed 7 of the 15 home dialysis patients to assess their perceptions of the quality of their care.<sup>60</sup>

## Quality of Care Findings and Recommendations

The OIG determined that clinicians who provided end-stage renal disease care to patients in VISN 15’s home dialysis program generally met requirements for training, monitoring, and

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<sup>56</sup> VHA Handbook 1042.01.

<sup>57</sup> VHA Handbook 1042.01.

<sup>58</sup> For patients who had been in the VISN 15 home dialysis program long enough to warrant annual home visits, the OIG reviewed electronic health record documentation for two years prior to the beginning of the inspection’s study period and allowed a grace period of three months, from April 1, 2017, to July 1, 2019.

<sup>59</sup> Eight patients had not been in the VISN 15 home dialysis program long enough to require recurring annual visits.

<sup>60</sup> The OIG made two attempts to contact patients by telephone. Four of the 15 patients were deceased and thus excluded, and 4 either did not respond to the OIG’s calls or voice messages or declined to provide information.

ongoing support, including provision of equipment and supplies. However, the OIG found deficiencies with monthly clinician visits and home visits for patient safety.

VHA requires providers of end-stage renal disease care to see all dialysis outpatients at least monthly, with documentation in a progress note “endorsed by the responsible independent renal practitioner.”<sup>61</sup> According to the VHA National Program Director for Kidney Disease and Dialysis, patients meet with the care team, including the end-stage renal disease provider and home dialysis nurse, on a monthly basis either in-person or by a telehealth appointment. Further, the director clarified that the monthly note is required for documenting medical care, and a home dialysis nursing note alone would not meet the requirement.

The OIG found that for patients in the VISN 15 home dialysis program, 16 of the 27 electronic health records (59 percent) lacked evidence that a renal provider documented care monthly, and 9 of 27 (33 percent) had progress notes that were completed by the home dialysis nurse in the absence of the renal provider’s notes. As a result, VISN 15 leaders could not ensure provision of high-quality medical dialysis care when there were gaps in care delivery by renal providers.

After discussions with VISN 15 leaders and home dialysis program staff, the OIG determined they were not aware of the VHA requirement. The leaders expressed that they were aware of a Centers for Medicare & Medicaid Services requirement to conduct and document monthly visits but believed it did not apply to VHA care. Regarding the nurse’s progress notes when the renal provider did not document medical care, VISN 15 leaders stated that renal providers had a high degree of confidence in the home dialysis nurse’s abilities and that the provider and nurse would see a patient together and the nurse would document the care provided.

## **Recommendation 1**

1. The VISN 15 Network Director ensures that an end-stage renal disease provider sees patients enrolled in the home dialysis program at least monthly, as evidenced by a progress note placed in the medical record and endorsed by the responsible independent renal practitioner.

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<sup>61</sup> VHA Handbook 1042.01.

VISN 15 concurred.

Target date for completion: February 1, 2023

VISN 15 response: The reasons for noncompliance were considered when developing the action plan. The VISN 15 Dialysis Committee developed an audit tool to monitor that the end-stage renal disease provider sees patients enrolled in the home dialysis program at least monthly, as evidenced by a progress note placed in the medical record and endorsed by the responsible independent renal practitioner. Updates and progress to goal will be reported [to] the Network Director during the Quality, Safety, and Value Council [meeting] on a quarterly basis.

Compliance will be monitored until a benchmark of 90% is met for six consecutive months.

Table 1 presents the OIG’s findings related to VISN 15 compliance with VHA requirements and patients’ reports of the quality of home dialysis care provided by non-VA providers.

