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VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers

Care in the Community Inspection	23-01739-26	January 16, 2025

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Executive Summary

The Office of Inspector General (OIG) Care in the Community program evaluates selected performance elements of the Veterans Health Administration (VHA) Veterans Community Care Program. The resulting report describes selected care coordination activities required to initiate and process referrals for non-VA care (community care). Using interview results and analysis of relevant data, the report also highlights opportunities and challenges for Veterans Integrated Service Network (VISN) and facility staff as they navigate current community care referral processes.[1]

Inspection Summary

The OIG reviewed community care processes at eight VA Desert Pacific Healthcare Network (VISN 22) medical facilities with a community care program from August 21 through September 5, 2023. The OIG evaluated each facility's processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, and Community Care Provider Requests for Additional Services. The OIG issued 12 recommendations across these four domains. The intent is for leaders to use recommendations as a road map to improve processes that support efficient delivery and coordination of community care going forward. The elements evaluated and OIG findings are summarized below.

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

Leadership and Administration of Community Care 	To determine how VISN and facility leaders supported community care services, the OIG evaluated the following elements: • Community care oversight councils • Resource utilization • Staffing and operations • Third-party administrator interactions • Patient safety event reporting • Medical documentation scanning performance • Community care concerns expressed by facility and VISN leaders • Primary care provider survey responses The OIG issued **five recommendations:** community care oversight councils function according to their charters (recommendation 1); staff complete the staffing tool reassessment (recommendation 2); staff enter patient safety events into the Joint Patient Safety Reporting system (recommendation 3); staff brief patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings (recommendation 4); and staff scan community care documents into patients' electronic health records within five business days of receipt (recommendation 5).
Community Care Diagnostic Imaging Results 	To assess how VHA facility community care staff communicated results of diagnostic imaging by community providers to the ordering VHA providers, the OIG determined whether facility community care staff used the required electronic health record progress note. The OIG also determined whether facility community care staff used the significant findings alert to notify ordering providers when those results were abnormal. The OIG issued **two recommendations:** staff attach diagnostic imaging results to the Community Care Consult Result note (recommendation 6) and staff use the significant findings alert to notify ordering providers of abnormal diagnostic imaging results (recommendation 7).

Administratively Closed Community Care Consults 	To evaluate whether facility community care staff managed the administrative closure of consults as required, the OIG determined whether staff • contacted the patient to confirm appointment attendance, • documented the first attempt at obtaining medical documentation, • administratively closed the consult if medical records were not received, and • made additional attempts to obtain the documentation after administratively closing the consult. The OIG issued **one recommendation:** staff make two additional attempts to obtain medical documentation following administrative consult closure (recommendation 8).
Community Care Provider Requests for Additional Services 	To assess how facility staff coordinated the processing and notifications when community providers requested additional services not covered by the initial referral, the OIG determined whether facility staff met timeliness requirements for • processing requests for additional services, • incorporating the requests and supporting medical documentation in electronic health records, • verifying community care providers' signatures on requests for additional services forms, and • notifying community providers of denials as required. The OIG issued **four recommendations:** staff process community care providers' requests for additional services within three business days (recommendation 9); staff incorporate the requests for additional services and supporting medical documentation into patients' electronic health records (recommendation 10); staff verify community care providers' signatures on requests for additional services forms (recommendation 11); and staff send letters to community providers when they deny requests (recommendation 12).

VA Comments and OIG Response

The Veterans Integrated Service Network concurred with recommendations 1, 4-8, 10, and 12, and concurred in principle with recommendations 2, 3, 9, and 11. The OIG considers recommendation 2 closed. The OIG considers the remaining recommendations open until sufficient evidence demonstrates sustained improvement and will follow up on the planned actions until they are completed. See appendix D for detailed responses.

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Contents

Abbreviations

IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Office of Inspector General (OIG) Care in the Community program routinely evaluates Veterans Health Administration (VHA) and Veterans Integrated Service Network (VISN) facilities' processes for coordinating community care and providing leadership and administrative oversight of VHA's Veterans Community Care Program.[1] The OIG's program also surveys facility primary care providers about their experiences with community care and assesses the feedback.

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, VHA's Veterans Community Care Program simplifies the process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[2] VHA's Office of Integrated Veteran Care (IVC) aims to provide veterans referred to community care timely access to high quality care through the Veterans Community Care Program in a way "that is easy to understand [and] simple to administer."[3] According to IVC leaders, the field guidebook outlines the program's requirements, "processes and tools related to eligibility, referral and care coordination."[4]

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101, https://www.congress.gov/115/plaws/publ182/PLAW-115publ182.pdf; US Senate Committee on Veterans' Affairs, "The VA MISSION Act of 2018: The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act," accessed July 8, 2021, VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

[3] VHA IVC, chap. 1 in *Community Care Field Guidebook,* November 21, 2022.

[4] Department of Veterans Affairs, "Office of Integrated Veteran Care (IVC) Community Care Field Guidebook," accessed July 1, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/SitePages/FGB.aspx. (This website is not publicly accessible.)

VA Desert Pacific Healthcare Network

The VA Desert Pacific Healthcare Network, also known as VISN 22, includes eight medical centers located in Arizona, New Mexico, and southern California and 65 outpatient centers.[5]

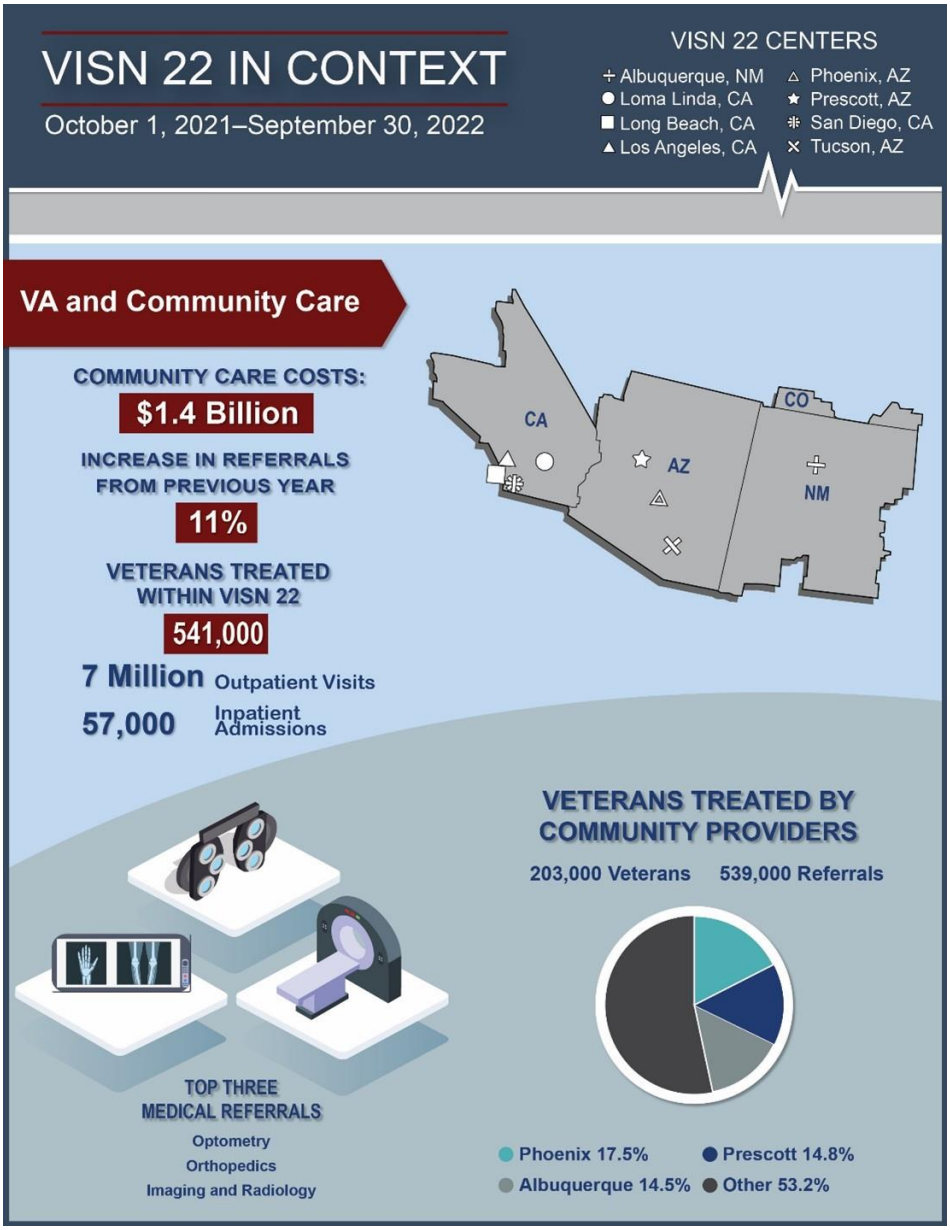

Figure 1. *Community care referral data for VISN 22: VA Desert Pacific Healthcare Network.*

Source: VA OIG. The OIG did not verify the accuracy of VHA data.

