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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities

AUDIT | REPORT #18-05121-36 | JANUARY 16, 2020

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Executive Summary

Veterans Integrated Service Network (VISN) 8—one of the Veterans Health Administration's (VHA) 18 VISNs—serves a population of more than 1.6 million patients across Florida, south Georgia, Puerto Rico, and the Caribbean. In fiscal year (FY) 2018, VISN 8 had an overall operating budget of approximately $5 billion and referred more than 206,500 requests for care to its community care departments so that patients could obtain care with a non-VA provider.

VA medical facilities fund and operate their own community care departments to timely process and coordinate appropriate care that patients need to obtain in the community. These departments review, authorize, and schedule requests for community care received through consults from their VA facility services.[1] Moreover, VA officials estimated that the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 will increase the number of patients eligible for private care. Accordingly, it is critical that requests for community care be promptly processed.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VISN 8 facilities were appropriately staffed and structured to meet their responsibilities of effectively and efficiently managing the community care needs of veterans.

What the Audit Found

The audit team found that VA medical facility community care departments in VISN 8 lacked sufficient administrative staffing and could improve consult processing to manage the needs of patients. The community care departments' staffing and structure challenges delayed processing patients' care with community providers. On average in FY 2018, VA medical facility clinical services (such as cardiology, urology, ophthalmology, and physical therapy) took about 10 days to refer patients to community care departments. After that, community care staff took an average of three days to accept the consults, and an additional 43 days passed before the patients received care in the community. About 18 of those 43 days elapsed while the care was awaiting authorization by community care staff, after which the scheduling process would begin.

Of the consults VISN 8 facilities referred to community care in FY 2018, 39 percent were referred because VA facilities could not provide access to care in a timely manner. However, based on the audit team's assessment, VISN 8 facilities did not have a mechanism to identify, compare, and share appointment wait times for similar services obtained either at the VA facility or in the community. As a result, VA facility schedulers could not tell patients what their wait would be if they opted for community care. The deputy executive director of clinical integration

[1] A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem.

at the VA Office of Community Care (OCC) stated that identifying wait times in the community and comparing them to in-house wait times would allow staff to make an informed decision about referring patients. Furthermore, comparing wait time data for services at the VA facility to the same services in community care could provide valuable insight for leaders about where specific delays in care occur.

The audit team identified that community care departments lacked sufficient staffing, primarily for administrative functions, and could improve consult processing, particularly when staff needed to authorize and schedule patients for care in the community. The audit team's assessment of staffing levels in the community care departments indicated that five of seven VISN 8 facilities remained short of administrative staffing needs as of October 2018. Cumulatively, the data showed the facilities had 237 administrative staff in the pertinent departments, whereas the OCC recommended a minimum of 313 administrative staff. According to VISN 8 community care service chiefs, this was because the fluctuating workload made it difficult to determine how many staff were needed, and they did not agree the staffing tool accounted for the complexity of care.

In 2018, VISN 8's community care departments needed to process consults returned by their former third-party contractor. According to VISN 8 leadership, this occurred because the contractor was not successfully scheduling referrals, causing a delay in care. In addition, responsibilities of community care departments increased as a result of the authorization process being transitioned back to the facilities. This transition of duties occurred because VISN 8 leadership believed that sending the authorizations to OCC contributed to delays. Interviews with community care department staff indicated that the unpredictable number of consults for processing during 2018 made it difficult for the community care departments to manage their workloads.

The audit team identified separate consult processes at the VISN 8 facilities' community care departments that contributed to delays in patient care. Some administrative staff typically only worked on creating authorizations, while other staff only scheduled appointments. The OCC's deputy executive director of clinical integration and the nurse executive of clinical integration stated that they recommended the authorization and scheduling functions be performed by the same administrative staff because it would facilitate an active partnership between the patient and the community care staff. Separating the authorization and scheduling functions began in August 2014, when VISN 8 transferred the authorization responsibilities of the community care consult process to the OCC. A VISN 8 operations council review of consult processing determined that assigning authorization duties to the OCC contributed to delays in creating authorizations for community care consults across VISN 8. Although VISN 8 made this determination in November 2017, the authorization processing task—and respective staff—did not return to the facility community care departments until July 2018. According to the VISN 8 business development officer, the delay in transferring the authorization task back to facilities

was due to concerns regarding concurrence from the OCC on the validation of full-time equivalent (FTE) staffing to be returned, the transition of VISN 8's director, and union notification and approval. Once returned, only one of the seven community care departments merged the scheduling and authorization tasks. Staff at the other facilities indicated they did not merge the scheduling and authorization process because they did not prioritize cross-training staff due to the number of open consults they needed to process.

According to VA, the number of patients eligible to receive care in the community is expected to significantly increase from 684,000 to approximately 3.7 million because of broader eligibility requirements under the MISSION Act of 2018. Overall, as of July 2019, VISN 8 community care departments had more than 74,500 open consults, which generally meant these patients were not yet scheduled; were scheduled and waiting for their appointment; or had already completed care, but the VA facility had yet to receive or record the non-VA provider medical documentation. Further, according to VISN 8's data, the number of consults sent to community care departments had increased from an average of about 3,350 per month to about 4,430 per month.[2] Given the current workload and potential increase in patients eligible to receive community care, it is critical that VHA ensures sufficient staffing and efficient processing to effectively manage the workload.

