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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers

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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 seven VA Sierra Pacific Network (VISN 21) medical facilities with a community care program from February 21 through March 8, 2024. 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, Community Care Provider Requests for Additional Services, and Care Coordination: Scheduling and Communication with Patients Referred for Community Care. The OIG issued 13 recommendations across the five 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 **four recommendations:** community care oversight councils function according to their charters (recommendation 1); staff enter community care patient safety events in VHA's reporting system (recommendation 2); staff brief patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings (recommendation 3); and staff scan community care documents in patients' electronic health records timely (recommendation 4).
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 VHA providers when those results were abnormal. The OIG issued **one recommendation:** staff use the significant findings alert to notify providers when diagnostic imaging results are abnormal (recommendation 5).

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, • attempted to obtain the community care provider's documentation and recorded the effort in the electronic health record if they have not received it within 14 days of the scheduled appointment, • closed the consult administratively and made two additional attempts to obtain the documentation within 90 days of the appointment, and • used the significant findings alert to notify providers when they close the consult without medical documentation. The OIG issued **two recommendations:** staff confirm patients attended their appointments and attempt to obtain medical documentation prior to administratively closing the consult (recommendation 6) and staff make two additional attempts to obtain the documentation following closure of consults that are not low risk (recommendation 7).
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 and sent approval and denial letters to community providers and patients for requests for additional services, as required. The OIG issued **three recommendations:** staff process requests for additional services within three business days (recommendation 8), and staff send approval and denial letters to community providers and patients for requests for additional services (recommendations 9 and 10).
Care Coordination: Scheduling and Communication with Patients Referred for Community Care 	To evaluate how effectively facility community care staff coordinated care for patients referred for community care, the OIG determined whether facility staff followed VHA timeliness requirements for scheduling appointments, confirmed patients attended appointments, documented care coordination using the Community Care–Care Coordination Plan note, and contacted patients based on VHA-recommended frequencies. The OIG issued **three recommendations:** staff schedule community care appointments within seven days of consult entry or receipt (recommendation 11), staff confirm patients attended their scheduled appointments (recommendation 12), and staff document care coordination activities using the Community Care–Care Coordination Plan note (recommendation 13).

VA Comments and OIG Response

The Veterans Integrated Service Network concurred with recommendation(s) 1, 3, 4, 6, 12, and 13 and concurred in principle with recommendations 2, 5, and 7-11. The OIG considers these 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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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 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 Sierra Pacific Network

The VA Sierra Pacific Network, also known as VISN 21, includes seven medical centers located in northern and central California, Nevada, and Hawaii, and 41 outpatient centers.[5]

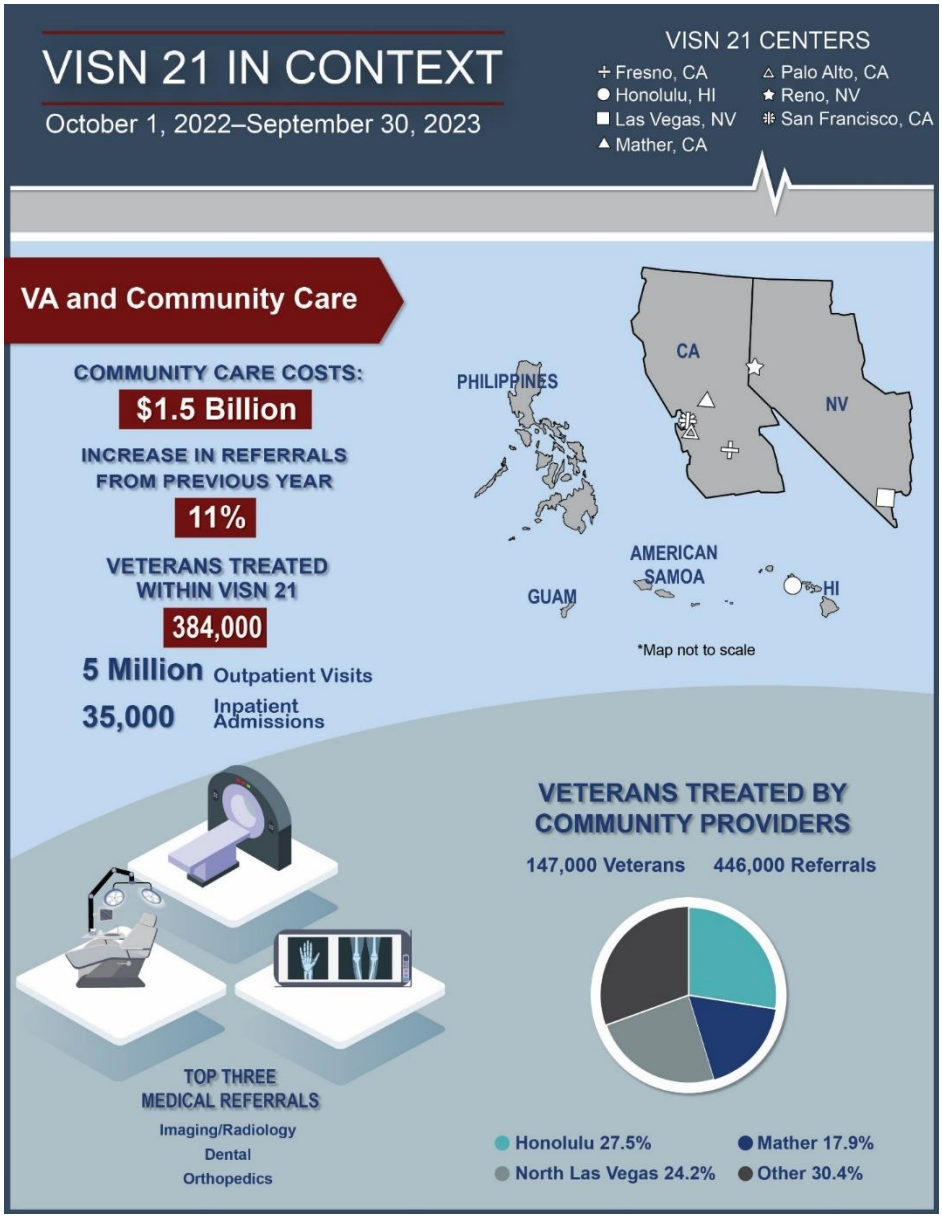

Figure 1. *Community care referral data for VISN 21: VA Sierra Pacific Healthcare Network.*
Source*: VA OIG. The OIG did not verify the accuracy of VHA data.*

[5] "About the VA Sierra Pacific Network," Department of Veterans Affairs, accessed January 22, 2024, https://www.visn21.va.gov/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 each selected VISN 21 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, Community Care Provider Requests for Additional Services, and Care Coordination: Scheduling and Communication with Patients Referred for Community Care. 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 delivered through the medical facility or care in the community.[8]

To determine how VISN 21 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 determined that all VISN 21 facilities had community care councils that reviewed relevant issues, including community care utilization and third-party administrator performance data. The OIG examined the council charters and meeting minutes for the reviewed facilities for fiscal year 2023 and determined that councils in Mather and San Francisco did not meet at the frequency required by their charters. For example, the council at San Francisco only met 7 of the 12 times required by its charter for the fiscal year. Facilities without a consistently functioning oversight council may be unable to ensure patients receive quality care. 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 fiscal year.