**Table 1. Comparison of VISN 15 and Non-VA Compliance with Home Dialysis Program Requirements**

Requirement	VA Care*	Non-VA Care
Training by a registered nurse	6 of 27 patients began home dialysis during the study period and all 6 (100 percent) received training by a registered nurse	7 of 7 patients (100 percent) confirmed training by a registered nurse
Review of patient’s self-monitoring data at least every two months	26 of 27 patients (96 percent) had their self-monitoring data reviewed at least every two months	7 of 7 patients (100 percent) reported their self-monitoring data were reviewed at least every two months
Clinical support when needed	27 of 27 patients (100 percent) had clinical support documented in their electronic health records	7 of 7 patients (100 percent) reported receiving clinical support when needed
Home visit—prior to acceptance into the home dialysis program	4 of 6 patients (67 percent) received a home visit prior to acceptance into the program‡	7 of 7 patients (100 percent) reported receiving a home visit prior to acceptance into the program
Home visit—annual	0 of 13 patients (0 percent) received an annual home visit§	6 of 7 patients (86 percent) reported receiving an annual home visit
Provision of supplies and equipment	27 of 27 patients’ electronic health records (100 percent) had documented provision of supplies and equipment by the VISN 15 home dialysis program	7 of 7 patients (100 percent) confirmed provision of supplies and equipment by the non-VA home dialysis program

Source: VA OIG.

\*The OIG determined these results based on a review of patients’ electronic health records for evidence of VHA requirements met or not met from July 1, 2019, through June 30, 2020.

The OIG determined these results based on patient interviews because there was no non-VA provider documentation available in the electronic health records. In interviews, the OIG did not restrict patients’ responses to the study period.

‡The OIG evaluated these visits for patients accepted into the VISN home dialysis program during the study period.

§The OIG evaluated this visit for patients accepted into the VISN home dialysis program for a time period long enough to require an annual visit.

VHA requires home dialysis program staff to ensure an initial home visit is made prior to accepting a patient into the home dialysis program and annually thereafter. However, VHA does not require program staff to make the visit; it may be accomplished through other means such as visiting nurses assessing patients’ environmental safety and providing reports to the dialysis

program staff.<sup>62</sup> The OIG found that in the VISN 15 home dialysis program, 15 of the 19 patients (79 percent) did not receive home visits as required.<sup>63</sup> Additionally, one of seven patients (14 percent) in non-VA home dialysis programs reported not receiving home visits. Home visits are essential to confirm environmental safety and patients' adjustment to home dialysis. The OIG determined that VISN 15 leaders could not ensure efficient, high-quality dialysis care because staff did not make certain home visits were conducted as required.

Leaders in VISN 15 and its home dialysis program staff reported believing that the VHA requirement allowed the initial home visit to occur after acceptance into the program, stating that time required for a visit prior to acceptance could delay the start of home dialysis. They further explained that staff making a visit after the patient began home dialysis allowed them to assess the patient's training needs. However, the VHA National Program Director for Kidney Disease and Dialysis stated that home visits are to be made while the patient is being evaluated for home dialysis to confirm that they are not homeless, verify space is available to safely perform dialysis, and ensure adequate storage space for supplies and equipment.

## Recommendation 2

2. The VISN 15 Network Director makes certain that staff ensure home visits are performed prior to accepting patients into the home dialysis program, and at least annually thereafter.

VISN 15 concurred.

Target date for completion: February 1, 2023

VISN 15 response: The reasons for noncompliance were considered when developing the action plan. The VISN 15 Dialysis Committee developed an audit tool to monitor that staff ensure home visits are performed prior to accepting patients into the home dialysis program and at least annually thereafter. Updates and progress to goal will be reported [to] the Network Director during the Quality, Safety, and Value Council [meeting] on a quarterly basis. Compliance will be monitored until a benchmark of 90% is met for six consecutive months.

When VHA facilities cannot offer home dialysis services due to geographic inaccessibility or lack of a home dialysis program, providers must offer veterans access to home dialysis through non-VA providers. VA is then responsible for monitoring the contracted dialysis services.<sup>64</sup> Without medical documentation from non-VA dialysis providers available to review, the OIG

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<sup>62</sup> VHA Handbook 1042.01.

<sup>63</sup> Six patients were accepted into the VISN 15 home dialysis program during the study period and their care required an initial home visit. Thirteen patients had been in the program multiple years and required annual home visits.