What the OIG Recommended

The OIG made five recommendations to the VISN 8 director to improve timeliness of community care consults and address staffing deficiencies. The recommendations included implementing a mechanism for VA facility services and community care departments to identify and routinely exchange wait time data. The exchange of data will ensure patients understand potential wait times and will help routinely monitor the timeliness of each community care processing stage to identify specific delays. The OIG also recommended that VISN 8 routinely monitor the OCC staffing tool, ensure community care administrative staff are effectively cross-trained to carry out applicable administrative consult processing duties, and monitor whether community care departments are processing consults in accordance with OCC's guidance and recommendations. VISN 8 should implement specific facility plans to address the backlog of open consults and the growing number of new consults as well.

Management Comments

The VISN 8 network director concurred with all five recommendations and provided responsive action plans for each recommendation. The OIG will monitor implementation of planned actions

[2] This average was measured using data from October 2018 through May 2019 (prior to the MISSION Act implementation) and compared to data from June 2019 through August 2019 (after the MISSION Act was implemented on June 6, 2019).

and will close the recommendations when VISN 8 provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

DUSHOM	deputy under secretary for health operations and management
FY	fiscal year
FTE	full-time equivalent
Health Net	Health Net Federal Services LLC
MISSION Act	Maintaining Internal Systems and Strengthening Integrated Outside Networks Act
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted this audit to determine whether Veterans Integrated Service Network (VISN) 8 facilities were appropriately staffed and structured to meet their responsibilities for effectively and efficiently managing the community care needs of veterans.

Community care staff in VA facilities are responsible for reviewing, authorizing, and scheduling requests for care in the community that they receive as consults from their VA facility services. Coordinating community care for VA patients in a timely manner is a significant VA medical facility responsibility. In June 2019, VA began implementing new eligibility requirements under the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which also consolidated community care into one program. Under this program, VA community care staff in VA facilities are responsible for coordinating and scheduling community care appointments for patients.[3] According to VA, the number of patients eligible to receive care in the community is expected to increase from 684,000 patients under the Veterans Choice Program to approximately 3.7 million patients under the MISSION Act because of broader eligibility requirements. Given the expected significant increase in community care demand, it is critical that the Veterans Health Administration (VHA) ensure sufficient staffing and processing to manage the workload.

Coordinating Community Care Appointments

When VA facility staff determine a patient needs care that the facility cannot provide in a timely manner—or at all—or if there is an excessive burden for the patient, they refer the patient to his or her community care department using a consult.[4] In general, VISN 8 community care staff are responsible for reviewing and accepting incoming consults, authorizing care with a community provider, scheduling the appointment with the patient and community provider, and obtaining appointment records after the care. Authorizing care is a critical administrative function that gives a non-VA provider the authority to provide care to the VA patient and receive payment for the services.

[3] Prior to the MISSION Act, Health Net Federal Services LLC was VISN 8's third-party administrator responsible for coordinating and scheduling patient appointments, and paying providers for services rendered for care delivered through the Veterans Choice Program. VA facilities were responsible for coordinating appointments for traditional non-VA care.

[4] A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem.

Under the Veterans Choice Program, patient consults were generally referred to a provider in the community if VA could not provide the services the patient needed or if the patient

- Could not receive an appointment within 30 days of the clinically indicated date,[5]
- Lived more than 40 miles (driving distance) from the nearest VA facility,
- Had to travel by air, boat, or ferry to get to the nearest VA facility, or
- Faced an excessive burden in traveling to the nearest VA facility.[6]

VHA consults are in an open status while community care staff are processing them and moved to a closed status once processing is finished. An open consult can be in a status of pending, active, or scheduled. The VHA Support Service Center allows staff to review consult timeliness by measuring the specific number of days a consult spends in each open status phase or until it is moved into a closed status. Figure 1 shows a general overview of the community care consult lifecycle.

[5] VHA Directive 1232(1), *Consult Processes and Procedures*, August 23, 2016, and amended September 23, 2016. This directive states, "The clinically indicated date (CID), previously referred to as the earliest appropriate date, is the date care is deemed clinically appropriate by the VA sending provider." An amended version of VHA Directive 1232 was published on June 29, 2019. The updated criteria did not affect the findings or recommendations.

[6] Subsequent to the audit team's data analysis, VA implemented new eligibility requirements on June 6, 2019, under the MISSION Act that broadened eligibility to allow patients to use community care if their average drive time is longer than 30 minutes for primary care or 60 minutes for specialty care, if VA cannot provide care within 20 days for primary care and 28 days for specialty care, if it's in the patients' best medical interest, or if the VA service does not meet certain quality standards.