[5] "About the VA Desert Pacific Healthcare Network," Department of Veterans Affairs, accessed April 29, 2024, https://www.desertpacific.va.gov/DESERTPACIFIC/about/index.asp.

Community Care Consult Management

In general, to refer a patient to a community provider for care, a VHA provider enters a consult (an order) in the patient's electronic health record. Facility community care staff receive the consult and schedule the appointment. After the appointment, staff request the community provider's medical documentation if the provider did not send it promptly. Facility community care staff complete the process by closing the consult, which may occur with or without receipt of the associated medical documentation from the community care provider. While facility community care staff work on the consult, they also coordinate care for the patient, which may include processing requests for services not preapproved in the consult or incorporating test results into the patient's electronic health record.

Inspection Elements

The OIG evaluated selected VISN 22 facility processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, and Community Care Provider Requests for Additional Services. The inspection results describe the OIG's findings related to care coordination activities for patients referred for community care. The report highlights opportunities and challenges for VISN and facility staff as they navigate current community care referral processes (see appendix A for a list of all report recommendations).

Inspection Results

Leadership and Administration of Community Care

Effective leaders make decisions that directly or indirectly have an impact on every aspect of operations.[6] In health care, leaders "create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services."[7] Leaders should ensure patients receive the same level of care whether it is delivered through the medical facility or care in the community.[8]

To determine how VISN 22 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook. The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when the OIG found noncompliance with requirements. The team also sought input from the leaders and primary care providers about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

VHA requires VISN directors to ensure that all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[9] The OIG examined the council charters and meeting minutes for the reviewed facilities for calendar year 2022 and determined that they all had community care councils, and council members reviewed relevant issues like the timeliness of community care appointment scheduling. However, not all facility oversight councils met at the frequency required by their charters. For instance, the council at Prescott only met two of the nine times required by its charter for the calendar year. Facilities without a consistently functioning oversight council may be unable to ensure patients receive quality care. For example, failing to routinely review and track the timeliness of community care appointment scheduling may create missed opportunities to address deficiencies in patient care or safety. The OIG made one recommendation in this area.

[6] The Joint Commission, *Standards Manual*, E-dition, LD.04.01.05, July 2021.

[7] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[8] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[9] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to Network Directors (10N1-23), October 17, 2017.

Recommendation 1

1. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures community care oversight councils function according to their charters and meet the required number of times per calendar year.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

Resource Utilization

When analyzing ongoing community care decisions, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[10]

All eight facilities' leadership teams reported evaluating whether to continue purchasing specific care in the community or providing the care internally and taking actions accordingly. For example, leaders at Albuquerque analyzed data to identify where most of their patients lived. They determined that expanding dental services in northwest Albuquerque would be most effective in reducing community care use, but they were limited in space. The leaders said they found a solution by partnering with the University of New Mexico to construct a new building for space to offer VA dental services. Phoenix leaders reported sending a large volume of optometry care to the community and recently addressed this by relocating their primary care services and planning to expand the optometry clinic into the vacated space. According to these leaders, this expansion will double the size of the VA optometry clinic and decrease the amount of care sent to the community.

San Diego leaders said they expanded the physical therapy clinic but were still unable to satisfy demand, so they began providing physical therapy at primary care clinics, which decreased referrals to the community. However, leaders at five of the eight facilities explained that difficulties recruiting certain staff, such as ophthalmologists, orthopedic surgeons, dental subspecialists, and radiology technologists, had negatively affected their ability to expand VA care in these areas.[11]

Leaders at all eight facilities discussed actions taken to monitor underutilization of VHA clinical resources, which could increase referrals to community care. Long Beach leaders reported using a new software tool in the neurology clinic, created by the facility's Group Practice Manager, to

[10] VHA IVC, "RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document," updated January 26, 2022, https://dvagov.sharepoint.com/ReferralCoordinationInitiative. (This website is not publicly accessible.)

[11] These facilities were Albuquerque, Long Beach, Phoenix, Tucson, and Los Angeles.

help scheduling staff identify available appointments.[12] They explained that previously, staff had to look at numerous screens for multiple clinics in the scheduling application to identify available appointment slots, which the new tool performed automatically; leaders said the new process had reduced neurology appointment wait times by 30 days. Leaders at Albuquerque reported that an appointment access review board evaluated each clinic's bookable hours, staffing plan, and efficiency data to identify opportunities for improvement.[13] The review board was considering adjusting primary care staff's work schedules to enable Saturday appointments and increase clinic capacity.

To decrease community care use, VISN leaders described creating a telehealth emergency care program with participation from all facilities in the VISN. For example, a staff member at one facility could provide telehealth emergency care in the morning, and a provider from a different facility could offer additional care in the afternoon. The telehealth emergency nurse and provider were able to treat patients who had conditions suitable for telehealth when they were unable to go to a nearby VA facility. According to VISN leaders, this program was very effective; the VISN's community care emergency care costs were decreasing while other VISNs had seen an increase.

The OIG found that VISN and facility leaders regularly assessed internal resources, changes in healthcare service availability, and both internal and external capacity to provide services. Therefore, the OIG made no recommendations in this area.

Staffing and Operations

The OIG found that Loma Linda and Phoenix personnel could not provide documentation that leaders reassessed staffing at the required intervals. VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[14] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their community care programs.[15] VHA requires facility leaders to conduct

[12] Group practice managers provide oversight of "access to care in outpatient clinic services." VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

[13] Bookable clinic hours are the number of hours each provider has designated within their clinic schedule to treat patients. VHA Directive 1231(4).

[14] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum; VA Community Care, "VA Community Care Operating Model" (fact sheet), May 12, 2017.

[15] The tool uses average task times, workload data, types of staff (administrative or clinical), other nonclinical tasks (work that does not involve processing consults or coordinating care), and staff's projected time off to calculate program needs. Laura Osborne and John Leskovich, VHA OCC, "Office of Community Care (OCC): Staffing Tool Training," (PowerPoint presentation), February 2022.

an initial assessment using the tool, then reassess staffing every 90 days.[16] When facility leaders do not reassess staffing at the required intervals, they may fail to meet workload demands, which could negatively affect community care program operations and patient care.

Phoenix community care leaders stated that VHA's staffing tool was inaccurate in estimating staffing levels, so they created a different staffing model they felt was more effective. For example, they reported that according to the VHA staffing tool, they were overstaffed because the tool did not include time frequently spent on hold in telephone calls. Additionally, community care program leaders at every facility told the OIG that the staffing tool did not accurately assess community care staffing needs.

Leaders at all facilities, except Tucson, stated they used information in addition to the staffing tool's determinations to make staffing decisions, such as their own observations about time needed for tasks. Tucson community care staff said they had reported concerns about the staffing tool's inaccuracy but received guidance to continue using it. The OIG made one recommendation.

Recommendation 2

2. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff complete the operating model staffing tool reassessment every 90 days.