<sup>64</sup> VHA Handbook 1042.01.

team assessed complications potentially related to quality of contracted home dialysis by reviewing electronic health records that were available from other non-VA sources, such as care provided during outside hospital stays or emergency department visits.<sup>65</sup> The OIG found that although these records were incorporated into patients' electronic health records, there was no evidence that VISN facilities' renal clinicians were aware of the complications.

The OIG team inquired whether VISN 15 leaders were aware of these complications and, if so, whether they raised concerns about the quality of care from non-VA dialysis providers. VISN 15 leaders stated they were not aware of the complications but expressed an interest in knowing when these events occurred. Leaders also explained that they did not receive communication about patient care from non-VA dialysis providers and attributed this to dialysis contractual agreements.

The OIG determined that clinicians at VISN 15 facilities referred patients to non-VA home dialysis programs without having internal processes to monitor the quality of clinical services. Additionally, non-VA providers' lack of care documentation hindered VISN 15 leaders from being able to monitor the quality of care delivered.

The OIG is concerned that VHA's referring clinicians were unaware of complication events and thus not monitoring the quality of non-VA home dialysis services. As a result, clinicians could not respond effectively to coordinate care needs or reassess the appropriateness of home dialysis.

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<sup>65</sup> "Peritoneal dialysis is a treatment for kidney failure that uses the lining of [the] abdomen, or [the] belly, to filter blood inside [the] body. Health care providers call this lining the peritoneum." Potential complications associated with peritoneal dialysis include peritonitis (an infection of the patient's body fluid) or a hernia (an area of weakness in the abdominal muscle). "Peritoneal Dialysis," National Institute of Diabetes and Digestive and Kidney Diseases, accessed April 29, 2021, <https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/peritoneal-dialysis#problems>.

### Recommendation 3

3. The VISN 15 Network Director ensures VISN leaders and clinicians monitor the quality of contracted clinical services for patients receiving non-VA home dialysis services.

VISN 15 concurred.

Target date for completion: March 1, 2023

VISN 15 response: The reasons for noncompliance were considered when developing the action plan. The VISN 15 Community of Care Committee will develop a reporting tool to monitor the quality of contracted clinical services for patients receiving non-VA home dialysis services. Monitoring will be accomplished by audit of medical records of Veterans receiving home dialysis through non-VA community providers. The audit will assess whether Veterans receiving home dialysis services received/are receiving an initial home visit from the vendor prior to initiation of home dialysis services, annual home visit[s], and monthly nephrology oversight. Initially, a sample (20%) of Veterans who have been receiving home dialysis from non-VA community providers for greater than two years (as of March 1, 2022) will have their medical records audited to ensure that they have received an annual home visit from the vendor in the prior 12-16 months (target for compliance = 90%). Updates and progress to goal will be reported to the Network Director during the Quality, Safety, and Value Council [meeting] on a quarterly basis. Compliance will be monitored until reporting is met for two consecutive quarters.

## Women’s Health: Mammography Services by Non-VA Providers

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment in all VA medical facilities. Every site of care in the VA healthcare system must provide women’s health services; however, not every site provides mammography services.<sup>66</sup> For these locations, patients are referred to non-VA mammography providers.

VHA established timeliness requirements applicable to VA and non-VA providers regarding notification of mammography results to ordering providers and patients. When a mammogram result is negative (normal), a report must be communicated to the ordering provider in writing within 30 days of the procedure.<sup>67</sup> VHA then requires the ordering provider (or designee) to “communicate the results of normal mammograms completed in-house or through contract or non-VA care to the patient within 14-calendar days of receiving the results.”<sup>68</sup>

Reports of positive (abnormal) mammography results should include a recommended course of action and must be communicated to the ordering provider as soon as possible (defined by VHA as being no more than 7 calendar days), followed by a written report within 30 days of the procedure date. The ordering provider must then communicate abnormal results to the patient within 7 calendar days from the date of receipt.<sup>69</sup> VHA requires the ordering provider to document the communication of the mammography results to the patient in the electronic health record.<sup>70</sup>

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<sup>66</sup> VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017, amended July 24, 2018, and further amended on June 29, 2020, as VHA Directive 1330.01(3). This directive was in effect during the period for documents reviewed in this report (July 1, 2019, through June 30, 2020). The directive was further amended on January 8, 2021, as VHA Directive 1330.01(4). The documents contain similar language regarding notification time frame requirements.