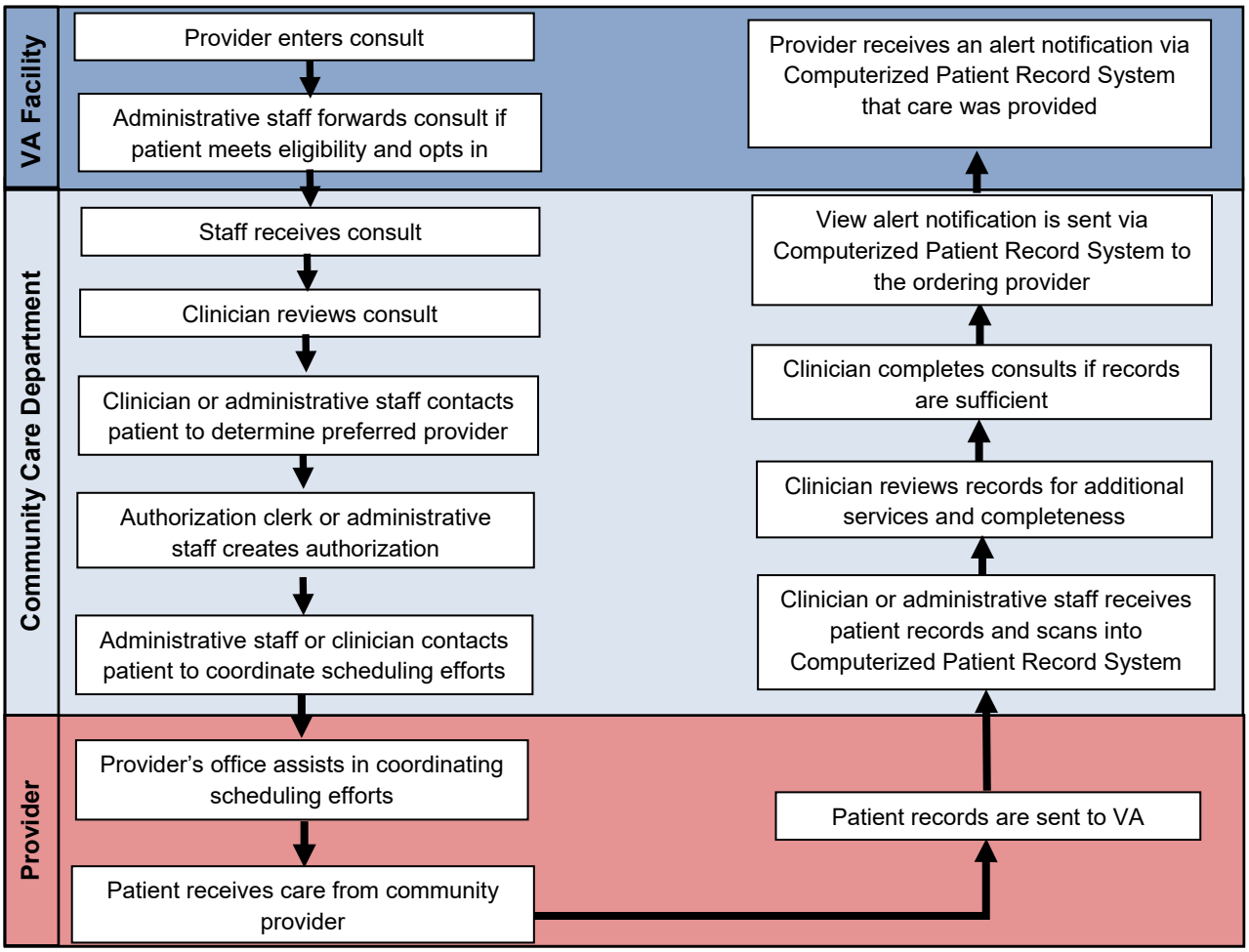

***Figure 1**. Summary of VISN 8 facilities' community care consult process as of November 2018*
Source: VA OIG interviews and analysis of VISN 8 procedures related to community care consult processing

Providing Patients Care in the Community

VHA is geographically divided into 18 VISNs, with each overseeing several VA facilities. VA facilities provide care under VHA guidance, as well as fund and operate their own community care departments. The VA facilities employ clinical and administrative staff in their community care departments to process and coordinate care that patients need to obtain in the community.

VHA's Office of Community Care (OCC) manages programs that allow patients to receive care and services through community providers outside of VA, like the Veterans Choice Program and non-VA community care. The VHA OCC is responsible for functions that support community care administration, planning, and oversight.

VISN 8

VISN 8 serves a population of more than 1.6 million patients across Florida, south Georgia, Puerto Rico, and the Caribbean. Its total fiscal year (FY) 2018 operating budget was about

$5 billion, of which approximately $637 million was used for community care programs. VISN 8 includes more than 60 community-based outpatient clinics and seven primary VA facilities:[7]

- C.W. Bill Young VA Medical Center (Bay Pines, Florida)
- North Florida/South Georgia Veterans Health System (Gainesville, Florida)
- Miami VA Healthcare System (Miami, Florida)
- Orlando VA Medical Center (Orlando, Florida)
- VA Caribbean Healthcare System (San Juan, Puerto Rico)
- James A. Haley Veterans Hospital (Tampa, Florida)
- West Palm Beach VA Medical Center (West Palm Beach, Florida)

VISN 8 facilities submitted more than 206,500 requests for community care in FY 2018—a substantial increase from about 172,400 requests in FY 2016. With the exception of Orlando, all VISN 8 facilities saw increases in requests for community care from FY 2016 to FY 2017, whereas in 2018 three facilities did not experience increases, and of the remaining facilities, the increases were experienced more by some facilities than others. Figure 2 shows the requests for community care at each facility from FY 2016 to FY 2018.

[7] For the purpose of this report, "VA facility" refers to a VA medical center, healthcare system, hospital, or outpatient clinic.