The VISN Director concurred in principle and provided an action plan. The OIG considers the recommendation closed.

Third-Party Administrator Interactions

VHA established contracts with third-party administrators to create regional networks of community providers able to provide care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues (such as adverse events or close calls) to ensure that, if needed, appropriate follow-up actions are taken.[17]

Facility patient safety managers communicate with third-party administrator representatives, which enables them to evaluate the effectiveness of third-party administrators' actions and provide information to the facility community care program team regarding any issues. Of the

[16] Assistant Under Secretary for Health for Operations (15), "National Implementation of the Community Care Operating Model Staffing Tool," memorandum to Veterans Integrated Service Network Directors (10N1-23), March 1, 2021.

[17] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.*

eight facilities reviewed, Albuquerque, Los Angeles, and Phoenix community care leaders reported having a process to evaluate third-party administrator performance.

During interviews, facility leaders shared some concerns about third-party administrator performance. For example, a community care leader from Phoenix discussed the adequacy of the provider network, highlighting disagreements between the needs identified by VHA and those identified by the third-party administrator. According to this leader, the third-party administrator evaluates the adequacy of the network by reviewing their provider lists. However, the third-party administrator provided the community care leader with a list of over 1,800 mental health providers in the Phoenix area, and when facility staff researched the list, they determined that fewer than 200 of the providers were available to treat veterans.

In another example, the Phoenix community care leader said the third-party administrator considered a list of 200 cardiology providers adequate. However, taking veteran travel into consideration, the providers might not be in areas convenient for veterans needing cardiology care. A leader from Los Angeles also expressed concerns about the provider network's adequacy and described similar disagreements with the third-party administrator about it.

The OIG asked facility leaders to discuss changes needed to improve third-party administrator performance or oversight. Responses included

- improving third-party administrator reports of findings for issues reported by VHA facility staff,
- developing a proactive rather than reactive quality assurance program,
- improving network provider education on how to work with the VA, especially for new providers, and
- increasing community provider accountability for returning medical documentation.

Facility community care leaders expressed concerns about third-party administrator performance and suggested that changes to their contracts could improve patient care quality and access. The OIG made no recommendation but suggests VHA leaders discuss these concerns with third-party administrators.

Patient Safety Event Reporting

The OIG found that at some reviewed facilities, staff did not enter and track events related to patient safety or quality of care in VHA's reporting system. The OIG compared reports to the third-party administrator with those entered into the Joint Patient Safety Reporting system and

found discrepancies.[18] For example, facility community care staff submitted five patient safety events for Loma Linda to the third-party administrator that they did not enter into the reporting system.

Facility staff should refer all patient safety and quality events involving a community provider to the third-party administrator for investigation.[19] In addition, VHA requires staff to report these events internally through its Joint Patient Safety Reporting system, and facility patient safety managers to review the events to determine the need for any immediate actions.[20] When staff do not report events internally, patient safety managers could miss adverse events that occurred and subsequently fail to take corrective actions to address community care patient safety risks.

The OIG reviewed community care oversight council meeting minutes and found that those for Albuquerque, Long Beach, Prescott, and San Diego did not always include patient safety event information. VHA requires facility patient safety managers or designees to brief the community care oversight council on patient safety event trends, lessons learned, and corrective actions.[21] Failing to analyze community care patient safety events could jeopardize safe, high quality care. The OIG made two recommendations.

Recommendation 3

3. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system.

The VISN Director concurred in principle and provided an action plan with a completion date of June 30, 2025.

Recommendation 4

4. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

[18] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[19] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[20] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.*

[21] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

Medical Documentation Scanning Performance

VHA requires staff to import all community care documents in the patient's electronic health record within five business days of receipt.[22] All facility leaders discussed tracking medical documentation scanning to identify backlogs, and Albuquerque, Los Angeles, Loma Linda, and San Diego leaders reported having a backlog. A leader at Los Angeles stated they received 700 medical documents from community providers in one day. A community care leader from Loma Linda described recently getting 22 boxes of paper records that were found in the Health Information Services department. At the time of the OIG inspection, the leader said staff had sorted 4 of the boxes trying to determine who should scan the records, community care or Health Information Services staff, and discovered the oldest records were dated February 2019. Additionally, the leader identified a scanning backlog of 3,357 community provider medical documents received by fax.

Failing to promptly scan incoming medical documentation from community care providers could negatively affect care coordination and quality of care monitoring. Therefore, it is critical that staff receive and scan these documents in patients' electronic health records in a timely manner. The OIG made one recommendation.

Recommendation 5

5. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.

The VISN Director concurred and provided an action plan with a completion date of September 30, 2025.

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns about their community care programs overall. The top concerns included care coordination, timely access to care, and facility staffing challenges. Some examples are given below.

Care coordination. Leaders at Albuquerque and Loma Linda discussed difficulties caused by community care providers failing to return medical documentation, including challenges for VHA providers in determining patients' care coordination needs. Further, all facility leaders expressed concerns about the effects of contractual agreements on the receipt of community

[22] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements," March 2021.

providers' medical documentation; leaders at several facilities attributed the problem to VHA paying community care providers for services before they returned the documentation.[23] VISN leaders reported feeling limited in their ability to change this process because of contractual agreements VHA made with third-party administrators, saying the agreements did not allow for control over payments at their level.

Timely access to care. Albuquerque leaders expressed concerns about wait times, saying they believed appointments were available sooner at the facility, and leaders at Phoenix, Los Angeles, Tucson, and Albuquerque had concerns with the limited numbers of community providers available to see patients.

Facility staffing challenges. Leaders at several facilities described clinical staff vacancies and explained that community care referrals would decrease if their facilities could provide care at VHA.[24] These leaders provided some examples, including loss of imaging technicians due to higher pay available at other institutions and primary care staffing shortages, all of which they stated led to thousands of referrals for community care.

VHA leaders shared concerns that provide insight into potential community care vulnerabilities, challenges, and areas for improvement that IVC leaders could consider for program changes at these facilities.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs, such as diagnosing and managing conditions and coordinating their overall care, and may initiate referrals for care by community care providers.[25] The OIG surveyed VISN 22 primary care providers anonymously for feedback about issues they encountered with the community care program, including questions about community care referrals (see appendix B for detailed survey information).[26] The survey feedback could lead to process improvements at both the local and national levels. Table 1 lists selected survey results.

[23] Leaders at Albuquerque, Loma Linda, Prescott, and San Diego expressed concern about VHA paying community providers prior to receiving the medical documentation.

[24] Leaders at Albuquerque, Loma Linda, Long Beach, Phoenix, Prescott, San Diego, and Tucson described staffing challenges.

[25] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[26] The OIG administered a survey of VISN primary care providers' experiences with the community care program. Survey responses may not be representative of all primary care providers in the VISN 22 due to the low response rate.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community provider medical documentation	92
No call when results had a significant finding or required immediate attention for patients referred to community care for diagnostic testing	1
Appointment delays negatively affecting patient outcomes	73
Appointment scheduling delays	68
Documentation receipt delays negatively affecting patient outcomes	65
Quality of care concerns when referring patients to community care	55

Source: VA OIG survey of VISN 22 primary care providers' experience with community care.

**Some respondents did not answer every survey question; percentages are reported based on the number of responses for the relevant question.*

VHA primary care providers generally reported concerns similar to those from VISN and facility leaders regarding delayed medical documentation, quality of care, and care coordination. Some providers who reported concerns about the quality of community care submitted additional comments. The OIG identified the following recurring themes:

- Lack of community providers' medical documentation or images, which could contribute to inefficient patient care coordination
- Concerns that community care providers did not use evidence-based medicine or ordered unnecessary tests[27]
- Concerns that community appointment wait times were not much shorter than facility wait times; one provider gave an example of a patient referred to community care because the facility wait time exceeded 30 days, and the patient waited longer than that to be seen by the community provider

[27] Evidenced-based medicine is "the integration of the best research evidence, clinical expertise and the patient's unique values and circumstances." Kamlesh Bhargava and Deepa Bhargava, "Evidence Based Health Care, A Scientific Approach to Health Care," *Sultan Qaboos University Medical Journal* 7, no. 2(August 2007):105-107, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074860/.