<sup>67</sup> VHA Directive 1330.01(3).

<sup>68</sup> In this report, a negative result is a normal result. VHA Directive 1330.01(3).

<sup>69</sup> According to the Food and Drug Administration, a “positive mammogram” refers to a mammogram with an overall assessment of findings that are either “suspicious” or “highly suggestive of malignancy.” “Mammography Quality Standards Act Regulations,” Food and Drug Administration, accessed July 6, 2021, <https://www.fda.gov/radiation-emitting-products/regulations-mqsa/mammography-quality-standards-act-regulations>. In this report, a positive result is considered an abnormal result. VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018. VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. This directive was in effect during the period for documents reviewed in this report (July 1, 2019, through June 30, 2020). It was amended on January 24, 2022, to VHA Directive 1088(1). The two directives contain the same language regarding communication of mammography results to patients within 7 calendar days.

<sup>70</sup> VHA Directive 1088; VHA Directive 1105.03.

To determine compliance with VHA requirements, the OIG reviewed documentation for 80 randomly selected patients who received non-VA mammography referrals and had the procedures performed during the study period (July 1, 2019, through June 30, 2020). The OIG evaluated the following requirements:

- Completeness of mammography reports
  - Patient name and identifier
  - Non-VA provider name with signature<sup>71</sup>
  - Procedure date
  - Recommendations for further action and follow-up if indicated
- Linking of mammography reports into the electronic health record<sup>72</sup>
- Communication of normal or abnormal results within required time frames<sup>73</sup>

## Women's Health Findings and Recommendations

The OIG found that community-based mammography results were complete, linked to orders in the patient's electronic health record, with generally timely communication of results to VA ordering providers and patients. The OIG had no findings or recommendations regarding mammography services by non-VA providers.

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<sup>71</sup> VHA Directive 1105.03.

<sup>72</sup> "If reports are received on paper, they must be scanned into VistA [Veterans Health Information Systems and Technology Architecture] Imaging and linked to an administrative report in VistA/CPRS [Computerized Patient Record System]. Patient reports must be incorporated into VistA either by software modifications or by scanning a copy of the paper report into VistA Imaging and associating it with an order for an outside radiology procedure in CPRS." For this report, the OIG considered the term *linking* to be associating the report with an order for an outside radiology procedure and incorporating the report into the patient's VHA electronic health record, and that *linking* was achieved by scanning a hard copy or using software modifications. VHA Directive 1105.03.

<sup>73</sup> VHA Directive 1105.03; VHA Directive 1330.01(3); VHA Directive 1088.

## Report Conclusion

The OIG conducted this review of the VISN 15: VA Heartland Network, which is responsible for oversight of the care provided by its associated medical facilities, CBOCs, and contracted providers. This focused review was accomplished by examining key clinical and administrative processes associated with quality care and positive patient outcomes.

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

While the OIG's recommendations do not reflect the caliber of services delivered in the community by VHA and non-VA providers, they illuminate areas of concern and provide a road map for improvement. A summary of OIG recommendations is presented in appendix A.

## Appendix A: Care in the Community Recommendations

The table below outlines three OIG recommendations attributable to the VISN 15 Network Director. The intent is for the Network Director and other leaders to use the recommendations to help improve operations and clinical care. The recommendations address systems' issues that may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of OIG Recommendations**