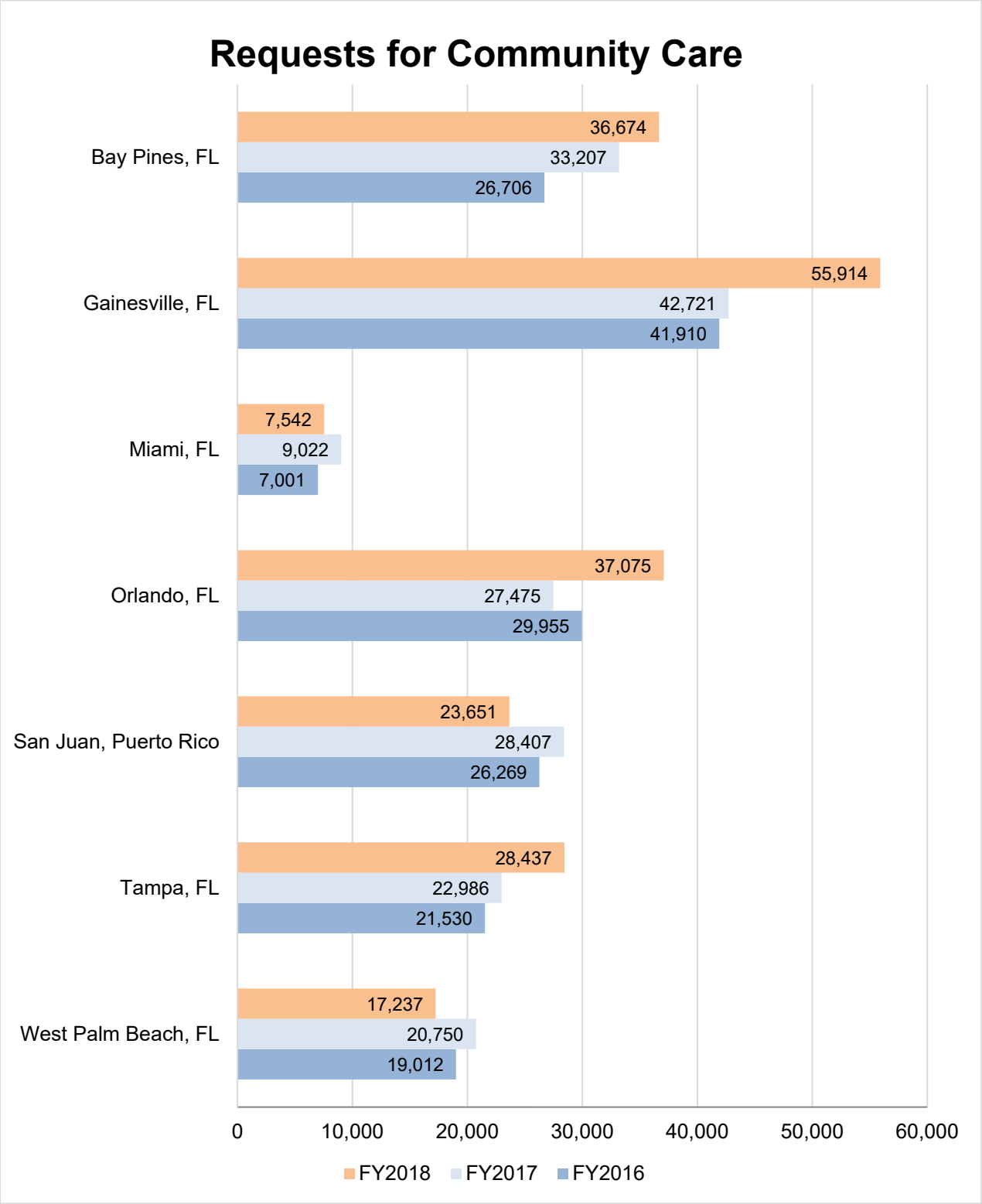

***Figure 2**. Requests for community care*
Source: VA OIG analysis of VHA Corporate Data Warehouse data obtained in April 2019

Results and Recommendations

Finding: Patients Experienced Community Care Appointment Delays Due to Insufficient Staffing and Processing Structure

The audit team found that community care departments lacked sufficient staffing, primarily for administrative functions, and could improve the structure for processing community care consults in a timely manner. On average in FY 2018, VA medical facility services took about 10 days to refer patients to the facility's own community care departments.[8] When community care staff received a referral from clinical services within the facility, they took an average of three days to accept the consults. Patients then waited an average of 43 days from when the community care department accepted the consult to when they attended a scheduled appointment.[9] During that period, an average of 18 days elapsed while staff worked to authorize the care. In the remaining time, staff contacted patients and providers to schedule appointments, and patients waited to receive care. These delays were experienced, in part, because facilities did not hire enough staff to support processing consults returned from the OCC and Health Net Federal Services LLC (Health Net) in 2018 while also trying to keep pace with an increase in consults from services within VA.

A VISN 8 operations council identified delays in completing authorizations for community care across its facilities—a task that OCC staff had performed since late 2014. In November 2017, the council requested approval from the acting director of VISN 8 at the time to realign staff and authorization duties back to the facilities to remedy the delays in the authorization process. However, the transition of duties and staff from the OCC did not occur until July 2018. The delay in transferring the authorization task back to the facilities occurred because VISN 8 stated they had to wait on concurrence from the OCC regarding the number of full-time equivalent (FTE) staff and for the associated funding to be returned.