Community Care Diagnostic Imaging Results

Patients may receive diagnostic imaging by community providers if the imaging service is not available at a VHA facility or if access to the facility is an obstacle for the patient. VHA staff must ensure the results are entered into the electronic health record correctly, so providers are able to locate the results, especially when they are abnormal.[28]

The OIG selected diagnostic imaging results as an inspection domain because imaging was the service most often referred to community providers during calendar year 2022. The OIG found that facility staff did not consistently attach medical documentation correctly in patients' electronic health records and did not alert VHA providers of abnormal test results.

VHA providers may refer patients to community care if a required diagnostic service is not available at a VHA facility or if the patient meets eligibility criteria, such as standards for wait time for an appointment or drive time to the facility.[29] When facility staff receive the imaging results, VHA requires them to attach the results to a progress note titled Community Care Consult Result.[30] The note title indicates to VHA providers where the results can be found. If the results are abnormal, VHA expects facility community care staff to use the significant findings alert to notify ordering providers.[31]

Incorporating Results into the Electronic Health Record

The OIG found that San Diego community care staff did not consistently attach diagnostic imaging results to the correct progress note.[32] The OIG determined that for diagnostic imaging

[28] VHA Office of Community Care, "Veteran Community Care General Information." VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements." VHA IVC, chap. 4 in *Community Care Field Guidebook*, November 21, 2022.

[29] "Diagnostic radiology helps health care providers see structures inside your body." "Using the diagnostic images…physicians can often: diagnose the cause of your symptoms…monitor how well your body is responding to a treatment…screen for different illnesses." Examples of diagnostic imaging procedures are MRI, ultrasound, and computed tomography (commonly called CT) scans. National Institutes of Health, National Library of Medicine, MedlinePlus, *A.D.A.M. Medical Encyclopedia*, "Imaging and radiology," accessed August 18, 2023, https://medlineplus.gov/ency/article/007451.htm; VHA Office of Community Care, "Veteran Community Care General Information."

[30] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements."

[31] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

[32] Statistical estimates for facility noncompliance are reported in appendix C.

results reviewed for patients referred by San Diego providers, staff did not attach them to the Community Care Consult Result note in 21 percent of cases (95% CI: 8 to 34).[33]

When staff fail to attach diagnostic imaging results to the correct note, VHA providers may be unable to locate results efficiently, which could delay patients' diagnosis and treatment or lead to patients unnecessarily repeating procedures. During interviews, a San Diego community care leader said staff were updating internal processes to ensure they attach results to the correct note title. The OIG made one recommendation.

Recommendation 6

6. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff attach diagnostic imaging results to the Community Care Consult Result note.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

Provider Notification for Abnormal Imaging Results

The OIG found that community care staff at all eight facilities failed to consistently use the significant findings alert to notify providers of abnormal diagnostic imaging results as expected.[34]

[33] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

[34] Statistical estimates for facility noncompliance are reported in appendix C.

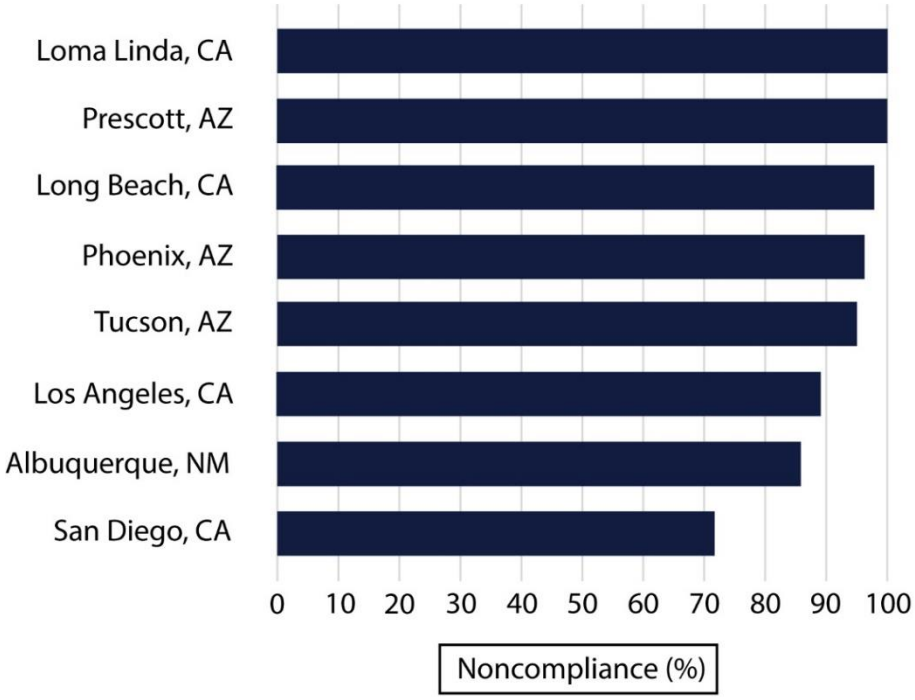

Figure 2. *Provider notification of abnormal diagnostic imaging results via the significant findings alert.*

Source: OIG analysis of VHA data.

When staff do not use the significant findings alert, providers may be unaware of abnormal test results, which could delay patients' diagnosis and treatment. Facility community care leaders reported many reasons staff did not use the significant findings alert to notify providers of abnormal test results, including staff

- using alternative methods of communication (emails, instant messages, and comments added to consults) to notify providers;
- completing the consult, which sends a standard view alert to the provider; and
- sending an alert to the provider requesting their signature on the note with the results to acknowledge their receipt and review.

During interviews, Prescott leaders reported believing that community care staff should not be responsible for deciding whether results were abnormal and said the ordering or community care provider should make this determination. The OIG made one recommendation.

Recommendation 7

7. The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert to notify ordering providers of abnormal diagnostic imaging results.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

Administratively Closed Community Care Consults

Documentation of health care from community providers conveys treatment decisions to VHA providers and is important in the patient's care coordination. Delays in the return of medical documentation may affect continuity of patient care, and VHA staff must take steps to obtain the medical documentation and notify the referring provider if the consult is closed without it.

The OIG determined that only community care staff at Phoenix consistently made the required continued attempts to obtain medical documentation from community providers or alerted providers when they administratively closed community care consults. Within VHA, consults to other VHA providers are closed after the requested services are provided and the documentation of care is readily available in the electronic health records.[35] In contrast, when community providers perform the requested services, VHA facility community care staff administratively close the consults if they do not receive the medical documentation from those providers after their first attempt to obtain it.[36]

VHA established a process for staff to administratively close consults if they do not get the medical documentation following their first attempt. After the date of the community care appointment, facility community care staff

- contact the patient to confirm appointment attendance,
- attempt to obtain the community care provider's documentation and record the effort in the electronic health record if they have not received it within 14 days of the scheduled appointment, and

[35] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022.
[36] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

- close the consult administratively and make two additional attempts to obtain the documentation within 90 days of the appointment.[37]

Additional Attempts to Obtain Medical Documentation after Administrative Closure

The OIG found that only Phoenix community care staff consistently met requirements for making two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults.[38]

