



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Inappropriate Community
Care Consult Edits
Unsubstantiated at the
VA Puget Sound Health Care
System in Seattle,
Washington

REVIEW

REPORT #22-01853-09

DECEMBER 7, 2022



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Executive Summary

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 allows veterans to receive care from non-VA healthcare providers in their area (known as community care) under certain circumstances, including when they meet specific driving distance and wait time criteria for accessing appointments.¹ In January 2022, a complainant alleged that (1) a leader at the Puget Sound VA Health Care System (the facility) inappropriately edited referrals for patients, known as consults, to reduce the community care backlog; (2) a community care scheduler at the facility enrolled patients in self-scheduling without asking them; and (3) facility leaders encouraged staff to inappropriately edit community care consults to reduce the backlog and improve wait times. The VA Office of Inspector General (OIG) conducted a review to assess the merits of the allegations. The review's scope and methodology are described in appendix A.

The OIG did not substantiate the first and third allegations based on its analysis and could not substantiate the second due to insufficient evidence. As to the first allegation, although the review team found that a facility leader made approximately 5,300 edits to about 4,400 community care consults between June and December 2021, the team did not substantiate the allegation that the edits were inappropriate and intended to improperly reduce the backlog.

Regarding the second allegation, available records show that the scheduler registered veterans for the self-scheduling option on 1,158 consults during a two-week period in June 2021.² Evidence was insufficient to determine whether (1) the scheduler spoke with veterans before converting them to the self-schedule option and (2) sent them letters concerning the self-scheduling option. The review team was informed that facility staff were not able to document the letter in any electronic system until October 2021, about five months after this scheduler made these changes.³ Furthermore, in May 2022, an Office of Integrated Veteran Care leader said that schedulers were not required to document their conversations with veterans.⁴ Therefore, the team could not verify whether the scheduler properly enrolled the veterans in self-service scheduling.

¹ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018). The specific time and distance requirements are detailed on page 1 of this report.

² *Office of Community Care Field Guidebook*, sec. 3.16, March 10, 2022. This guidance states that "VSS [veteran self-scheduling] begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider."

³ The letters provide veterans with contact information for community care providers and instructions for how to manage their consults once appointments are made.

⁴ The team also checked five consults to look for documentation, but because no records existed as to whether a conversation was held with the veteran or whether notification letters were sent, there was no benefit in checking additional consults, and no conclusions related to the specific allegation could be drawn.

The team was unable to interview the scheduler who left VA employment prior to the team's site visit where that interview was to take place.⁵ Absent documentary evidence or a supporting interview with the scheduler, the team could not substantiate this allegation.

In response to the final allegation, the team reviewed more than 3,800 VA email records and interviewed leaders and staff but found no evidence to substantiate that facility leaders encouraged staff to inappropriately edit community care consults to reduce the backlog and improve wait time metrics.

The OIG made no recommendations to VA for corrective actions given the lack of substantiated allegations.

Veterans Health Administration Comments and OIG Response

The Veterans Integrated Service Network 20 director and the Puget Sound VA Health Care System executive director concurred with the OIG's findings. The full text of their comments can be found in appendixes B and C.



LARRY M. REINKEMEYER
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⁵ At the time of this review, the VA OIG lacked testimonial subpoena authority to compel the scheduler to talk to the team.

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Abbreviations

CPRS	Computerized Patient Record System
HSRM	HealthShare Referral Manager
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration



Introduction

The VA Office of Inspector General (OIG) conducted this review to assess the merits of a January 2022 hotline allegation from a complainant that staff at the Puget Sound VA Health Care System (the facility) in Seattle, Washington, inappropriately edited patients' community care consults. Specifically, the complainant alleged the following:

1. One facility leader inappropriately edited patients' community care consults to reduce the backlog.
2. One community care scheduler enrolled patients in self-scheduling without asking them.
3. Facility leaders encouraged staff to make inappropriate edits to consults to reduce the community care backlog and improve wait times.