Furthermore, the community care departments used VHA's web-based tracking database to measure the timeliness of VA facility and community care consults; however, the database did not specifically measure the timeliness of each processing stage of a consult. Establishing specific processing timeliness metrics would allow VA facility leaders to identify distinct processing delays within the community care departments.

[8] The calculation to determine this average number of days was based on consults sent to community care when the service determined it could not provide access to care in a timely manner, and did not include consults sent directly to the community care department when it did not offer the clinical service.

[9] The calculation to determine this average number of days was based on completed consults that had a scheduled appointment linked to the consult.

What the OIG Did

Of the nearly 206,500 requests for community care submitted in FY 2018, approximately 104,000 were completed as of November 29, 2018. To assess the timeliness of consults processed during the various phases of the consult life cycle, the audit team analyzed data for the approximately 104,000 completed consults. From July 2018 through March 2019, the audit team interviewed more than 200 individuals, including VISN 8 leaders, facility directors, and chiefs of staff. The team also interviewed facility personnel such as physicians, service chiefs, supervisors, nurses, and medical support assistants, as well as representatives from VA's OCC.

This report discusses how

- Patients experienced delays getting community care appointments,
- Most VISN 8 community care departments were not sufficiently staffed, and
- VISN 8 facilities separated the authorization and scheduling processes.

Patients Experienced Delays Getting Community Care Appointments

VHA's OCC *Transition Field Guidebook* established various consult processing metrics to measure timeliness from the initial care request date to when care was forwarded to the community care department for action. Specific metrics outline that 90 percent of consults should be reviewed and moved to active or scheduled status within seven days of referral, scheduled within 30 days, and scheduled no more than 90 days from the date the consult was created.

Using "average days" as the measure, the audit team found that prior to accepting a consult, VA facility services in VISN 8 took 10 days to refer consults to their community care departments. Community care staff then took three more days to accept the consults. After that, patients waited an additional 43 days before receiving care in the community. Within the 43 days, about 18 days elapsed while staff worked to authorize the care. In the remaining time, staff contacted patients and providers to schedule appointments, and patients waited to receive care.[10]

An additional 50 days elapsed, on average, before the community care department staff obtained and documented appointment results from the community provider. This time is significant because in some cases, if the patient scheduled his or her own appointment and VA staff did not confirm the scheduled appointment with the patient, receiving appointment results was the first time community care staff learned that an appointment was scheduled. Figure 3 identifies the average days to complete community care consults for VISN 8 facilities.

[10] Elapsed time reported in this section represents the average number of days based on the audit team's analysis of data for the approximately 104,000 completed consults.

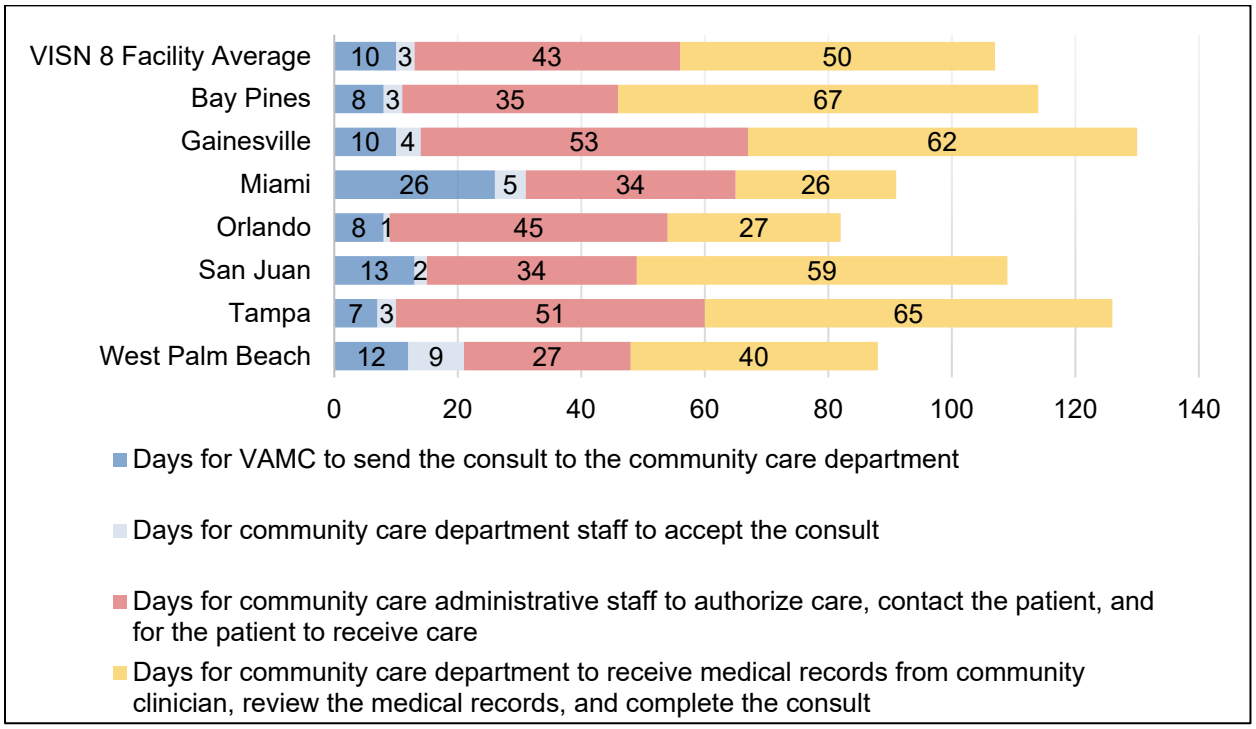

Figure 3. *VA OIG analysis of the average number of days to complete community care consults by facility*
Source: VA OIG analysis of VHA's consult data in the Corporate Data Warehouse