The VISN Director concurred and provided an action plan with a completion date of March 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 seven reviewed facilities' leadership teams reported evaluating whether to continue purchasing specific types of care in the community or providing the care internally and taking actions accordingly. For example, leaders at Reno described performing a thorough analysis to determine the costs of providing rehabilitation services at the facility compared to purchasing these services in the community. They found that providing these services in the community was more cost effective and easily accessible.

San Francisco leaders reported meeting regularly to evaluate whether they could deliver services more efficiently at the facility or if services should be sent to the community. They identified patients' distance from the facility as the reason for most of their imaging referrals to community providers. To address this issue, leaders said they added mobile computed tomography scanning services to their clinic in Eureka, which is more than 250 miles from San Francisco.[11]

Leaders at Honolulu stated that roughly $50 million of the $250 million spent on community care the preceding year was for emergency and urgent care. They plan to reduce some of this cost by offering urgent care at their Akaka clinic.

VISN leaders described efforts to identify and use all available VISN healthcare service capacity to reduce the need for community care. For example, radiologists at VISN facilities with excess

[10] VHA IVC, "RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document," updated January 26, 2022, https://dvagov.sharepoint.com/:w:/r/sites/ReferralCoordinationInit/_layouts/15/Doc.aspx. (This website is not publicly accessible.)

[11] A computerized tomography scan "is a type of imaging that uses X-ray techniques to create detailed images of the body. It then uses a computer to create cross-sectional images" of those images. "CT Scan," Mayo Clinic, accessed September 4, 2024, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

capacity were used to read images for those with a backlog, reducing the need for community care. The OIG made no recommendations in this area.

Staffing and Operations

VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[12] 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.[13] VHA requires facility leaders to conduct an initial assessment using the tool, then reassess staffing every 90 days.[14]

Community care program leaders at every facility reviewed told the OIG the staffing tool did not accurately assess community care staffing needs. For example, Fresno leaders explained the staffing tool did not include all community care tasks or services, such as customer service. The leaders received over 3,000 customer service phone calls per month, leading to additional staffing needs. Leaders at Fresno, Honolulu, and Reno stated the tool indicated their facilities were overstaffed because it underestimated the complexity and amount of time needed to complete tasks.

Leaders at Fresno, Honolulu, Palo Alto, and San Francisco said they used other information in addition to the tool's determinations when making staffing decisions, such as their own observations about time needed for tasks. The OIG made no recommendations in this area.

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.[15]

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

[13] 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.

[14] 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.

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

Facility patient safety managers communicate with the 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. During interviews, facility community care leaders shared concerns about third-party administrator performance.

- Mather leaders said they used the third-party administrator to schedule patient appointments and described concerns about the timeliness of scheduling and the number of referrals returned to the facility because of the third-party administrator's inability to schedule appointments.
- San Francisco leaders reported that the community care provider network database, which is maintained by the third-party administrator, was not always accurate and contained providers who no longer participated.

North Las Vegas and Reno leaders suggested contractual changes that could improve patient care quality. For example, third-party administrators could issue a community care provider report card containing quality of care metrics (determined by VHA) and ensure community providers send the medical documentation from veterans' visits to the facilities. The OIG made no recommendation in this area but suggests VHA leaders discuss these concerns with third-party administrators.

Patient Safety Event Reporting

The OIG found that staff at some reviewed facilities did not log and track events related to patient safety or quality of care in VHA's reporting system. Facility staff provided the OIG a list of potential quality issues reported to the third-party administrator in fiscal year 2023. The OIG compared the list with incidents entered into the Joint Patient Safety Reporting system in fiscal year 2023 and found discrepancies for Honolulu, Mather, and San Francisco.[16] For example, Mather staff submitted five events to the third-party administrator but did not enter them into the reporting system.

Facility staff should refer all patient safety events involving a community provider to the third-party administrator for investigation.[17] In addition, VHA requires staff to enter these events into the Joint Patient Safety Reporting system, and facility patient safety managers to review the events to determine the need for any immediate actions.[18] When staff do not enter the events,

[16] "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.

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

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

patient safety managers could miss adverse events that occurred and subsequently fail to take corrective actions to address community care quality and patient safety risks.

The OIG found that only San Francisco's community care oversight council meeting minutes included discussions of patient safety event trends, lessons learned, and corrective actions. VHA requires facility patient safety managers or designees to brief the oversight council on these items.[19] Failing to analyze patient safety event trends and take corrective actions as warranted could jeopardize safe, high-quality care. Leaders at Mather explained that one reason the oversight council did not discuss these items is because they were reported in other meetings, such as Veterans Experience Council and Quality Council meetings. The OIG made two recommendations for patient safety event reporting.

Recommendation 2

2. 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 March 2025.

Recommendation 3

3. 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 March 2025.

Medical Documentation Scanning Performance

VHA requires staff to import all community care documents into the patient's electronic health record within five business days of receipt.[20] All facility community care leaders discussed tracking medical documentation scanning to identify backlogs. Only North Las Vegas leaders stated they have a backlog; they reported an average scanning time of 17 days due to short staffing, explaining that only two staff scanned documents and they needed an additional seven.

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

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

They also discussed actions taken to resolve the backlog, such as having staff work overtime and using contractors to index medical documentation.[21]

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 into patients' electronic health records in a timely manner. The OIG made one recommendation related to medical documentation scanning.

Recommendation 4

4. The Veteran Integrated Service Network Director, in conjunction with facility directors, ensures facility 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 March 2025.

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns for their community care programs overall. Top concerns included care coordination and quality of care, increased community care costs, and standardized episodes of care.[22] Some examples are given below.

Care coordination and quality of care. Facility leaders discussed difficulties caused by community care providers failing to return medical documentation, including challenges for facility providers to assess the extent and quality of care patients received and determine additional care needs.

Increased community care costs. VISN and Hawaii, Mather, Palo Alto, and Reno leaders expressed concerns with the increased community care costs. For instance, a facility leader at Mather said that VHA expanded eligibility for air ambulance use, which increased at their facility from 4 to 6 times annually to 10 times a month, with each trip costing $90,000.

[21] Indexing describes the process of associating a scanned pdf image with a community care consult in the electronic health record. "Enterprise Precision Scanning and Indexing (EPSI) Resources," EPSI Training Materials, accessed July 6, 2024, https://dvagov.sharepoint.com/Why-we-are-here-.aspx. (This website is not publicly available.)

[22] Standardized episodes of care are "a standardized…group of services and procedures a VA Medical Center (VAMC) is authorizing a community provider to perform" for a patient. VHA Office of Community Care, *Standardized Episodes of Care (SEOCs) Community Care Network*, March 2, 2022. Standardized episodes of care "are in place to reduce administrative burden by lowering the need for" additional approval from the VA to provide clinically necessary services and procedures. VHA Office of Community Care, *SEOC Frequently Asked Questions for VA Staff, OCC [Office of Community Care] Facility Staff, and Community Providers*, May 6, 2022.

Standardized episodes of care. VISN and Hawaii leaders shared instances when facility providers referred patients to community care and they received additional services or procedures not requested. For example, a Hawaii leader explained that a standardized episode of care authorized a patient to receive multiple cardiac services from a community care provider when the VHA provider only ordered a single cardiac test.