Patient Community Care Consults

According to the Veterans Health Administration (VHA), VA medical facility providers use consults to request care or seek an opinion, advice, or expertise from other VA or community healthcare providers regarding the evaluation or management of patients.⁶ Once a consult referral is made, facility staff such as clinicians, nurses, or schedulers determine whether the veteran is eligible for community care. Under the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, a veteran may receive community care under any of the following circumstances if they are eligible to receive VA care:⁷

- VA does not offer the care or services the veteran requires.
- The veteran lives in a US state or territory without a full-service VA medical facility.
- The service line at the local VA medical facility does not meet quality standards.
- VA is unable to provide the needed care or services in a manner that complies with designated access standards.
- The covered veteran's referring provider, with agreement from the veteran, determines community care is in the veteran's best medical interest.
- 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 a VA facility.⁸

⁶ VHA Directive 1232(3), *Consult Processes and Procedures*, April 5, 2021.

⁷ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) §1703.

⁸ VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019, accessed August 20, 2021, https://www.va.gov/communitycare/docs/pubfiles/factsheets/va-fs_cc-eligibility.pdf.

- 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.⁹

If a veteran is eligible for community care, facility staff are required to explain the options of receiving care within VA or in the community by sharing key information such as wait times to help the patient decide which option to pursue.¹⁰ If the veteran opts for community care, facility staff ascertain the veteran's community care preferences, such as specific care providers, days, and times, and forward the consult to the community care department for scheduling.

Once the community care department receives the consult, a scheduler should verify the veteran is eligible for care in the community.¹¹ If eligible, the community care scheduler would then contact the veteran to ask whether VA should schedule the appointment or if the veteran prefers to self-schedule. According to the *Office of Community Care Field Guidebook*, "VSS [veteran self-scheduling] begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider."¹² In the event facility staff did not document the veteran's community care preferences in the previous step, the community care scheduler should ascertain them.¹³

Veteran Self-Scheduling

According to one of its leaders, VHA's Office of Integrated Veteran Care (IVC) created a voluntary process in October 2020 to give veterans the option to schedule consults directly with community care providers by using a self-scheduling process.¹⁴ IVC also developed complementary self-scheduling procedures, scripts, process flow maps, and templated letters that facility staff could use to implement this new scheduling option.

⁹ VHA Office of Community Care, "Veteran Community Care Eligibility."

¹⁰ *Office of Community Care Field Guidebook*, sec. 2.0, March 10, 2022.

¹¹ *Office of Community Care Field Guidebook*, sec. 2.9.

¹² *Office of Community Care Field Guidebook*, sec. 3.16.

¹³ *Office of Community Care Field Guidebook*, sec. 2.19.

¹⁴ In May 2022, VHA announced that it had integrated the Office of Veterans Access to Care and its Office of Community Care into one office (the IVC) to help VHA better coordinate care while also streamlining and simplifying access processes. This report refers to the office as IVC because the consolidation of the two offices occurred before publication. IVC, "IVC Frequently Asked Questions (FAQs)," May 2022.

If the veteran opts to self-schedule, a scheduler from the facility's community care department first confirms that the community provider is accepting VA patients. Then the scheduler documents that choice for self-scheduling in the veteran's electronic health record and sends a letter to the veteran. This letter is important because it reminds veterans that they chose to self-schedule their appointments, provides them with contact information for their community care providers, and outlines other instructions to ensure veterans take appropriate actions, such as notifying VA of their appointment dates. According to an IVC leader, at the time the team's sampled self-scheduling edits occurred, VA policy did not require that copies of the letters be stored in any specific electronic system.

Results of the Review

Finding: Alleged Inappropriate Edits to Patient Community Care Consults Were Not Substantiated

As previously stated, the complainant made three allegations:

1. A facility leader made inappropriate edits to patient community care consults to reduce the backlog.
2. One community care scheduler enrolled patients in self-scheduling without asking them.
3. Facility leaders encouraged staff to inappropriately edit community care consults to reduce the backlog and improve wait times.

The OIG did not substantiate the first and third allegations and could not substantiate the second due to insufficient evidence.¹⁵ Accordingly, the OIG made no recommendations.