Patient Wait Times from the Clinically Indicated Date Were Over VHA's Wait Time Goal for Some VISN 8 Facilities

VHA measures wait time from the clinically indicated date, which is the date the requesting provider decides care is clinically appropriate. There is typically an agreement between the provider and the patient when setting the clinically indicated date, but the decision on the date is ultimately a clinical one. This date is either the same as the date the consult was created or a later date. The audit team assessed if consult-processing timeliness delays affected VISN 8 facilities' ability to meet VHA's overall wait time goal. Appointments should be scheduled within 30 calendar days from the clinically indicated date to achieve this goal.[11] Table 1 identifies the average wait time for an appointment in the community for each VISN 8 facility, measured from the clinically indicated date of the referring VA provider.

[11] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016. The directive states, "The VHA wait time goal is 30 calendar days or less from the date that an appointment is deemed clinically appropriate by a VA health care provider, which is the Clinically Indicated Date (CID), or in the absence of a CID, the Veteran's Preferred Date (PD)."

Table 1. Average Days from Clinically Indicated Date to Appointment Date

	Bay Pines	Gainesville	Miami	Orlando	San Juan	Tampa	West Palm Beach
Average days from clinically indicated date to appointment date	32	42	45	39	26	52	30

Source: VA OIG analysis of VHA's completed consult data in the Corporate Data Warehouse
Note: The audit team did not assess whether the clinically indicated dates were appropriate.

Community Care Wait Times Were Not Transparent to VA Facility Schedulers

Around 39 percent of the consults VISN 8 facilities referred to their community care departments in FY 2018 were sent because the VA facility determined they could not provide access to care within 30 days of the VA provider's clinically indicated date (or in the absence of a clinically indicated date, the patient preferred date). Based on the audit team's assessment, VISN 8 facilities did not have a mechanism to identify, compare, and share appointment wait times for similar services obtained either at the VA facility or in the community. As a result, VA facility schedulers stated they were not able to tell patients what the wait times would be if they opted for community care. In other words, VA facility staff sent the consults to community care departments without the assurance that the patient wait time would be shorter than VA facility wait times. The OCC deputy executive director of clinical integration stated that identifying wait times in the community and comparing them to in-house wait times would allow staff to inform the patient so he or she could make the decision as to whether to keep the appointment within VA or to be seen in the community. Furthermore, comparing wait time data for services at the VA facility to the same services in the community would provide valuable information for leaders to better identify where specific holdups are occurring.

At the time of the audit team's review, a patient was eligible for community care under a number of different circumstances:

- The VA facility normally did not provide the service.
- The travel distance was greater than 40 miles.
- The VA facility could not see the patient within 30 days.
- The patient had to travel by air, boat, or ferry to get to the nearest VA medical facility.
- The burden to the patient was excessive.

The audit team found that one of the primary reasons VISN 8 facilities referred patients to community care was because the facility did not provide the required service (41 percent). A smaller percentage of consults indicated that patients were referred to the community because they lived further than 40 miles from the VA facility, or because they had an unusual or excessive burden in accessing the VA facility (15 percent). In addition, 5 percent of consults indicated "other" as the reason for referral and did not include standardized language regarding the reason the consult was sent to the community.

As stated previously, the remaining 39 percent of the consults referred to the community care departments in FY 2018 were sent because the VA facility determined they could not provide timely access to care. Of that 39 percent, the audit team found that patients who opted to receive care in the community because the VA clinic did not have availability within 30 days waited an average of 38 days longer than the VA provider's clinically indicated date to receive care. The audit team determined that VA facility staff and the community care staff did not routinely discuss wait times for their respective services. As a result, the facility staff did not know if the wait time in their clinic was longer or shorter than the anticipated wait time in the community. The audit team reviewed consult data to assess the average wait times for the same services in the VA facility and through community care, based on the referring providers' clinically indicated date.[12]

Example 1

At the James A. Haley Veterans Hospital in Tampa, Florida, it took an average of 37 days for patients to receive ophthalmology care.[13] When patients opted to receive community care because the clinic determined they were not able to provide care within 30 days, it took an average of 66 days to receive ophthalmology services in the community. Of those 66 days, 34 days were spent waiting for community care staff to create an authorization for care.

Recommendation 1 addresses the need for VISN 8 to develop and implement a mechanism for VA facilities and their respective VA community care departments to routinely identify and exchange patient wait time data. This would provide VA facility staff with the information their patients need to make an informed decision about being seen within the VA facility or being referred to the community for care.

[12] This average is calculated from the providers' clinically indicated date to appointment date and does not represent total processing time. This calculation was limited to consults where VA staff provided a justification for why the consult was sent to the community.