According to IVC, standardized episodes of care are written broadly to include allowable services or procedures customary to a specific category of care or specialty. IVC also states that community care providers should use episodes of care as a reference of allowable services or procedures, not as authorization to perform all the listed services or procedures unless they determine it to be clinically necessary.[23] Broadly written standardized episodes of care may increase the risk of patients receiving care not requested by the ordering provider and lead to rapid increases in community care expenditures. Concerns shared by VISN and facility leaders provide insight that clarification may be needed to the standardized episodes of care to indicate when allowable services or procedures may be provided.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs by diagnosing and managing conditions and coordinating their overall care and may initiate referrals for care by community care providers.[24] The OIG surveyed VISN 21 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). The feedback could lead to process improvements at both the local and national levels.[25] Table 1 lists selected survey results.

[23] Kathy Benjamin, Office of Integrated Veteran Care (IVC), "Consult PI [Performance Improvement] Call," (PowerPoint presentation), June 30, 2022.

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

[25] Survey responses may not be representative of all primary care providers in the VISN 21 due to the low response rate.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community provider medical documentation	92
Appointment scheduling delays	85
No call when results had a significant finding or required immediate attention for patients referred to community care for diagnostic testing	83
Appointment delays negatively affecting patient outcomes	79
Documentation receipt delays negatively affecting patient outcomes	76
Quality of care concerns when referring patients to community care	60

Source: VA OIG survey of VISN 21 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 and quality of community care. Some providers who reported concerns about quality of community care submitted additional comments. The OIG identified the following recurring themes:

- Lack of community provider medical documentation or images, which delayed appointments for continued care
- Providers perceived community care to be lower quality than VHA care
- Community care providers routinely performed services that were unnecessary and not requested by the VHA provider
- Delays in scheduling appointments because community providers were booked far in advance and had insufficient capacity to meet the demand

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.[26]

[26] 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.

The OIG selected diagnostic imaging results as an inspection domain because imaging was the service most often referred to community providers during fiscal year 2023. The OIG found that community care staff at all facilities reviewed failed to consistently use the significant findings alert to notify providers of abnormal test results as expected (see figure 2).[27]

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.[28] When facility staff receive the imaging results, VHA requires them to attach the results to a progress note titled Community Care Consult Result.[29] 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.[30]

[27] The OIG statisticians did not calculate percentage of compliance for San Francisco because the sample size was less than 11. Statistical analysis for facility noncompliance is reported in appendix C.

[28] "Diagnostic radiology helps health care providers see structures inside your body." Examples of diagnostic imaging procedures are magnetic resonance imaging (MRI), ultrasound, and computed tomography (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."

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

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

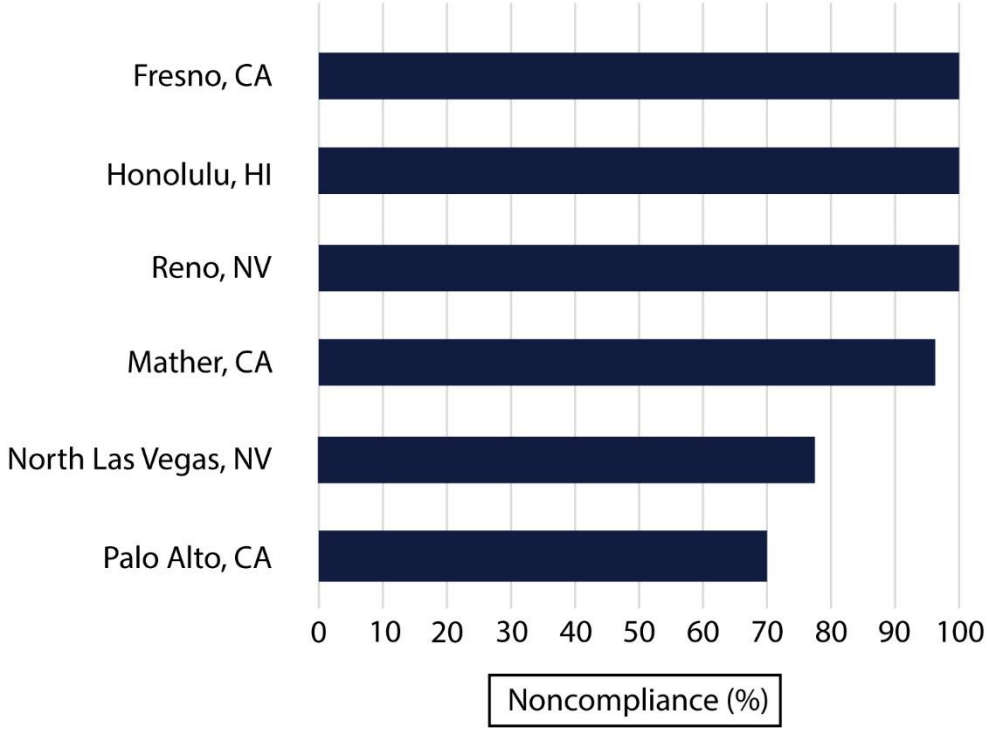

Figure 2. *Percent noncompliance for provider notification of abnormal diagnostic imaging results via the significant findings alert.*

Source: OIG analysis of VHA data.

When staff do not use the significant findings alert, VHA providers may be unaware of abnormal test results, which could delay patients' diagnosis and treatment. Community care leaders at these facilities reported many reasons staff did not use the significant findings alert, including staff

- being unaware of the requirement to use the alert for all abnormal results,
- using the critical results note instead, and
- sending an alert to the provider requesting their signature on the note with the results to acknowledge their receipt and review.

Additionally, a community care leader at Fresno acknowledged not using the significant findings alert due to concerns about the large volume of alerts VHA providers already receive. The OIG made one recommendation.

Recommendation 5

5. 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.

The VISN Director concurred in principle and provided an action plan with a completion date of September 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.

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,
- close the consult administratively and make two additional attempts to obtain the documentation within 90 days of the appointment for consults that are not low risk, and
- use the significant findings alert to notify providers when they close the consult without the documentation.[31]

The OIG reviewed administratively closed consults at these VISN 21 sites:

Honolulu, HI
Mather, CA
North Las Vegas, NV
Palo Alto, CA
Reno, NV

[31] VHA IVC, chap. 3 in *Community Care Field Guidebook*, June 2022, and chap. 4 in *Community Care Field Guidebook*.

Confirmation of Appointment Attendance and Attempts to Obtain Medical Documentation

The OIG estimated that Honolulu community care staff did not consistently confirm patients attended their appointments and attempt to obtain community providers' medical documentation prior to administratively closing 22 percent (95% CI: 12 to 35) of consults, which could hinder VHA ordering providers in further coordinating care.[32] An explanation offered by the Honolulu Associate Chief Nurse of Community Care for the failed confirmation of appointment attendance was a misunderstanding that if staff identified a paid healthcare invoice in the third-party administrator portal, this was an acceptable method for confirming appointment attendance. Leaders did not explain possible reasons for staff failing to attempt to obtain the medical documentation. The OIG made one recommendation.

Recommendation 6

6. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended their appointments and attempt to obtain medical documentation prior to administratively closing consults.

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

Additional Attempts to Obtain Medical Documentation After Administrative Closure

The OIG found that Honolulu and Mather community care staff failed to consistently make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults that are not low risk.[33] The OIG estimated that, following administrative closure and within 90 days,

- Honolulu community care staff did not make the required additional attempts for 70 percent (95% CI: 50 to 88) of records reviewed; and

[32] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed Honolulu, Mather, North Las Vegas, Palo Alto, and Reno for this domain. 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. Statistical estimates for facility noncompliance appears in appendix C.