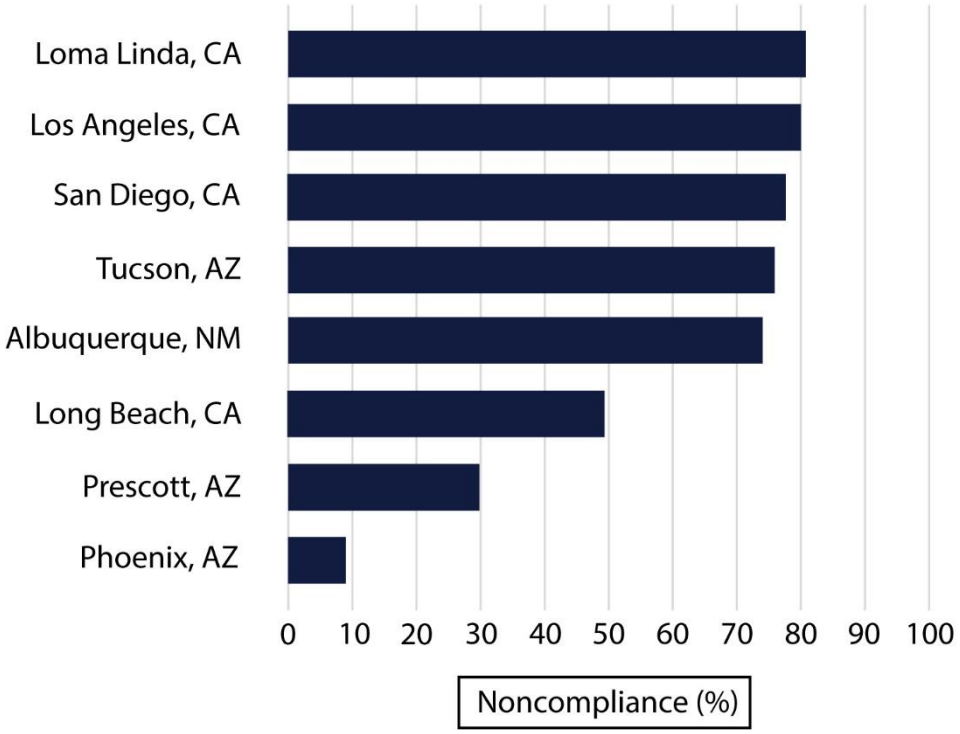

Figure 3. *Additional attempts to obtain documentation after administrative consult closure.*
Source: OIG analysis of VHA data.

Leaders at noncompliant facilities said they prefer to keep consults open while staff make the two additional attempts to obtain medical documentation, rather than following VHA's

[37] Facility community care staff close the consult administratively and make two additional attempts to obtain the documentation within 90 days of the appointment except for community care consults that VHA designates as "low-risk." VHA IVC, chap. 4 in *Community Care Field Guidebook*; Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consults Process (VIEWS #06042227)," memorandum to Veterans Integrated Service Network Directors (VISN 1-23), October 1, 2021.

[38] Statistical estimates for facility noncompliance are reported in appendix C.

administrative closure process. Leaders explained that staff track consults more effectively when they remain open while making the additional attempts. The OIG made one recommendation.

Recommendation 8

8. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative consult closure.

The VISN Director concurred and provided an action plan with a completion date of September 30, 2025.

Community Care Provider Requests for Additional Services

Community providers may submit requests for services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA clinical staff review and make timely decisions on the requests.[39]

The OIG determined that facility community care staff did not consistently process community providers' requests for additional services in a timely manner. VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[40] The process requires community providers to submit the request and supporting medical documentation on a VHA-provided form. Then, facility community care staff must

- review the request for the provider's signature and supporting documentation,
- approve or deny the request within three business days of receipt,
- incorporate the request and supporting medical documentation in the electronic health record, and
- send a letter to the community provider explaining reasons for any denied requests.[41]

[39] Tamika Taylor, VHA IVC, "Requests for Services (RFS) Form 10-10172 Training," (PowerPoint presentation), September 2023; VHA IVC, chap. 3 in *Community Care Field Guidebook*, June 2022.

[40] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[41] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

Requests for Additional Services Approvals or Denials

The OIG determined that only the Phoenix community care staff consistently processed requests for additional services within three business days of receipt.[42]

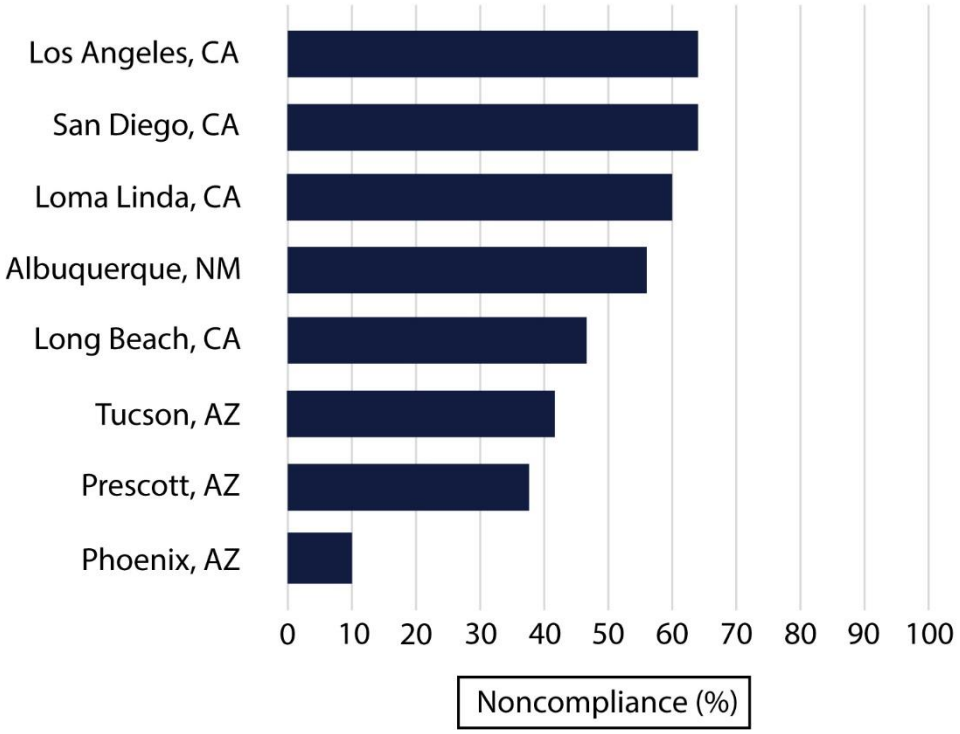

Figure 4. *Requests for additional services processed within three business days of receipt.*
Source: OIG analysis of VHA data.

When staff do not process requests for additional services in three business days, it may delay needed care and negatively affect patient outcomes. Facilities' community care staff shared several reasons they did not process the requests within three business days:

- Complexity of certain requests that required multiple clinical reviews
- Volume of requests for additional services received each month
- Staffing shortages
- Community providers not following VHA's process

Albuquerque community care leaders said delays occurred in processing requests for additional services when VHA providers did not review and act on requests promptly, which is outside of community care staff's control. One of these leaders added that complicated requests might

[42] Statistical estimates for facility noncompliance are reported in appendix C.

require input from multiple VA specialty care providers, which creates challenges in staff making prompt decisions. According to Loma Linda community care leaders, the monthly volume of requests for primary care services increased from about 30 per month in July 2022 to as many as 1,000 per month at the time of the inspection. These leaders reported receiving approval for three more registered nurses and one nurse practitioner to address the increased number of requests. Long Beach community care leaders said they did not meet the timeliness requirement because of delays in Chief of Staff designees approving or denying requests.

The acting Community Care Chief at Prescott reported implementing a process in which community care administrative staff worked on requests for additional services in the morning, and clinical staff reviewed the requests and forwarded them to primary care teams for approval in the afternoon.[43] According to the acting chief, primary care teams were very responsive, making decisions within two to three days. The acting chief further explained that community care nurses set reminders at seven days for each request to monitor timeliness. This leader also reported monitoring the reminders to ensure processing requests for additional services did not exceed seven days. They believed this process was effective but also acknowledged the decision-making process sometimes took five or six business days rather than three. The OIG made one recommendation.

Recommendation 9

9. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community care providers' requests for additional services within three business days of receipt.

The VISN Director concurred in principle and provided an action plan with a completion date of June 30, 2025.

Incorporating Requests for Additional Services and Supporting Medical Documentation in Electronic Health Records

The OIG found that Albuquerque and Los Angeles community care staff did not consistently incorporate requests for additional services into patients' electronic health records. The OIG determined that

- for patients referred by Albuquerque providers, facility community care staff did not incorporate the requests for additional services in electronic health records for 23 percent of them (95% CI: 12 to 35); and

[43] Prescott's acting Community Care Chief reported being in the position since July 2023.