What the OIG Did

Using data from the Computerized Patient Record System (CPRS) and the HealthShare Referral Manager (HSRM), the review team analyzed community care consult data from October 1, 2019, to March 2, 2022.¹⁶ The team analyzed and categorized the types of edits made by the facility leader and the community care scheduler based on the allegations, and then reviewed a sample of each.¹⁷

The team visited the VA Puget Sound Health Care System in Seattle, Washington, in May 2022 to interview leaders and staff who were involved in overseeing or processing community care consults.¹⁸ The team also reviewed VA email records for the individuals named in the allegations. For additional information on the team's methodology, see appendix A.

¹⁵ The OIG *substantiates* allegations when the facts and findings support that the alleged events or actions took place. The OIG *does not substantiate* allegations when the facts show the allegations are unfounded. The OIG *cannot substantiate* allegations when there is no conclusive evidence to either sustain or refute the allegation.

¹⁶ CPRS provides clinicians, managers, support staff, researchers, and others an integrated patient record system. HSRM is an electronic referral and authorization processing system used by VA to accelerate veterans' access to community care. HSRM allows VA, third-party administrators, and community providers to manage community care referrals, authorizations, and claims.

¹⁷ The review team determined edits included (1) adding comments to consults, (2) marking consults as received, (3) canceling consults, (4) marking consults as veteran self-scheduled, and (5) discontinuing consults. For more on the sampling, see appendix A.

¹⁸ These allegations were initially made to the OIG review team while it was conducting fieldwork for another unrelated review. The team conducted fieldwork for the new allegations simultaneously. The review team did not inform facility leaders of the consult mismanagement allegations at that time because the team was actively evaluating potential evidence of individuals' inappropriate actions.

Available Evidence Indicated the Facility Leader Made Appropriate Edits to Consults

The complainant alleged that a facility leader inappropriately edited patients' community care consults to reduce the community care backlog.¹⁹ The complainant said the facility had reduced its community care backlog by about 33,000 consults over the previous four months. The review team conducted its own analysis of the facility's community care consults and determined the facility decreased its backlog from about 28,700 in June 2021 to about 8,400 by the end of December 2021, a decrease of about 20,300 consults.

The review team determined that a facility leader made approximately 5,300 edits to about 4,400 community care consults from June through December 2021. The team analyzed these edits to identify those at greatest risk of being inappropriate, such as edits made in bulk.²⁰ Based on this analysis, the team focused its review on the veteran self-scheduling and cancellation edits made by this facility leader. These edits would have reduced the community care backlog, and the complainant specifically mentioned them as a concern.

Of these 4,400 consults, the leader enrolled veterans in self-scheduling on 1,002 consults and canceled 715 additional consults. The team interviewed the facility leader and tested a sample of 10 consults—five in which veterans were enrolled in self-scheduling and five that were canceled—to check whether they were edited appropriately.

The team examined the appropriateness of the self-scheduling and cancellation edits that staff should make based on the following actions outlined in the *Office of Community Care Field Guidebook*.²¹

- Use CPRS to document the veteran's preferences for community care scheduling.
- Send an authorization package to a community provider and document this activity in HSRM.
- Confirm that a letter regarding self-scheduling was sent to the veteran.

¹⁹ The review team's assessment of potential inappropriate edits is described in more detail in appendix A.

²⁰ The team considered edits to be made "in bulk" when the same activity (e.g., canceling consults) occurred for five or more consults within a minute of a previous edit. Editing consults in bulk is not a definitive indicator that the edits were made inappropriately, but it warrants closer scrutiny because it is the quickest way for an individual to reduce the backlog and improve various wait time metrics.

²¹ *Office of Community Care Field Guidebook*, sec. 3.16.

- Make minimum attempts to contact a veteran and document them within CPRS prior to canceling a consult.²²

For the consults that did not appear to meet all relevant criteria, such as when the team was unable to confirm through documentation that self-scheduling letters had been sent to veterans, the team interviewed the facility leader to understand why criteria were not met. Based on the review of criteria and these discussions, the team did not identify any instances of inappropriate edits by the facility leader.

The team also asked the facility leader to answer questions that would clarify her role in helping to reduce the backlog of community care consults generally. She told the team that Veterans Integrated Service Network leaders had tasked the facility with eliminating the community care backlog. Accordingly, the facility leader took a more active role in processing consults.²³ In addition, she said the facility was able to reduce its backlog using overtime and by temporarily assigning additional staff to help.