[33] The OIG reviewed five facilities for this requirement. Three of the facilities had fewer than 11 patients in the sample, so the OIG statisticians could not calculate estimates. Statistical estimates for facility noncompliance are reported in appendix C.

- Mather community care staff did not make the required additional attempts for 97 percent (95% CI: 88 to 100) of records reviewed.

Honolulu community care leaders reported lacking the staff needed to make the additional attempts to obtain medical documentation. Failure to administratively close community care consults after the first attempt to obtain medical documentation keeps consults in an open status, which is inconsistent with VHA's intentions to separately track administratively closed consults.[34] Community care leaders at Mather reported that staff made two attempts to obtain medical documentation before administratively closing the consult instead of after. The OIG made one recommendation.

Recommendation 7

7. 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 closure of consults that are not low risk.

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

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

Community Care Provider Requests for Additional Services

Community providers may submit requests for additional 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 staff review and make timely decisions on the requests.[35]

The OIG determined that facility community care staff did not consistently process community providers' requests for additional services in a timely manner or send letters to community providers, veterans, or both when requests for service were approved or denied.[36] VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[37] The process requires community providers to submit the request and supporting medical documentation on a VHA-provided form. Then, facility community care staff must

The OIG reviewed requests for additional services at these VISN 21 sites:

Fresno, CA
Mather, CA
North Las Vegas, NV
Palo Alto, CA
Reno, NV
San Francisco, CA

- 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 into the patient's electronic health record, and
- send a letter to the community provider and patient when they approve or deny a request, explaining the reasons for a denied request.[38]

[35] 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.

[36] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed Fresno, Mather, North Las Vegas, Palo Alto, Reno, and San Francisco for this domain.

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

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

Requests for Additional Services Decisions

The OIG found that community care staff at Fresno, Mather, North Las Vegas, Palo Alto, Reno, and San Francisco did not consistently process requests for additional services within three business days of receipt, which may delay care and negatively affect patient outcomes.[39]

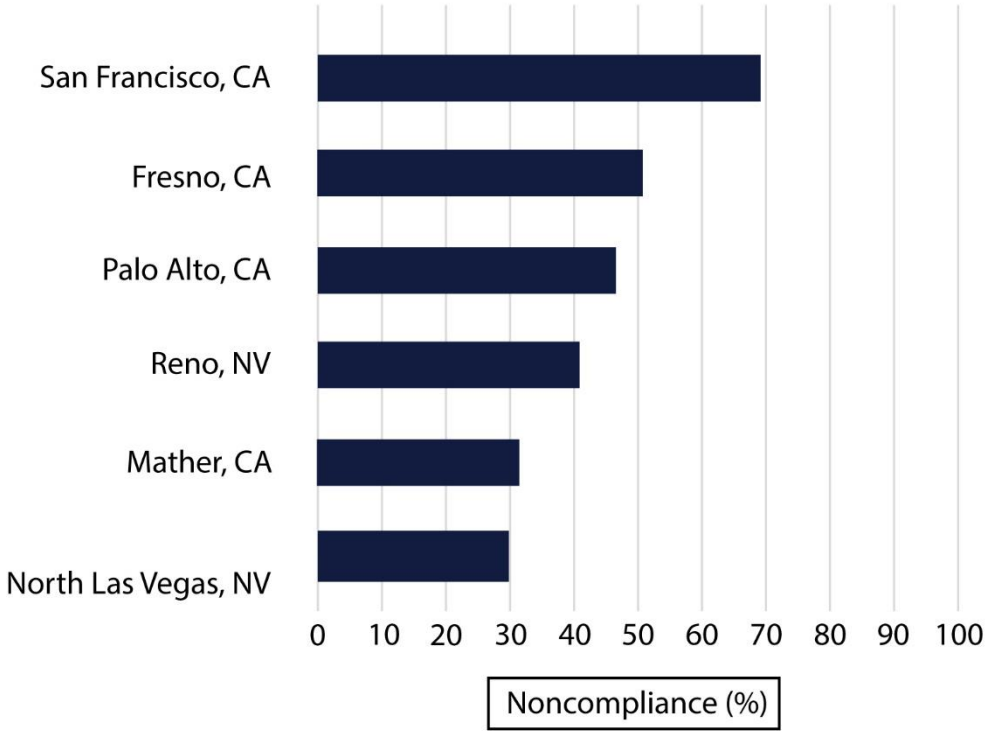

Figure 3. *Percent noncompliance for requests for additional services processed within three business days of receipt.*

Source: OIG analysis of VHA data.

Facilities' community care leaders reported many reasons staff did not process the requests in three business days:

- Staffing shortages
- Large volumes of requests
- Competing priorities of VHA providers who review requests for clinical necessity and respond to community care staff with the decisions

The OIG made one recommendation.

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

Recommendation 8

8. 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 March 2025.

Community Provider Notification of Requests for Additional Services Decisions

The OIG found some facilities' community care staff failed to consistently send letters to community providers when they approved or denied requests for additional services, as required.[40] The OIG estimated that community care staff at Fresno, Mather, North Las Vegas, and San Francisco did not consistently send community providers approval letters for requests for additional services, which could delay care.[41]

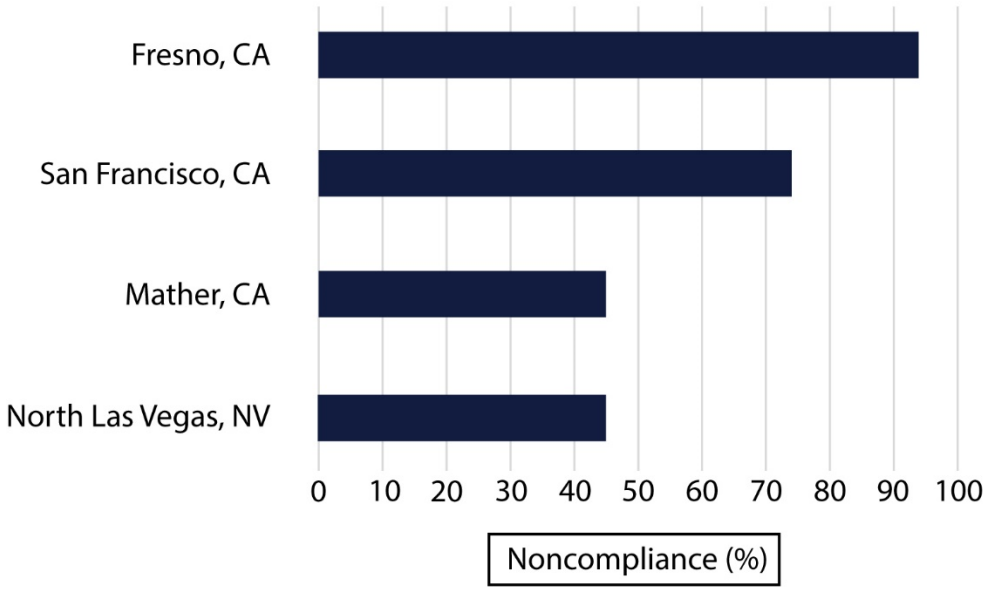

Figure 4. *Percent noncompliance for community provider notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

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

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

The OIG also estimated that facility community care staff at Fresno did not send letters to notify 58 percent (95% CI: 29 to 87) of community providers that their requests for additional services were denied. When staff do not send denial letters, it may delay community providers' in coordinating alternative treatment options or addressing deficiencies with the initial request. Additionally, staff may miss opportunities to educate community providers on the requests for additional services process.