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Congestive Heart Failure	<ul style="list-style-type: none"> <li>• Post-discharge contact following a VHA inpatient stay</li> <li>• Alternative care modalities</li> <li>• Medication reconciliation</li> <li>• Patient education on home care and monitoring</li> <li>• Hypertension monitoring and interventions</li> <li>• Referrals to non-VA specialty care providers</li> <li>• Communication of results to the ordering provider</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Primary and Mental Health Care: Diagnostic Evaluations	<ul style="list-style-type: none"> <li>• Diagnostic evaluations in response to positive depression or alcohol use disorder screenings</li> <li>• Diagnostic evaluations include all required elements</li> <li>• Timeliness of scheduling referrals to specialty providers</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality of Care: Home Dialysis Care	<ul style="list-style-type: none"> <li>• Patient training</li> <li>• Periodic patient monitoring</li> <li>• Support services included required elements</li> <li>• Monitoring of contracted home dialysis service</li> </ul>	<ul style="list-style-type: none"> <li>• An end-stage renal disease provider sees patients enrolled in the home dialysis program at least monthly, as evidenced by a progress note placed in the medical record and endorsed by the responsible independent renal practitioner.</li> <li>• Staff ensure home visits are performed prior to accepting patients into the home dialysis program, and at least annually thereafter.</li> <li>• VISN leaders and clinicians monitor the quality of contracted clinical services for patients receiving non-VA home dialysis services.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Women's Health: Mammography Services by Non-VA Providers	<ul style="list-style-type: none"> <li>• Completeness of mammography reports</li> <li>• Linking of community mammography reports into the electronic health record</li> <li>• Communication of normal or abnormal results within required time frames</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

## Appendix B: VA Outpatient Clinic Profiles

Table B.1 provides information relative to each of the VISN 15 clinics.<sup>1</sup>

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

Location	Station No.	VHA Site Tracking Classification	Classification (Urban/Rural/Highly Rural)	Outpatient Encounters	Community Care Referrals
Warrensburg, MO	589G1	Multi-Specialty CBOC	Rural	18,241	1,620
Dodge City, KS	589G2	Primary Care CBOC	Rural	6,321	2,907
Hays, KS	589G4	Primary Care CBOC	Rural	8,553	2,920
Parsons, KS	589G5	Primary Care CBOC	Rural	8,403	2,512
Hutchinson, KS	589G7	Primary Care CBOC	Rural	12,737	1,120
Jefferson City, MO	589G8	Multi-Specialty CBOC	Urban	19,318	929
Belton, MO	589GB	Primary Care CBOC	Urban	21,723	510
Paola, KS	589GC	Primary Care CBOC	Rural	5,455	363
Nevada, MO	589GD	Primary Care CBOC	Rural	10,194	1,492
Kirksville, MO	589GE	Primary Care CBOC	Rural	6,392	1,200
Waynesville, MO	589GF	Primary Care CBOC	Rural	19,671	1,898
Osage Beach, MO	589GH	Primary Care CBOC	Rural	10,991	2,032
St. Joseph, MO	589GI	Primary Care CBOC	Urban	9,718	601
Kansas City, KS	589GJ	Primary Care CBOC	Urban	5,583	135

<sup>1</sup> Table B.1. includes all outpatient clinics in the community that were in operation as of July 1, 2019. An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.” VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

Location	Station No.	VHA Site Tracking Classification	Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Junction City, KS	589GR	Primary Care CBOC	Rural	20,253	2,113
Lawrence, KS	589GU	Primary Care CBOC	Urban	3,609	360
Fort Scott, KS	589GV	Primary Care CBOC	Rural	3,304	478
Salina, KS	589GW	Primary Care CBOC	Rural	19,008	4,164
Mexico, MO	589GX	Primary Care CBOC	Rural	8,097	831
St. James, MO	589GY	Primary Care CBOC	Rural	7,925	887
Sedalia, MO	589JA	Primary Care CBOC	Rural	9,646	1,533
Excelsior Springs, MO	589JB	Primary Care CBOC	Rural	14,660	412
Marshfield, MO	589JD	Primary Care CBOC	Rural	12,258	3,558
Platte City, MO	589JE	Primary Care CBOC	Rural	4,694	611
Kansas City, MO	589JF	Primary Care CBOC	Urban	68,174	2,261
Shiloh, IL	657GA	Primary Care CBOC	Urban	18,475	896
Florissant, MO	657GB	Primary Care CBOC	Urban	18,785	837
O'Fallon, MO	657GD	Primary Care CBOC	Urban	18,829	945
West Plains, MO	657GF	Primary Care CBOC	Rural	17,865	7,657
Paragould, AR	657GG	Primary Care CBOC	Rural	8,419	1,928
Cape Girardeau, MO	657GH	Primary Care CBOC	Urban	22,164	5,235
Farmington, MO	657GI	Primary Care CBOC	Rural	17,967	4,224
Mount Vernon, IL	657GK	Primary Care CBOC	Rural	11,958	2,428
Paducah, KY	657GL	Primary Care CBOC	Rural	21,160	3,666