Evidence Was Insufficient to Support Allegations That a Scheduler Enrolled Veterans in Self-Scheduling without Asking Them

The complainant alleged that a community care scheduler enrolled patients in self-scheduling without asking them. The team found that the scheduler made edits to 1,158 consults that enrolled veterans in the self-scheduling option during a two-week period in June 2021. From these consults, the team also tested a sample of five consults in which veterans were enrolled in self-scheduling. There was insufficient evidence, however, to determine whether the scheduler spoke with the veterans before signing them up for self-scheduling or whether the scheduler sent each veteran a letter containing important information on self-scheduling. An IVC leader told the review team that facility staff were not required to document the letter in any system until October 2021, about five months after this scheduler made these changes.²⁴ Furthermore, in May 2022, an IVC leader said that schedulers were not required to document their conversations with veterans.²⁵

²² Facility staff will generally make two attempts to contact the veteran, including one phone call and an “unable to contact veteran letter” if the veteran does not answer the phone. If the veteran does not respond to those attempts within 14 days from the date the letter was sent, staff may cancel the consult. *Office of Community Care Field Guidebook*, sec. 3.13.

²³ VHA is organized into 18 Veterans Integrated Service Networks, which are regional systems of care working together to better meet local healthcare needs and provide greater access to care.

²⁴ The letters provide veterans with contact information for community care providers and instructions for how to manage their consults once appointments are made.

²⁵ Because no documentation requirement was in place at the time of the scheduler’s actions, there was no evidence to determine whether the scheduler improperly enrolled patients in self-scheduling. For this reason, the team reviewed only five consults. Reviewing additional consults would not have changed the outcome.

To determine whether veterans were properly consulted, the team intended to speak with the scheduler during a site visit in May 2022, having previously confirmed with a facility leader the scheduler's availability for an interview. However, the team learned the scheduler left VA employment in February 2022 and facility staff could not provide the team with contact information for this individual, and a routine search was not successful.²⁶ Therefore, the team could not determine whether the scheduler spoke with veterans before signing them up for self-scheduling, or if the scheduler sent letters concerning self-scheduling to the veterans. Without documentary evidence or a supporting interview with the scheduler, the team could not substantiate this allegation.

To determine whether the veterans who were enrolled in the self-scheduling option had appointments, the team analyzed VHA's community care consult data and determined that of the 1,158 consults in which the scheduler enrolled veterans in self-scheduling, 721 showed a status of being scheduled (over 62 percent). For context, during the same period, 63 percent of this facility's community care consults that did not contain a self-scheduling entry also showed a status of being scheduled.

Available Evidence Did Not Support That Facility Leaders Encouraged Staff to Inappropriately Edit Community Care Consults

The complainant alleged that facility leaders encouraged staff to make inappropriate edits to community care consults to reduce the backlog and improve wait time metrics. The complainant reported sharing numerous concerns with facility leaders related to inappropriate consult management but alleged the leaders either did not respond or did not take the allegations seriously.

The team reviewed more than 3,800 VA emails sent between VA leaders and staff and did not identify any emails that substantiated these claims. In addition, after interviewing facility leaders and staff, none reported making or being directed to make inappropriate edits to reduce the community care backlog or improve wait times.

Conclusion

The OIG did not substantiate the complainant's allegations that one facility leader made inappropriate edits to community care consults, or that facility leaders directed or encouraged staff to inappropriately edit community care consults. Moreover, the OIG could not substantiate that one community care scheduler enrolled patients in self-scheduling without asking them. Accordingly, the OIG made no recommendations.

²⁶ At the time of this review, the VA OIG lacked testimonial subpoena authority to compel the scheduler to talk to the team.

VHA Comments and OIG Response

The Veterans Integrated Service Network 20 director and the Puget Sound VA Health Care System executive director concurred with the OIG's findings. The full text of their comments can be found in appendixes B and C.