Facility community care leaders reported several reasons staff did not send approval or denial letters to community providers for requests for additional services, including

- facility community care leaders had not established a process, and
- staff sent community providers a new authorization when they approved requests.

The OIG made one recommendation.

Recommendation 9

9. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to community providers for requests for additional services.

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

Patient Notification of Requests for Additional Services Decisions

The OIG found some facilities' community care staff failed to consistently send letters to patients when they approved or denied requests for additional services, as required.[42] The OIG estimated that community care staff at Fresno, Mather, North Las Vegas, Palo Alto, and San Francisco, failed to consistently send patients approval letters (see figure 5).[43] Failure to send approval letters to patients may cause them to be uninformed of the decision in a timely manner.

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

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

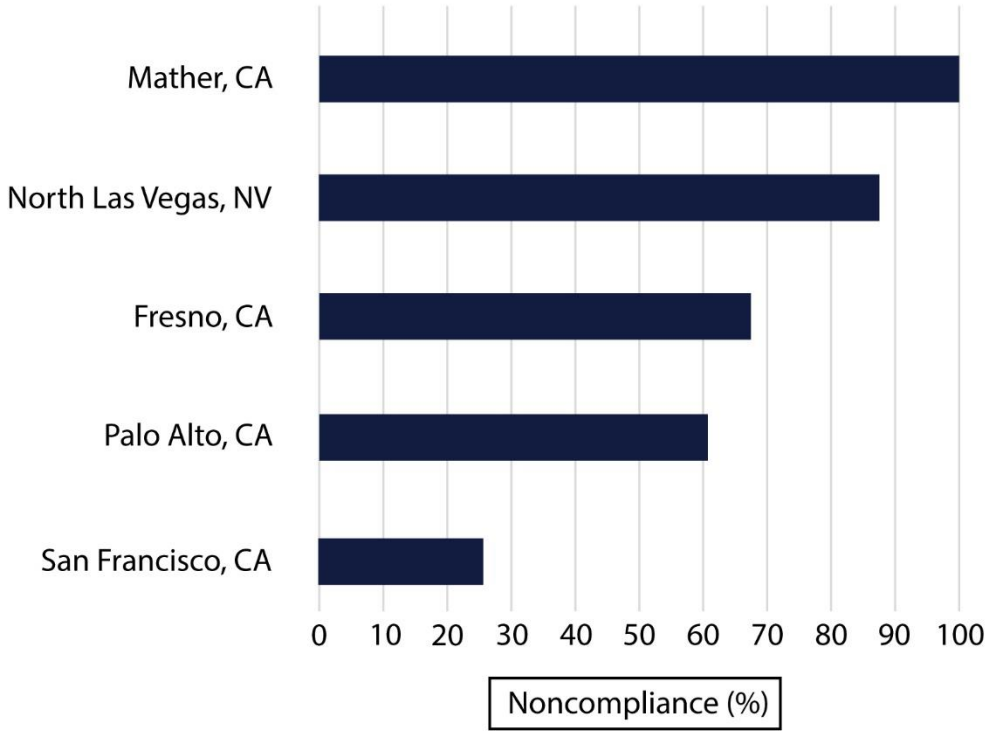

Figure 5. *Percent noncompliance for patient notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

The OIG also estimated that community care staff at Fresno, Mather, North Las Vegas, Palo Alto, Reno, and San Francisco, failed to consistently send letters to patients when they denied requests (see figure 6).[44] Failure to send denial letters to patients may delay them in working with the VHA provider to find an alternative source of care.

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

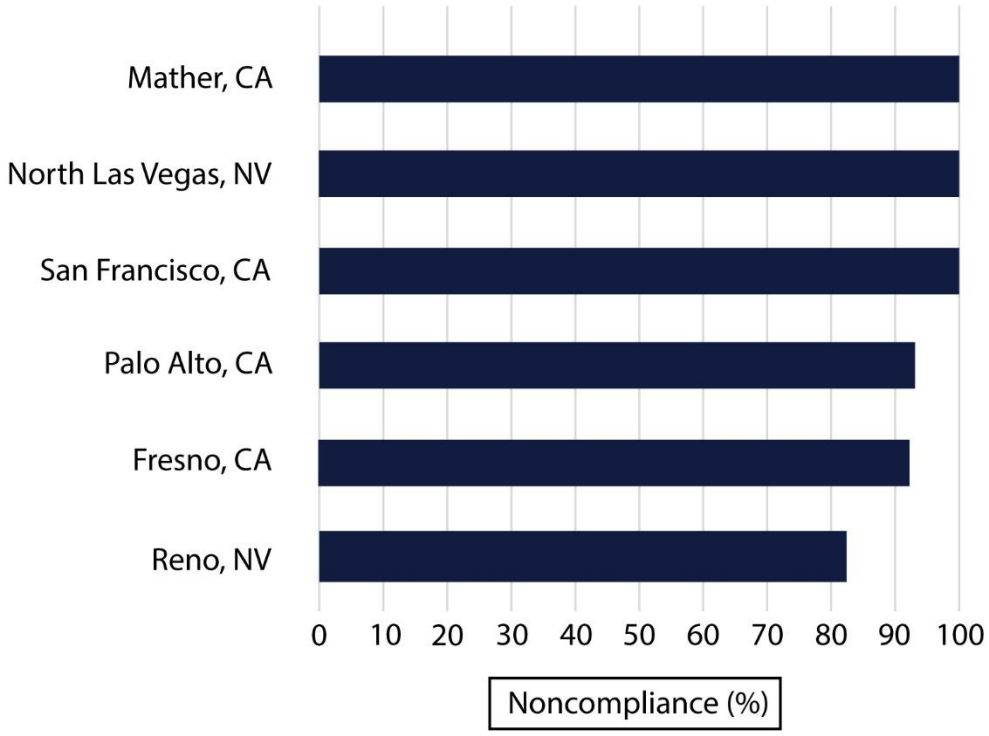

Figure 6. *Percent noncompliance for patient notification of requests for additional services denials.*

Source: OIG analysis of VHA data.

A Reno community care leader stated patient notification of requests for additional services decisions was a relatively recent requirement that was on hold nationally but failed to provide the OIG with supporting documentation. The leader added that staff prioritized coordinating patients' care, ensuring they received care even if they did not receive a decision letter. The OIG made one recommendation.

Recommendation 10

10. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval or denial letters to patients for requests for additional services.

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

Care Coordination: Scheduling and Communication with Patients Referred for Community Care

Facility community care staff use care coordination to organize services and resources with patients and community care providers based on an individual patient's needs. A VHA care coordination plan addresses activities, such as appointment scheduling, follow-up, communication with the patient and community providers, and transition back to VHA medical care.[45]

The OIG reviewed Care Coordination at this VISN 21 site:

San Francisco, CA

The OIG found that San Francisco community care staff did not consistently schedule patient appointments in a timely manner, verify patients attended their appointments, use the Community Care–Care Coordination Plan note, or contact patients according to VHA recommendations.[46] VHA has established a care coordination model as a framework for overseeing care and aligning resources based on the individual patient's needs. The model details the required activities of facility care coordination staff, defines roles and responsibilities, and describes specific ways to accomplish goals, such as improved care transitions between VHA and community providers.[47]

Facility community care staff use an automated algorithm called the Screening Triage Tool to determine the appropriate level of care coordination for each consult.[48] Levels are based on the intensity, frequency, duration, and type of care coordination each patient needs. As care complexity increases, so does the type and frequency of care coordination services, including contact with the patient.[49] Table 2 lists the levels of care and corresponding recommended frequency of patient contact.[50]

[45] VHA IVC, "Community Care–Care Coordination Plan (CC-CCP) Note Standard Operating Procedure," June 2022.