- for patients referred from Los Angeles, facility community care staff did not incorporate the requests for 20 percent.[44]

If staff do not incorporate community providers' requests for additional services into the electronic health records, it may delay subsequent needed patient care. Albuquerque community care leaders said their staff sent the requests to Health Information Management Service staff who scan community care documents into electronic health records, but they did not complete the task. A Los Angeles community care leader stated that staff do not upload requests for additional services that are incomplete or illegible, but return those to the community provider for correction, delaying approval.

The OIG also found that Albuquerque and Los Angeles community care staff did not consistently incorporate supporting medical documentation with the requests for additional services into patients' electronic health records. The OIG determined that

- for patients referred by Albuquerque providers, facility community care staff did not incorporate the supporting medical documentation into electronic health records for 23 percent of them (95% CI: 12 to 35); and
- for patients referred from Los Angeles, facility community care staff did not incorporate the medical documentation for 16 percent.[45]

When supporting documentation is not included with the requests for additional services, facility community care staff and clinical providers may not have the information necessary to make timely and appropriate healthcare decisions. A Los Angeles community care leader stated that community care staff did not upload the request for services forms into the record because they were not complete. The OIG made one recommendation.

Recommendation 10

10. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff incorporate requests for additional services and supporting medical documentation in patients' electronic health records.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

[44] Statistical analysis for facility noncompliance is reported in appendix C. A confidence interval is not included because the data represents every patient in the study population.

[45] Statistical estimates for facility noncompliance are reported in appendix C. A confidence interval is not included because the data represents every patient in the study population. In the sample reviewed for Los Angeles, the OIG found instances of supporting documentation scanned in the record without the corresponding request for additional services form.

Community Care Provider Signatures on Request for Additional Services Forms

The OIG determined that at Albuquerque, requests for additional services forms in electronic health records did not include the community care provider's signature 38 percent of the time (95% CI: 23 to 54).[46]

As part of its commitment to patient safety and prevention of adverse outcomes, VHA requires the community provider's signature to authenticate the request for additional services and ensure it is correct.[47] An Albuquerque community care leader said their process allowed nurses to accept the presence of the provider's signature on supporting medical documents and then match it to the request for additional services form. This leader added that they believed the presence of the requesting provider's signature in supporting medical documentation satisfied the requirement and could be considered in place of a signature on the form. The OIG made one recommendation.

Recommendation 11

11. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff verify community care providers' signatures on requests for additional services forms.

The VISN Director concurred in principle and provided an action plan with a completion date of June 30, 2025.

Community Provider Notification for Denied Requests for Additional Services

The OIG found Loma Linda and Phoenix community care staff failed to consistently send letters to community providers when requests for additional services were denied, as required.[48] The OIG determined that

- for the denied requests at Loma Linda, facility community care staff did not send letters to notify community providers for 75 percent of them (95% CI: 50 to 100); and

[46] Statistical estimates for facility noncompliance are reported in appendix C.

[47] Tamika Taylor, VHA IVC – Integrated Access, "RFS [Request for Services]/CPO [Community Provider Orders]" (PowerPoint presentation), August 2022.

[48] The OIG reported statistical estimates for facility noncompliance in appendix C.

- for the denied requests at Phoenix, facility community care staff did not send letters for 32 percent (95% CI: 17 to 49).

Failure to send denial letters can delay care coordination because community providers might be unaware of the denial and thus unable to address deficiencies with the initial request. Additionally, when community care staff may miss opportunities to educate community providers about the request for additional services process. Loma Linda community care leaders reported sending denial letters only when they determined the care requested to be medically inappropriate and not when it was already covered under the existing authorization, or the request for additional services lacked or had insufficient supporting documentation.

Phoenix community care leaders explained they did not send letters for all denials; instead, they sent denial letters only when they determined the care requested to be medically inappropriate, or when they denied additional services because the patient had completed the approved treatment plan or had received the approved number of visits. The OIG made one recommendation.

Recommendation 12

12. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send letters to community providers when they deny requests for additional services.

The VISN Director concurred and provided an action plan with a completion date of June 30, 2025.

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at facilities within VISN 22, the OIG conducted a detailed inspection from August 21 through September 5, 2023. Addressing four domains of community care across eight VISN facilities with community care programs, the inspection resulted in 12 recommendations on systemic issues that may adversely affect patient outcomes. The total number of recommendations does not necessarily reflect the overall quality of all services delivered by facility community care staff within this VISN. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A. Summary of Recommendations

Domain	Recommendation
Leadership and Administration of Community Care	1. Community care oversight councils function according to their charters and meet the required number of times per calendar year. 2. Facility community care staff complete the operating model staffing tool reassessment every 90 days. 3. Facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system. 4. Patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings. 5. VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.
Community Care Diagnostic Imaging Results	6. Facility community care staff attach diagnostic imaging results to the Community Care Consult Result note. 7. Facility community care staff use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.
Administratively Closed Community Care Consults	8. Facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative consult closure.
Community Care Provider Requests for Additional Services	9. Facility community care staff process community care providers' requests for additional services within three business days of receipt. 10. Facility community care staff incorporate requests for additional services and supporting medical documentation in patients' electronic health records. 11. Facility community care staff verify community care providers' signatures on requests for additional services forms. 12. Facility community care staff send letters to community providers when they deny requests for additional services.

Appendix B: Methodology

The OIG reviewed community care processes at eight VISN 22 medical facilities with a community care program from August 21 through September 5, 2023. The facilities were the VA New Mexico Healthcare System (Albuquerque), VA Loma Linda Healthcare System (Loma Linda), VA Long Beach Healthcare System (Long Beach), VA Greater Los Angeles Healthcare System (Los Angeles), VA Phoenix Health Care System (Phoenix), Northern Arizona VA Health Care System (Prescott), VA San Diego Healthcare System (San Diego), and Southern Arizona VA Health Care System (Tucson).

The OIG reviewed electronic health records, results from an OIG survey distributed to VHA facility primary care providers, and facilities' policies and standard operating procedures.[1] The OIG also examined the Community Care Oversight Council charters and meeting minutes for calendar year 2022 to determine if facilities had a council and if it met the minimum number of times per year, as required by their charter. The OIG interviewed leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance.

The OIG electronically distributed a survey to primary care providers from August 22 through September 1, 2023. The OIG emailed 562 surveys to VISN 22 primary care providers and received 193 replies, a 34 percent response rate.[2] The OIG's analysis relied on inspectors identifying information from surveys, interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*[3]

The inspection team examined operations and electronic health records from January 1 through December 31, 2022. The OIG reviewed each selected facility for performance in the Leadership and Administration of Community Care and Diagnostic Imaging Results domains. After reviewing facility performance data relevant to each respective domain, the OIG selected the two additional domains for review, Administratively Closed Community Care Consults and Community Care Provider Requests for Additional Services, for all eight facilities. OIG leaders approved selections based on content and professional judgment.

For each VISN 22 facility reviewed, the OIG used the following criteria to select electronic health records during the review period for each domain:

- Community Care Diagnostic Imaging Results: community care diagnostic imaging referrals for computed tomography, ultrasound, or magnetic resonance imaging.

[1] Facility liaisons identified primary care providers. The OIG contacted them using their VA email addresses, and staff from the OIG Office of Data Analytics analyzed the responses. Participation in the survey was voluntary.

[2] Survey responses may not be representative of all primary care providers in VISN 22 due to the low response rate.

[3] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

- Administratively Closed Community Care Consults: community care consults administratively closed without medical documentation, excluding referrals for low-risk, dental, and geriatrics and extended care services.
- Community Care Provider Requests for Additional Services: patients with requests for additional services submitted by community care providers, excluding requests for dental or geriatrics and extended care services. If a patient had more than one request, the OIG evaluated the earliest request during the study period.