Appendix A: Scope and Methodology

Scope

The review team performed its work from May 2022 through October 2022. This review evaluated allegations related to inappropriate edits to or actions taken on community care consults. The team analyzed community care consult data from FY 2020 through March 2, 2022. This review also evaluated facility leaders' roles in potential inappropriate edits by staff. In March 2022, the OIG team pulled VA email records for facility leaders and staff that were named in the allegations or that the team determined should be reviewed from the analysis of community care consult data for the period covered by the allegations.

Methodology

The OIG identified and reviewed applicable laws, regulations, policies, procedures, and guidelines related to the management of community care consults. The team conducted 14 interviews with facility leaders and staff who were involved in overseeing and processing community care consults. The team conducted a site visit to the VA Puget Sound Health Care System in Seattle, Washington, in May 2022. The team also interviewed the IVC field support team to gain a better understanding of the veteran self-scheduling process.

To assess the first two allegations, the team analyzed community care consult data from FY 2020 through March 2, 2022, to assess the merits of those allegations. Specifically, the team analyzed approximately 5,300 edits made by a facility leader to about 4,400 community care consults, and 1,158 instances when a community care scheduler opted veterans in for self-scheduling. The team analyzed and categorized the types of edits made by these employees relevant to assessing the allegations, such as canceling, discontinuing, and scheduling consults, or noting that the veteran opted for self-scheduling. The team focused on analyzing these specific edits because they would immediately reduce the backlog and potentially improve various wait time metrics. The team determined that the quickest way for facility staff to reduce the backlog would have been to make these types of edits in bulk. Therefore, to identify potentially inappropriate edits for these actions, the team assessed the extent to which they were made in bulk, meaning the same activity (e.g., canceling consults) occurred on five or more consults within a minute from a previous edit. The team then performed an extra check of a sample of five consults that the facility leader canceled, five consults in which the leader noted veterans as self-scheduling, and five consults in which the community care scheduler enrolled veterans in self-scheduling. These checks were made to identify whether there was documentation or other indicators of inappropriate cancellations or indications that these employees enrolled veterans in self-scheduling without asking them.

To assess the third allegation, the team conducted staff and leader interviews and also reviewed VA email records for facility leaders and one community care scheduler. The team searched

emails, as mentioned above, using key words to identify evidence of potential direction or encouragement from facility leaders to staff to make inappropriate edits to community care consults.

Internal Controls

The review team determined that internal controls were not significant to their review objective because (1) the team assessed allegations of potential wrongdoing by specific individuals, and (2) evaluating the facility's internal controls was not necessary to assess the allegations. Therefore, the team determined that performing an internal control step was not necessary unless internal control deficiencies were noted during the review. The team did not identify any internal control deficiencies significant to this review.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by reviewing community care consults, patient medical files, and VA email records, and by conducting interviews with facility leaders and staff. The OIG did not identify any instances of fraud or potential fraud significant to this review.

Data Reliability

The team assessed the reliability of patient consult data by reviewing medical records, conducting various reasonableness tests, and conducting interviews with VHA and facility leaders and staff to determine whether the data were sufficiently reliable for the purposes of the review. The team determined the data were sufficiently reliable for the purpose of this review.

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 B: VA Management Comments, Network Director, VISN 20

Department of Veterans Affairs Memorandum

Date: November 3, 2022

From: Network Director, VISN 20 (10N20)

Subj: Draft Report – Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Healthcare System in Seattle, Washington, (2022-01853-AE-0081)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the draft report – Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Healthcare System in Seattle, Washington, (2022-01853-AE-0081).
2. I concur with the findings.

(Original signed by)

Teresa D. Boyd, DO

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

Appendix C: VA Management Comments, Executive Director, VA Puget Sound Health Care System

Department of Veterans Affairs Memorandum

Date: October 27, 2022

From: Executive Director, VA Puget Sound HCS (663/00)

Subj: Draft Report- Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Healthcare System in Seattle, Washington, (2022-01853-AE-0081)

To: Network Director, VISN 20 (10N20)

1. Thank you for the opportunity to review the draft report – Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Healthcare System in Seattle, Washington, (2022-01853-AE-0081).
2. I concur with the findings.

(Original signed by)

Thomas S. Bundt, PhD, FACHE

Executive Director

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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