[46] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed San Francisco for this domain.

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

[48] The Screening Triage Tool is a tool in the electronic health record that community care staff use to assess a patient's care coordination needs. VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure," July 2, 2019.

[49] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

[50] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

Table 2. Levels of Care and Recommended Frequency of Patient Contact

Level of Care	Frequency of Patient Contact
Basic	As needed
Moderate	Monthly to quarterly
Complex/chronic	Weekly to monthly
Urgent	Hourly to daily

Source: VHA, "Screening Triage Tool Standard Operating Procedure."

VHA also developed a standardized progress note, called the Community Care–Care Coordination Plan note, that facility community care staff use to document aspects of care coordination, such as clinically indicated services and a patient's psychosocial needs, preferences, and goals. Staff are required to document all care coordination activities for each consult in the note, except for consults with a basic level of care coordination or those for geriatrics and extended care and direct scheduling.[51]

Timely Scheduling of Community Care Consults

The OIG found that San Francisco community care staff did not consistently meet timeliness requirements for scheduling community care appointments.[52] VHA requires facility community care staff to schedule appointments for patients within seven days of the community care consult entry or its receipt in the community care department.[53] The OIG estimated that, for patients referred by San Francisco providers, community care staff did not meet the scheduling requirement for 82 percent (95% CI: 70 to 92) of consults, and scheduling appointments took up to 168 days.

Failure to schedule patients' community care appointments promptly may delay the provision of needed care. San Francisco community care leaders attributed scheduling delays to a lack of oversight and staff training. The OIG made one recommendation.

[51] Deputy Under Secretary for Health for Operations and Management (10N), "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum to Veterans Integrated Service Network Directors (10N1-23), September 16, 2019; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

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

[53] VHA IVC, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022.

Recommendation 11

11. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff schedule patients for community care appointments within seven days of consult entry or receipt in the department.

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

Confirmation Patients Attended Community Care Appointments

The OIG found that San Francisco community care staff did not consistently confirm patients attended their scheduled appointments, as required.[54] Before searching for medical documentation from the visit, facility community care staff need to contact the patient, and if the patient cannot be reached, contact the community provider to determine if the patient kept the appointment.[55] The OIG estimated that San Francisco community care staff did not confirm 47 percent (95% CI: 33 to 61) of patients attended their scheduled appointments. The community care leaders reported a lack of their oversight to ensure staff complied with the requirement. The OIG made one recommendation.

Recommendation 12

12. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended scheduled community care appointments and received care.

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

Documentation of Care Coordination Activities

The OIG determined that San Francisco community care staff did not consistently use the Community Care–Care Coordination Plan note to document care coordination activities.[56] VHA requires staff to use the Community Care–Care Coordination Plan note in the electronic health record to document patients' care, including developing, monitoring, and tracking care

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

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

[56] No confidence interval is determined when there is 100% noncompliance. Statistical estimates for facility noncompliance are reported in appendix C. Deputy Under Secretary for Health for Operations and Management, "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

coordination activities for all consults with an assigned level of care other than basic.[57] When staff fail to use the required note, patients may experience delays in care or diagnosis or miss appointments. A San Francisco community care leader attributed the noncompliance to staff not understanding the requirement. The OIG made one recommendation.

Recommendation 13

13. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care other than basic.

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

Patient Contacts According to Recommended Frequencies

The OIG found that San Francisco community care staff did not contact any patients referred to community care according to the VHA-recommended frequency for consults requiring complex/chronic level of care coordination.[58] Although VHA requires staff to assign a level of care coordination to each consult, they are not required to follow up with patients according to the recommended frequencies.[59] Therefore, the OIG is concerned that patients may not receive adequate care coordination and follow-up, which could compromise patient safety. San Francisco community care leaders attributed the noncompliance to a shortage of nursing staff. Because the guidebook recommends but does not require contacts based on assigned levels of care, the OIG made no recommendation.

[57] Deputy Under Secretary for Health for Operations and Management, "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[58] No confidence interval is determined when there is 100% noncompliance. Statistical estimates for facility noncompliance are reported in appendix C.

[59] VHA IVC, chap. 2 in *Community Care Field Guidebook*, November 29, 2022.

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at selected facilities within VISN 21, the OIG conducted a detailed inspection from February 21 through March 8, 2024. Addressing five domains of community care across seven VISN facilities with community care programs, the inspection resulted in 13 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 fiscal year. 2. Facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system. 3. Patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings. 4. Facility staff scan all community care documents into the patient's electronic health record within five business days of receipt.
Community Care Diagnostic Imaging Results	5. Facility community care staff use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.
Administratively Closed Community Care Consults	6. Facility community care staff confirm patients attended their appointments and attempt to obtain medical documentation prior to administratively closing consults. 7. Facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative closure of consults that are not low risk.
Community Care Provider Requests for Additional Services	8. Facility community care staff process community care providers' requests for additional services within three business days of receipt. 9. Facility community care staff send approval or denial letters to community providers for requests for additional services. 10. Facility community care staff send approval or denial letters to patients for requests for additional services.
Care Coordination: Scheduling and Communication with Patients Referred for Community Care	11. Facility community care staff schedule patients for community care appointments within seven days of consult entry or receipt in the department. 12. Facility community care staff confirm patients attended scheduled community care appointments and received care. 13. Facility community care staff use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care other than basic.

Appendix B: Methodology

The OIG reviewed community care processes at seven VISN 21 medical facilities with a community care program from February 21 through March 8, 2024. The seven facilities were the VA Central California Health Care System (Fresno), VA Pacific Islands Health Care System (Honolulu), VA Northern California Health Care System (Mather), VA Southern Nevada Healthcare System (North Las Vegas), VA Palo Alto Health Care System (Palo Alto), VA Sierra Nevada Health Care System (Reno), and San Francisco VA Health Care System (San Francisco).

The team reviewed facilities' electronic health records and results from the OIG's survey distributed to VHA facility primary care providers.[1] The OIG reviewed the community care oversight council charters and meeting minutes for fiscal year 2023 to determine if they had a council and if it met the minimum number of times required by their charter. The OIG also 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 February 27 through March 10, 2024. The OIG emailed 470 surveys to VISN 21 primary care providers and received 152 replies, a 32 percent response rate. The OIG's analysis relied on inspector's 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.*[2]

The inspection team examined operations and electronic health records from October 1, 2022, through September 30, 2023. The OIG reviewed each facility for performance in the Leadership and Administration of Community Care and Community Care Diagnostic Imaging Results domains. After reviewing facility performance data relevant to each respective domain, the OIG selected two additional domains for each facility, for a total of four per facility. For Fresno and Honolulu, the OIG originally selected the four domains but after identifying many exclusions in the patient data, removed the Care Coordination: Scheduling and Communication with Patients Referred for Community Care domain. OIG leaders approved all domain selections based on content and professional judgment. The domains selected for each VISN 21 facility are shown in figure 7.