For all the above domains, the OIG randomly selected 50 electronic health records that met the criteria for the review period. During the review process, the OIG may have excluded some records, which resulted in the analysis of less than 50 records. In addition, for some facilities, less than 50 records met the criteria listed above during the review period, so the OIG examined all records, which is called a census review. The OIG statistically analyzed all randomly selected samples. The OIG reported the results of statistical analysis in appendix C.

The OIG reported a confidence interval for the statistical analysis for all random samples. A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. A 95 percent confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence interval 95 percent of the time. The OIG did not include confidence intervals for census reviews. The OIG also did not calculate a confidence interval if the noncompliance percent was equal to 100 or 0. The OIG made a finding and recommendation when the noncompliance percentage was statistically significantly above the 10 percent deficiency benchmark and the lower bound of the 95 percent confidence interval was above 10 percent.

This report is a review of VISN 22 and selected facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Findings cannot be generalized across VHA.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability. The OIG conducted the 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.

[4] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix C: Statistical Analysis

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that San Diego facility community care staff did not consistently attach diagnostic imaging results to the Community Care Consult Result note, as shown in Table C.1.

Table C.1. Facility Community Care Staff Attaching Diagnostic Imaging Results to the Community Care Consult Result Note in Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	47	6	0 to 15
Loma Linda	25	0	n/a*
Long Beach	50	2	0 to 6
Los Angeles	44	2	0 to 7
Phoenix	50	0	n/a*
Prescott	47	2	0 to 7
San Diego	39	21	8 to 34
Tucson	48	0	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that community care staff did not consistently use the significant findings alert to notify providers of abnormal diagnostic imaging results, as shown in Table C.2.

Table C.2. Facility Community Care Staff using the Significant Findings Alert to Notify Providers of Abnormal Diagnostic Imaging Results

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	37	86	74 to 97
Loma Linda	12	100	n/a*
Long Beach	43	98	93 to 100
Los Angeles	37	89	78 to 98
Phoenix	25	96	87 to 100
Prescott	12	100	n/a*
San Diego	25	72	54 to 89
Tucson	41	95	88 to 100

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that facility community care staff at Albuquerque, Loma Linda, Long Beach, Los Angeles, Prescott, San Diego, and Tucson did not consistently make two additional attempts to obtain medical documentation after administratively closing consults within 90 days of appointments, as shown in Table C.3.

Table C.3. Facility Community Care Staff Making Two Additional Attempts to Obtain Medical Documentation after Administratively Closing Consults within 90 Days of Appointments

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	47	74	61 to 87
Loma Linda	47	81	69 to 92
Long Beach	49	49	35 to 63
Los Angeles	45	80	68 to 91
Phoenix	46	9	2 to 17
Prescott	46	30	17 to 44
San Diego	46	78	66 to 89
Tucson	49	76	63 to 87

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that community care staff at Albuquerque, Loma Linda, Long Beach, Los Angeles, Prescott, San Diego, and Tucson did not consistently process requests for additional services within the three-day time frame, as shown in Table C.4.

Table C.4. Facility Community Care Staffs' Processing of Community Providers' Requests for Additional Services within Three Business Days of Receipt

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	45	56	41 to 70
Loma Linda	45	60	45 to 74
Long Beach	40	47	32 to 63
Los Angeles	25	64	Census review*
Phoenix	50	10	2 to 18
Prescott	47	38	25 to 52
San Diego	47	64	50 to 77
Tucson	49	43	30 to 57

Source: OIG analysis of VHA data.
**A confidence interval is not included for a census review because the data represents every patient in the study population.*

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that Albuquerque and Los Angeles community care staff did not consistently incorporate requests for additional services into patients' electronic health records, as shown in Table C.5.

Table C.5. Community Care Staff Incorporating Community Providers' Requests for Additional Services into Patients' Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	48	23	12 to 35
Loma Linda	46	2	0 to 7
Long Beach	44	2	0 to 7
Los Angeles	25	20	Census review*
Phoenix	50	0	n/a
Prescott	47	0	n/a
San Diego	49	0	n/a
Tucson	50	12	4 to 22

Source: OIG analysis of VHA data.

**A confidence interval is not included for a census review because the data represents every patient in the study population.*

A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that Albuquerque and Los Angeles community care staff did not consistently incorporate supporting medical documentation with the requests for additional services into patients' electronic health records, as shown in Table C.6.

Table C.6. Facility Community Care Staff Incorporating Supporting Medical Documentation with the Requests for Additional Services into Patients' Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	48	23	12 to 35
Loma Linda	46	2	0 to 7
Long Beach	44	7	0 to 15
Los Angeles	25	16	Census review*
Phoenix	50	2	0 to 6
Prescott	47	0	n/a
San Diego	49	2	0 to 6
Tucson	50	0	n/a

Source: OIG analysis of VHA data.

**A confidence interval is not included for a census review because the data represents every patient in the study population. In the sample reviewed for Los Angeles, the OIG found instances of supporting documentation scanned in the record without the corresponding request for services form.*

A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that Albuquerque community care staff did not consistently verify community care providers' signatures on requests for additional services forms, as shown in Table C.7.

Table C.7. Facility Community Care Staff Verifying Community Care Providers' Signatures on Request for Additional Services Forms

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	37	38	23 to 54
Loma Linda	45	9	2 to 18
Long Beach	43	0	n/a*
Los Angeles	20	0	Census review
Phoenix	50	10	2 to 18
Prescott	47	19	9 to 31
San Diego	49	4	0 to 10
Tucson	44	2	0 to 7

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*
A confidence interval is not included for a census review because the data represents every patient in the study population.

Based on the electronic health records reviewed for facilities in VISN 22, the OIG estimated that Loma Linda and Phoenix community care staff did not consistently send letters to community care providers when they denied requests for additional services, as shown in Table C.8.

Table C.8. Facility Community Care Staff Sending Letters to Community Care Providers when they Denied Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Albuquerque	8	n/a*	n/a
Loma Linda	12	75	50 to 100
Long Beach	9	n/a*	n/a
Los Angeles	4	n/a*	n/a
Phoenix	31	32	17 to 49
Prescott	4	n/a*	n/a
San Diego	20	25	7 to 45
Tucson	4	n/a*	n/a

Source: OIG analysis of VHA data.

**Estimates are omitted for Albuquerque, Long Beach, Los Angeles, Prescott, and Tucson because the number of patients in the sample was less than 11.*
A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 12, 2024

From: Network Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers (2023-01739-HI-1365)

To: Under Secretary for Health (10)

Director, Office of Healthcare Inspections (54CC02)

Executive Director, Office of Integrity and Compliance (10OIC)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) Draft Report, Care in the Community Healthcare Inspection of VA Desert Pacific Healthcare Network (VISN 22).
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Steven E. Braverman, MD

Appendix E: Action Plans

Recommendation 1

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures community care oversight councils function according to their charters and meet the required number of times per calendar year.

VISN concurs.

Target date for completion: June 30, 2025.

VISN response: Veterans Integrated Service Network (VISN) 22 will ensure facilities update their Facility Community Care Oversight Council charters and conduct Community Care Oversight Council meetings according to their charters. The VISN 22 Community Care Clinical Program Manager and Management Analyst will create a monthly suspense to track facility Community Care Oversight Council meeting minutes, with a target goal of 2 consecutive quarters of scheduled meetings of facility Community Care Oversight Council meeting sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 2

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff complete the operating model staffing tool reassessment every 90 days.

VISN concurs in principle.

Target date for completion: Completed.