[13] This average is calculated from the clinically indicated date to the completed appointment date.

VISN 8 Facilities Could Improve Monitoring of Community Care Staff Processing Time

VHA relies on a web-based tracking database to review various consult metrics, such as quantity and consult timeliness standards. This database can generate a variety of preformatted reports that VISN 8 facilities use to monitor consult timeliness. However, the audit team found that these reports did not specifically measure the processing time for consults in the facilities' community care department. Without information about specific community care processing time, the audit team concluded VHA did not have a standard method to accurately determine the time it takes for community care staff to process consults. The audit team determined assessing this data would allow VA facility leaders to identify distinct processing delays within their community care departments.

The audit team determined that there are two types of reports that show community care consult processing times. These reports have limitations that impede facilities' attempts to examine community care processing time exclusively:

- The first report does not differentiate the processing time in the VA facility service versus the processing time in the community care department. As a result, all actions and processing time are attributed to the community care department.
- The second report captures consults forwarded from the VA facility service, which only includes a fraction of the consult workload sent to the community care department.

In November 2017, VHA implemented a new process so staff could forward an existing VA facility consult from a provider to the community care department instead of creating a new one, allowing both the service within the VA facility and the community care staff to accept the same consult. However, this process presents a challenge in measuring processing timeliness. The database provides one report that calculates processing times whenever staff accept or schedule a consult, but the report attributes all activity to the staff of the current service name—in this case, attributing all activity and time to community care once the consult is referred. For example, if a community care consult started in the VA facility service, the VA facility service processing time is not separated from that of the community care staff processing time. Similarly, while the data measured consult timeliness overall—starting from initial creation in the VA facility service line—it did not allow facilities to specifically monitor how well community care staff perform their part of the consult process in a timely manner, as well as any backups within the community care department.

Accurately assessing and monitoring the time consults take to pass through community care is important for VHA, VISN 8, and facility leaders to accurately identify and resolve potential access to care issues. According to OCC's deputy executive director of clinical integration,

accurate timeliness measures also provide staff with wait time data to make an informed decision as to whether they should send a consult to community care or keep it within the VA facility. The audit team determined that several VISN 8 facilities attempted to calculate the time specifically for community care departments to process consults, but found their efforts included incomplete data or were too resource intensive. According to VHA's Support Service Center personnel, preformatted reports can be modified or created to capture this information. Utilizing a preformatted report in VHA's web-based tracking database to review the timeliness of each stage of the community care consult process would allow VISN 8 facilities to assess and monitor the time it takes for consults to pass through the community care department.

Recommendation 2 addresses the need for VISN 8 to routinely monitor the timeliness of each distinct stage of the community care consult process so VA facilities identify specific delays.

Most VISN 8 Community Care Departments Were Not Sufficiently Staffed

The audit team identified that VISN 8 community care departments were not sufficiently staffed for administrative functions. As of October 2018, five of seven VISN 8 facilities had administrative staffing shortages. The administrative staff contact patients, create authorizations, coordinate scheduling efforts, gather pertinent documents to send to community providers, and scan records of completed community care. The OCC released a staffing assessment tool in May 2017 to help facility community care departments estimate the number of clinical and administrative staff needed to support community care processes. The tool relied on facility input and considered average task times, workload data, staff positions involved, leave replacement, and other factors to estimate the number of clinical and administrative staff needed for each VA facility.

The OCC staffing tool estimated the number of employees needed to meet workload demands for VISN 8 facilities was 313 administrative FTEs across the organization as of October 2018. However, the community care departments only had 237 FTEs on board. VISN 8 community care service chiefs provided various reasons for why they had not hired the number of staff identified by the OCC staffing tool. For example, five chiefs found the OCC tool did not account for the complexity of care, which required a higher number of clinical resources to process consults. In addition, two community care service chiefs indicated that the fluctuating community care consult workload made it difficult to determine how many staff were needed. Although facilities were not leveraging the OCC staffing tool guidance, the tool indicated—and the audit team determined through analysis of consult timeliness and interviews—that the community care departments did not have sufficient administrative staff in place to process consults in a timely manner.

On September 27, 2018, the deputy under secretary for health operations and management (DUSHOM) issued a memo about concerns that facilities were not prepared for the future state

of community care. The memo stated that if a facility's community care department did not meet an OCC MISSION Act readiness score of 100 by December 15, 2018, the department must hire and onboard to within 15 percent of the OCC staffing tool recommendation by February 15, 2019.[14] According to OCC-provided data, none of the VISN 8 facilities met the readiness score by December 15, 2018.

The OCC's deputy executive director of clinical integration stated that he was concerned not all VA facilities nationwide were adequately staffed for the future of community care. Most VISN 8 community care departments indicated that they were hiring additional staff at the time the audit team conducted site visits, but not all facilities actually hired and onboarded the suggested number of staff based on the OCC staffing tool.[15]

VISN 8 reported to the OCC that 259 of the minimum 266 FTEs were on staff as of February 15, 2019. Table 2 displays the facilities' administrative FTEs on staff in October 2018 and February 2019, as well as the OCC's recommended administrative FTEs and FTEs needed to meet the OCC's 15 percent requirement. As of October 2018, two of seven facilities met the OCC-recommended staffing level. In February 2019, only one facility was within 15 percent of the recommended FTE levels, with the remainder between one and three staff short of the 15 percent mark. All the facilities were below the full recommended levels, however.