[1] Each VA Medical Center 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] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

	Fresno CA	Honolulu HI	Mather CA	North Las Vegas NV	Palo Alto CA	Reno NV	San Francisco CA
Leadership and Administration	✓	✓	✓	✓	✓	✓	✓
Diagnostic Imaging Results	✓	✓	✓	✓	✓	✓	✓
Administratively Closed Consults		✓	✓	✓	✓	✓	
Requests for Service	✓		✓	✓	✓	✓	✓
Care Coordination							✓

Figure 7. *Domain selections for VISN 21 facilities.*

Source: OIG analysis of VHA data.

For each VISN 21 facility, 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 consults for computed tomography, ultrasound, or magnetic resonance imaging.
- Administratively Closed Community Care Consults: community care consults administratively closed without medical records, excluding consults for low-risk, dental, and geriatrics and extended care services.
- Community Care Provider Requests for Additional Services: 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.
- Care Coordination: Scheduling and Communication with Patients Referred for Community Care: community care consults for which VHA community care staff scheduled the community care appointment for the patient and did not complete the consult within 90 calendar days, excluding referrals for low-risk, optometry, audiology, dental, future care, imaging, and geriatrics and extended care services. This domain also excluded patients who scheduled their own appointments.

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. The OIG conducted statistical analysis on all randomly selected samples. Results of statistical analysis are reported in appendix C.

The OIG reported a confidence interval for the statistical analysis for all random samples. The OIG did not calculate a confidence interval if the noncompliance percent was equal to 100 or 0.

A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. A 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and study design, the true value would have been covered by the confidence intervals 95 percent of the time. The OIG made a recommendation when the noncompliance percentage was statistically significantly above the 10 percent deficiency benchmark and the lower bound of the 95% confidence interval was above 10 percent.

This report is a review of VISN 21 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.[3] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability. 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.

[3] 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 21, the OIG estimated that Fresno, Honolulu, Mather, North Las Vegas, Palo Alto, and Reno community care staff did not consistently use the significant findings alert to notify providers of abnormal diagnostic imaging results, as shown in Table C.1.

Table C.1. Significant Findings Alert Used to Notify Providers of Abnormal Diagnostic Imaging Results

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	37	100	N/A*
Honolulu	18	100	N/A*
Mather	25	96	87 to 100
North Las Vegas	13	77	50 to 100
Palo Alto	37	70	55 to 84
Reno	25	100	N/A*
San Francisco	9	N/A‡	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.*

‡ Estimates are omitted for San Francisco because the number of patients in the sample was less than 11.

Based on the electronic health records reviewed for selected facilities, the OIG estimated that Honolulu community care staff did not consistently confirm patients attended appointments and attempt to obtain documentation prior to administratively closing community care consults, as shown in Table C.2.

Table C.2. Appointment Attendance Confirmed and Attempts to Obtain the Medical Documentation Made Prior to Administratively Closing Consults

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Honolulu	49	22	12 to 35
Mather	43	9	2 to 19
North Las Vegas	48	0	N/A*
Palo Alto	42	2	0 to 8
Reno	41	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, the OIG estimated that Honolulu and Mather community care staff did not consistently make two additional attempts within 90 days to obtain medical documentation after administratively closing consults that are not low risk, as shown in Table C.3.

Table C.3. Additional Attempts to Obtain Medical Documentation Made After Administrative Closure

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Honolulu	23	70	50 to 88
Mather	29	97	88 to 100
North Las Vegas	4	N/A*	N/A
Palo Alto	10	N/A*	N/A
Reno	4	N/A*	N/A

Source: OIG analysis of VHA data.

** Estimates are omitted when the number of patients in the sample was less than 11.*

Based on the electronic health records reviewed, the OIG estimated that Fresno, Mather, North Las Vegas, Palo Alto, Reno, and San Francisco community care staff did not consistently process requests for additional services within three business days of receipt, as shown in Table C.4.

Table C.4. Requests for Additional Services Processed within Three Business days of Receipt

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	45	51	37 to 65
Mather	50	32	20 to 46
North Las Vegas	50	30	18 to 44
Palo Alto	49	47	33 to 61
Reno	46	41	27 to 56
San Francisco	45	69	55 to 82

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG estimated that Fresno, Mather, North Las Vegas, and San Francisco community care staff did not consistently send approval letters for requests for additional services to community care providers, as shown in Table C.5.

Table C.5. Approval Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	33	94	84 to 100
Mather	38	45	29 to 61
North Las Vegas	31	45	28 to 63
Palo Alto	21	0	N/A*
Reno	35	17	6 to 30
San Francisco	34	74	58 to 88

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, the OIG estimated that Fresno staff did not consistently send denial letters to community care providers for requests for additional services, as shown in Table C.6.

Table C.6. Denial Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	12	58	29 to 87
Mather	12	25	0 to 50
North Las Vegas	19	11	0 to 27
Palo Alto	28	0	N/A*
Reno	11	18	0 to 45
San Francisco	11	18	0 to 44

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, the OIG estimated that Fresno, Mather, North Las Vegas, Palo Alto, and San Francisco community care staff did not consistently send approval letters to patients for requests for additional services, as shown in Table C.7.

Table C.7. Approval Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	33	67	50 to 82
Mather	38	100	N/A*
North Las Vegas	31	87	74 to 97
Palo Alto	21	62	40 to 82
Reno	35	20	8 to 34
San Francisco	34	26	12 to 42

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, the OIG estimated that Fresno, Mather, North Las Vegas, Palo Alto, Reno, and San Francisco community care staff did not consistently send denial letters to patients for requests for additional services, as shown in Table C.8.

Table C.8. Denial Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Fresno	12	92	73 to 100
Mather	12	100	N/A*
North Las Vegas	19	100	N/A*
Palo Alto	28	93	82 to 100
Reno	11	82	56 to 100
San Francisco	11	100	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, the OIG estimated that San Francisco community care staff did not consistently schedule community care appointments for patients within seven days of consult entry or its receipt in the community care department, as shown in Table C.9.

Table C.9. Appointments Scheduled within Seven Days of Entry or Receipt in the Community Care Department

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
San Francisco	49	82	70 to 92

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG estimated that San Francisco community care staff did not consistently confirm patients attended scheduled community care appointments, as shown in Table C.10.

Table C.10. Appointment Attendance Confirmed

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
San Francisco	49	47	33 to 61

Source: OIG analysis of VHA data.

Based on the electronic health records reviewed, the OIG determined that San Francisco community care staff did not use the Community Care–Care Coordination Plan note to document care coordination for any consults with an assigned level of care other than basic, as shown in Table C.11.

Table C.11. Community Care–Care Coordination Plan Note Used to Document Care Coordination for Consults with an Assigned Level of Care other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
San Francisco	47	100	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, the OIG determined that San Francisco community care staff did not contact patients according to the recommended frequency for consults with complex/chronic levels of care at, as shown in Table C.12.

Table C.12. Patient Contacts According to the Recommended Frequency for Consults with Complex/Chronic Level of Care Coordination

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
San Francisco	48	100	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.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 28, 2024

From: Director, VA Sierra Pacific Network (10N21)

Subj: Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers

To: Director, Office of Healthcare Inspections (54CC02)

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

1. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values, including leadership commitment, sensitivity to operations, and deference to expertise. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, VAOIG DRAFT REPORT - Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers.
2. We have reviewed and provided responses to the OIG recommendations and the action plans submitted by VISN 21.
3. I would like to thank the Office of Inspector General for their thorough review, and if there are any questions regarding responses or additional information required, please contact the VISN Quality Management Officer.