VISN response: The Office of Integrated Veteran Care (IVC) has implemented a quarterly suspense, requiring the completion of the Community Care operating model staffing tool since 2022. The Community Care Operating Model Staffing Tool submission was not required during the initial assessment period of review by OIG, as Office of IVC did not require VISNs to submit data during the period of time that updates were made to the staffing tool at the end of calendar year 2021 and the beginning of 2022. In March 2022, Office of IVC issued guidance to the VISNs to submit data to the updated Community Care Operating Model Staffing Tool. VISN 22 submitted the Community Care Operating Model Staffing Tool Reassessment to Office of IVC for Fiscal Year (FY) 2022 Quarter (Q) 2 through FY 2024 Q3 (March 2022 through June 30, 2024). Upon VISN 22 request, Office of IVC provided VISN 22 the submitted information for FY 2022 Q2 through FY2024 Q3 (March 2022 through June 30, 2024). In August 2024, Office of IVC issued communication that the Community Care Staffing Tool closed with the FY 2024 Q3 data collection and will reopen in December 2024 for the FY 2025 Q1 data collection period. VISN 22 will continue to ensure facility community care staff complete the Community Care Operating Model Staffing Tool Reassessment every 90 days.

VISN 22 would like to request closure for this recommendation prior to publication based on supporting evidence provided to OIG.

Based on evidence provided, the OIG considers this recommendation closed.

Recommendation 3

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system.

VISN concurs in principle.

Target date for completion: June 30, 2025.

VISN response: VISN 22 will collaborate with Office of Integrated Veteran Care (IVC) and VHA National Center for Patient Safety (NCPS) to ensure facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting System (JPSR) and, when applicable, a Potential Quality Issue (PQI) form will be submitted to the Third- Party Administrator (TPA). VISN 22 is currently awaiting updated patient safety guidance (Patient Safety Guidebook v6.2). This updated guidance, once released, will be disseminated to all VISN 22 Community Care staff. The VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with the VISN 22 Patient Safety Officer, will continue to monitor status of community care patient safety events entered in JPSR to the entry of Potential Quality Indicators involving patient safety events that are submitted to the Third-Party Administrator. Compliance monitoring will be reported to the VISN 22 Community Care Oversight Council for 2 consecutive quarters.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 4

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

VISN concurs.

Target date for completion: June 30, 2025.

The VISN 22 Patient Safety Officer reported community care patient safety event trends, lessons learned and corrective actions quarterly at the VISN 22 Community Care Oversight Council Meeting on November 1, 2023, January 3, 2024, March 24, 2024, July 18, 2024, and September 11, 2024. The VISN 22 Patient Safety Officer will continue to report community care patient safety events quarterly to the VISN 22 Community Care Oversight Council. VISN 22 will ensure that the Patient Safety Manager or designees brief community care patient safety event trends, lessons learned and corrective actions quarterly at the facility Community Care Oversight Council Meetings. Monitoring will be met through evidence of VISN 22 and facility Community Care Oversight Council meeting minutes, with a target goal of 2 consecutive quarters of sustainment.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 5

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures VHA staff scan all community care documents into the patient's electronic health record within five business days of receipt.

VISN concurs.

Target date for completion: September 30, 2025.

The VISN 22 Business Implementation Manager, through the Health Information Management (HIM) Program Office monitors the 5 business days scanning standard. VISN 22 reports Community Care Scanning backlogs of greater than 5 business days to the National HIM Office with facility action plans during monthly calls. The VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with the VISN 22 Business Implementation Managers, will monitor the Community Care scanning backlog of greater than 5 business days. Tracking will be monitored using the VISN 22 Business Office Program Monitor Dashboard, with a goal of 6 consecutive months of sustainment of no Community Care scanning backlogs. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 6

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff attach diagnostic imaging results to the Community Care Consult Result note.

VISN concurs.

Target date for completion: June 30, 2025.

The VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with facility Community Care Leadership, will ensure all Community Care staff, are provided education on attaching diagnostic imaging results to the Community Care Consult Result note. VISN 22 Community Care Leadership will submit a tasker request through the VISN 22 Action Tracker to each facility to ensure the training is completed. The VISN 22 Community Care Clinical Program Manager and Management Analyst will work with the VISN and facility Clinical Applications Coordinators to eliminate all facility-level created consult result note. This will allow standardization of the VISN 22 facilities to use the VHA Community Care Consult Result national template as recommended in the Office of IVC Community Care Field Guidebook. The VISN 22 Community Care Clinical Program Manager and Management Analyst will track monthly audit compliance of the attachment of diagnostics imaging results to the Community Care Consult Result note. Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 7

The Veterans Integrated Service Network Director, in conjunction with facility directors, requires facility community care staff to use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.

VISN concurs.

Target date for completion: June 30, 2025.

The VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with facility Community Care Leadership, will ensure all Community Care staff, are provided education on using the Significant Findings Action in the electronic health record to generate the alert for the ordering provider of abnormal diagnostic imaging results. VISN 22 Community Care Leadership will submit a tasker request through the VISN 22 Action Tracker to each facility to ensure the training is completed. Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 8

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative consult closure.

VISN concurs.

Target date for completion: September 30, 2025.

VISN 22 will ensure alignment with the current Office of IVC Community Care Field Guidebook. After one (1) documented attempt and administrative closure, Community Care staff will make two additional attempts to obtain community providers' medical documentation within 90-days of the appointment. VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with facility Community Care Leadership, will ensure all Community Care staff are provided education regarding the required attempts to obtain community providers' medical documentation within 90 days following administrative consult closure. VISN 22 Community Care Leadership will submit a tasker request through the VISN 22 Action Tracker to each facility to ensure the training is completed. The VISN 22 Community Care Clinical Program Manager and Management Analyst will track compliance. Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 9

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community care providers' requests for additional services within three business days of receipt.

VISN concurs in principle.

Target date for completion: June 30, 2025.

VISN 22 will monitor compliance by creating a monthly VISN 22 Community Care Request for Additional Services audit. Facilities will be required to use the VHA Request for Additional Services national template in the patient's electronic health record. Facilities will submit monthly data to include date the request for additional services was received, and adjudication (approval or denial) date. Any requests for additional services greater than 3 business days will be tracked and trended to identify gaps, barriers, and opportunities for improvement. Compliance of sustained improvement for 6 consecutive months will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 10

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff incorporate requests for additional services and supporting medical documentation in patients' electronic health records.

VISN concurs.

Target date for completion: June 30, 2025.

VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with facility Community Care Leadership, will ensure all Community Care staff, are provided education on incorporating requests for additional services and supporting medical documentation in patient's electronic health records. VISN 22 Community Care Leadership will submit a tasker request through the VISN 22 Action Tracker to each facility to ensure the training is completed. VISN 22 will work with the VISN and facility Clinical Application Coordinators to eliminate any community consult result notes created by the facilities. By doing this, the facilities will be limited to use the required national template when attaching community provider medical documentation Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 11

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff verify community care providers' signatures on requests for additional services forms.

VISN concurs in principle.

Target date for completion: June 30, 2025.

VISN 22 will ensure alignment of current VHA Office of IVC Community Care guidance. According to the Office of IVC, instruction to the community providers that RFS' must be signed is located in both the Optum and TriWest provider handbooks. Both TPA's have agreed to repush reminder training to their community providers in the next iteration of their provider education articles. VISN 22 will monitor verification of signature by appropriate authority by creating a monthly VISN 22 Community Care Request for Additional Services audit. Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 12

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send letters to community providers when they deny requests for additional services.

VISN concurs.

Target date for completion: June 30, 2025.

VISN 22 Community Care Clinical Program Manager and Management Analyst, in collaboration with facility Community Care Leadership, will ensure all Community Care clinical staff, are provided education on the use of the denial letter when a request for additional services is denied by the Delegation of Authority. VISN 22 Community Care Leadership will submit a tasker request through the VISN 22 Action Tracker to each facility to ensure the training is completed. VISN 22 Community Care Clinical Program Manager and Management Analyst will work with the VISN and facility Clinical Application Coordinators to eliminate any request for additional services denial letters created by the facilities. By doing this, the facilities will be limited to use the required VHA National template when sending the request for additional services denial letter. Tracking will be incorporated into the monthly VISN 22 Request for Additional Services audit. Compliance will be monitored with a goal of 6 consecutive months of sustainment. Compliance will be reported at the VISN 22 Community Care Oversight Council through the governance structure.

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

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