Location	Station No.	VHA Site Tracking Classification	Classification (Urban/Rural/ Highly Rural)	Outpatient Encounters	Community Care Referrals
Effingham, IL	657GM	Primary Care CBOC	Rural	13,613	2,114
Owensboro, KY	657GP	Primary Care CBOC	Urban	13,514	2,313
Vincennes, IN	657GQ	Primary Care CBOC	Rural	7,795	1,203
Mayfield, KY	657GR	Primary Care CBOC	Rural	16,821	4,941
Washington, MO	657GS	Primary Care CBOC	Rural	9,893	528
Carbondale, IL	657GT	Primary Care CBOC	Urban	11,738	1,539
Harrisburg, IL	657GU	Primary Care CBOC	Rural	5,774	1,055
Sikeston, MO	657GV	Multi-Specialty CBOC	Rural	8,658	2,060
Pocahontas, AR	657GW	Primary Care CBOC	Rural	4,857	1,537
St. Louis, MO	657GX	Primary Care CBOC	Urban	17,371	463
St. Louis, MO	657GY	Primary Care CBOC	Urban	17,208	733
St. Louis, MO	657QA	Primary Care CBOC	Urban	17,447	688
Marion, IL	657QD	Primary Care CBOC	Urban	18,044	4,214

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

## Appendix C: Expenditures for Community Care

**Table C.1. Community Care Disbursement Expenditures by Fiscal Year for VHA, VISN 15, and VISN 15 Facilities\***

Location	Fiscal Year 2018	Fiscal Year 2019	Fiscal Year 2020	Fiscal Year 2021
VHA	\$7,864,960,844	\$11,337,791,664	\$4,181,333,650	\$4,186,505,407
VISN 15 <sup>†</sup>	\$306,136,228	\$477,333,139	\$173,403,351	\$129,906,432
Columbia, MO (589/A4)	\$39,481,099	\$68,209,963	\$20,470,166	\$14,455,465
Kansas City, MO (589/00)	\$45,798,527	\$63,119,830	\$33,652,325	\$22,171,278
Topeka, KS (589/A5)	\$42,576,908	\$66,351,962	\$20,129,265	\$16,274,134
Wichita, KS (589/A7)	\$24,742,653	\$46,275,149	\$12,747,369	\$13,429,725
Marion, IL (657/A5)	\$67,621,489	\$119,413,808	\$37,807,093	\$24,235,497
Poplar Bluff, MO (657/A4)	\$25,758,969	\$60,439,526	\$16,926,984	\$11,450,192
St. Louis, MO (657/00)	\$60,156,582	\$53,522,901	\$31,670,150	\$27,890,140

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not verify the accuracy of this VHA disbursement information.

\*The OIG rounded the disbursement amounts up to the nearest dollar.

<sup>†</sup>Expenditures include CBOCs and other outpatient clinics associated with VA medical facilities.

## **Appendix D: VISN Network Director Comments**

### **Department of Veterans Affairs Memorandum**

Date: August 26, 2022

From: Director, VA Heartland Network (10N15)

Subj: Care in the Community Healthcare Inspection of the VISN 15: VA Heartland Network

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

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

Attached is the VISN 15 response to the CITC Healthcare Inspection of VA Heartland Network (VISN 15) draft report.

I have reviewed and concur with the response to the findings, recommendations and submitted action plans.

(Original signed by:)

Patricia L. Hall, PhD, FACHE

Network Director

VA Heartland Network (VISN 15)

## 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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