(*Original signed by:*)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

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 fiscal year.

VISN concurs.

Target date for completion: March 2025.

VISN response: Veterans Integrated Services Network (VISN) 21 conducted a review of all facility community care council charters. All sites are currently meeting as outlined by each facility's community care council charter. VISN 21 will continue to monitor facility community care council meetings and request signed minutes after each meeting for continued review and tracking. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN 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 enter community care patient safety events into the Joint Patient Safety Reporting system.

VISN concurs in principle.

Target date for completion: March 2025.

VISN response: In collaboration with Integrated Veteran Care (IVC), National Center for Patient Safety (NCPS), and the National Quality Patient Safety Program Office, VISN 21 will ensure facility community care staff enter all reported community care-related patient safety events by submitting a Joint Patient Safety and Reporting (JPSR) (VA side), and, when applicable, a Patient Quality Issue form will be submitted to TriWest for Community Care Network (CCN) Providers. The VISN is currently awaiting updated patient safety guidance (Patient Safety Guidebook v6.2). Once released, this updated guidance will be disseminated to all VISN 21 Community Care staff, and JPSR submissions tracked through the VISN Patient Safety Dashboard. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN Governance structure.

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

Recommendation 3

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: March 2025.

VISN response: The VISN 21 Patient Safety Officer reports community care patient safety event trends, lessons learned, and corrective actions to the VISN Community Care Oversight Committee. VISN 21 facility Patient Safety Managers or designees will brief community care patient safety event trends, lessons learned, and corrective actions quarterly at the facility Community Care Oversight Council Meetings. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN Governance structure.

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

Recommendation 4

The Veteran Integrated Service Network Director, in conjunction with facility directors, ensures facility 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: March 2025.

VISN response: As of quarter three of fiscal year 2024, VISN 21 Community Care does not have a backlog in scanning of medical records and is tracking the five-day standard within Healthcare Information Management (HIM) and through a VISN-level weekly suspense. VISN 21 reports Community Care backlogs (>5 days) to the National HIM Program Office through a quarterly monitor of facility scanning backlogs. Action plans are provided, as required, through the national process. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN Governance structure.

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, requires facility community care staff to use the significant findings alert to notify the ordering provider of abnormal diagnostic imaging results.

VISN concurs in principle.

Target date for completion: September 2025.

VISN response: Current IVC Field Guidebook (FGB) guidance directs staff to utilize significant findings alerts for both abnormal imaging results and when no medical records are received stating: "Significant finding alerts should only be used for abnormal tests, study or procedure results or for no records returned on screening/testing referrals." VISN 21 collaborated with IVC to provide feedback on this guidance that would assist with aligning to other VHA enterprise initiatives such as REBOOT to address provider alert fatigue. Per IVC, guidance within the IVC FGB is currently being reviewed, and expected to be released providing more clarity to the field regarding the use of 'significant findings' alerts. Once updated guidance is received, VISN 21 will ensure this information is disseminated to the field by a VISN-led training, evidenced by documentation within VISN 21 Community Care Oversight Committee minutes.

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 confirm patients attended their appointments and attempt to obtain medical documentation prior to administratively closing consults.

VISN concurs.

Target date for completion: March 2025.

VISN response: VISN 21 will ensure facility community care staff confirm patients attended their appointments and attempt to obtain medical documentation before administratively closing consults. VISN 21 will conduct reviews of consults closed administratively, without medical records. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN 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, ensures facility community care staff make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative closure of consults that are not low risk.

VISN concurs in principle.

Target date for completion: March 2025.

VISN response: VISN 21 will continue to engage with IVC to clarify and align the IVC FGB regarding the number of additional attempts to obtain community providers' medical documentation within 90 days of the appointment following administrative consult closure. When updates to the Guidebook are made that impact this process, the VISN 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. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN 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 process community care providers' requests for additional services within three business days of receipt.

VISN concurs in principle.

Target date for completion: March 2025.

VISN response: There remain additional opportunities related to the current tracking mechanisms of Request for Service (RFS) documents and statuses with the provided IVC RFS data sources. Accurate tracking of RFS documents and statuses are dependent upon individual user's utilization of the Consult Toolbox (CTB). Clinical review of RFS documents may require additional time, for example, due to lack of medical record justification from CCN [community care network] providers, or RFS clinical review through referral coordination team (RCT) pathways.

VISN 21 facilities will review RFS documents, utilization of the CTB, and escalate delays to facility leadership. Individual facility RFS tracking compliance will be captured and reported at facility Community Care Oversight Council meetings. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN 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 send approval or denial letters to community providers for requests for additional services.

VISN concurs in principle.

Target date for completion: March 2025.

VISN response: All VISN 21 facility Community Care teams are currently sending Community Care related Request For Additional Services (RFS) approval/denial letters to community providers in response to RFS documents received. VISN 21 Community Care leadership will require facility attestations ensuring that facilities have implemented RFS letters to community providers. Monitoring will be met through facility attestation. Compliance will be reported at the VISN 21 Community Care Oversight Committee 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 send approval or denial letters to patients for requests for additional services.

VISN concurs in principle.

Target date for completion: March 2025.

VISN response: All VISN 21 facility Community Care teams are currently sending RFS approval/denial letters to patients in response to RFS documents received. VISN 21 Community Care leadership will require facility attestations ensuring that facilities have implemented RFS letters to veterans. Monitoring will be met through facility attestation. Compliance will be reported at the VISN 21 Community Care Oversight Committee 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 schedule patients for community care appointments within seven days of consult entry or receipt in the department.

VISN concurs in principle.

Target date for completion: September 2025.

VISN response: All seven of the VISN 21 sites have an active action plan in place to improve this metric over time. The actions are monitored by the VISN Community Care leadership. VISN 21 is committed to working towards the improvement of this metric across the seven facilities. Monitoring will be met through evidence of VISN 21 Community Care Oversight Council meeting minutes, with a target goal of two (2) consecutive quarters of sustainment. Compliance will be reported at the VISN 21 Community Care Oversight Committee through the VISN 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 confirm patients attended scheduled community care appointments and received care.

VISN concurs.

Target date for completion: March 2025.

VISN response: FGB Chapter 4:05.04.00 states community care staff will verify the Veteran attended the appointment by calling the Community Provider, calling the Veteran or using other tasks including the Health Share Referral Manager Task List (including obtaining Medical Records).

The VISN 21 Business Implementation Manager and Community Care Nurse Manager confirmed that VISN 21 facilities currently comply with outlined FBG methods of verifying patient care was received. In addition, all VISN 21 sites utilize VetText as a modality to confirm community care appointments. The Veteran can reply with Attended, Not Attended, Cancelled or Rescheduled (and enter the new appointment information). Subsequent consult actions, follow all outlined IVC FGB guidance, and VISN 21 currently tracks all 'scheduled linked to past appointment' Community Care metrics. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN Governance structure.

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

Recommendation 13

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care other than basic.

VISN concurs.

Target date for completion: July 2025.

VISN response: All VISN 21 sites utilize the Community Care–Care Coordination Plan Note as outlined by IVC FGB guidance.

Continued training and tracking will be monitored by VISN using the IVC-provided data resource dashboard. A facility-level review will be conducted by facility Community Care Leadership. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 21 Community Care Oversight Committee through the VISN Governance structure.

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

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