[14] A readiness score is a calculation that assists the OCC in determining whether community care departments are prepared for the MISSION Act. The score is calculated from consult management data, workload data, and qualitative data derived from facility responses to an OCC questionnaire.

[15] The audit team did not evaluate the accuracy of the OCC staffing tool.

Table 2. OCC Actual and Recommended Administrative FTEs, as of October 2018 and February 2019

	October 2018		February 2019		OCC staffing tool-recommended FTEs	
Facility	**Approved facility FTE**	**Actual facility FTEs**	**Approved facility FTE**	**Actual facility FTEs**	**OCC-recommended FTEs**	**Number of staff needed to be within 15% of OCC-recommended level**
Bay Pines, FL	72	60	72	**47**	59	50
Gainesville, FL	65	**43**	73	**51**	63	54
Miami, FL	20	**17**	20	**20**	25	21
Orlando, FL	55	55	55	52	60	51
San Juan, PR	19	**19**	34	**31**	37	32
Tampa, FL	29	**29**	35	**29**	35	30
West Palm Beach, FL	14	**14**	32	**29**	35	30
VISN Total*	**274**	**237**	**321**	**259**	**313**	**266**

Source: VA OIG analysis of data provided by the OCC and VISN 8
Note: Red figures indicate onboard staff below the 15 percent of OCC-recommended FTEs.
**Due to rounding, calculations may not sum.*

Recommendation 3 addresses the need for VISN 8 to ensure facilities routinely assess staffing levels and take appropriate actions to ensure community care actual staffing levels are sufficient to meet current workloads.

Referrals Returned by the Contractor and Internal Processing Changes Created Increased and Unpredictable Community Care Workload

During 2018, the VISN 8 facilities' community care departments processed consults returned by the former third-party contractor (Health Net). Health Net was VISN 8's third-party administrator responsible for maintaining a network of community providers, coordinating and scheduling consults for patients, and paying providers for services rendered, specifically for care delivered through the Veterans Choice Program. VA's contract with Health Net expired on September 30, 2018. According to VISN 8 representatives, VISN 8 facilities started to decrease the number of consults sent to Health Net as early as January 2018 in anticipation of the expiring contract and because Health Net was not successfully scheduling the referrals. This meant the VISN 8 community care departments were responsible for coordinating and scheduling appointments for nearly all patient consults for community care during that time.

The VISN 8 facilities' community care departments also processed authorizations for community care that were once tasked to OCC staff but had not been completed. Interviews with community

care department staff in VA facilities indicated that the unpredictable number of consults for processing during 2018 made it difficult to manage their workloads.

The audit team's assessment of information from VISN 8 facilities found that from June through September 2018, VISN 8 community care departments received an estimated 4,500 consults back from Health Net.[16] These consults had not yet been completed, meaning the patients were awaiting appointments.

In addition to the Health Net returns, the facilities' community care departments became responsible for the consult authorization duties, which increased their workload. Specifically, while authorization duties were located with the OCC from late 2014 to mid-2018, there were more than 200 FTEs authorizing community care consults for VISN 8. While not all 200 FTEs were always authorizing community care consults, the OCC had the ability to move FTEs whenever a backlog developed. Once the VISN 8 facilities obtained the responsibility and workload in July 2018, however, only 53 FTEs were transferred back to the community care departments, making it difficult for the facilities' community care departments to keep up with the demand of consults they had to process. These heightened workloads contributed to the number of consults that did not meet VHA's timeliness metrics. When the transition took place in July 2018, community care staff for five of the seven VISN facilities stated they received a total of at least 19,000 consults for community care that still needed an authorization.[17] The VA facility in Orlando, Florida, reported it received about 6,200 community care consults awaiting authorization in July 2018.

VISN 8 Facilities Separated the Authorization and Scheduling Processes

The Veterans Access, Choice, and Accountability Act of 2014 required VA to transfer the authority to pay for hospital care, medical services, and other health care furnished through community care from the VISNs and medical centers to the Chief Business Office, now known as OCC. Previously, VA facilities were responsible for managing their own budgets for VA community care and associated staff.

Generally, the front-end care coordination process—receiving consults, authorizing community care, and scheduling appointments—remained with VA medical facility staff. However, from August 2014 through July 2018, VISN 8 officials transferred the consult authorization responsibilities and the respective FTEs from the VA facility community care departments to the

[16] This number does not include Tampa community care, as staff were unable to calculate the total consults returned from Health Net. In addition, the San Juan community care department provided the team with an estimate of between 800 and 1,000 incomplete consults returned from Health Net; therefore, the audit team used the lower estimate of 800.

[17] This number does not include Tampa and San Juan, as they stated they were unaware of the specific number of consults returned.

OCC. VISN 8 decided to transfer its authorization responsibilities to OCC in an effort to expedite the consult process to provide timely care for patients. VISN 8 leaders stated they were not aware of any other VISNs that made this process change.

This meant that part of the community care consult process was no longer under the oversight of the VA facilities within VISN 8. After OCC staff authorized the patient's care, they would send the consult back to the community care staff at the VA facility to begin the scheduling process. Figure 4 shows the community care consult process under this structure.

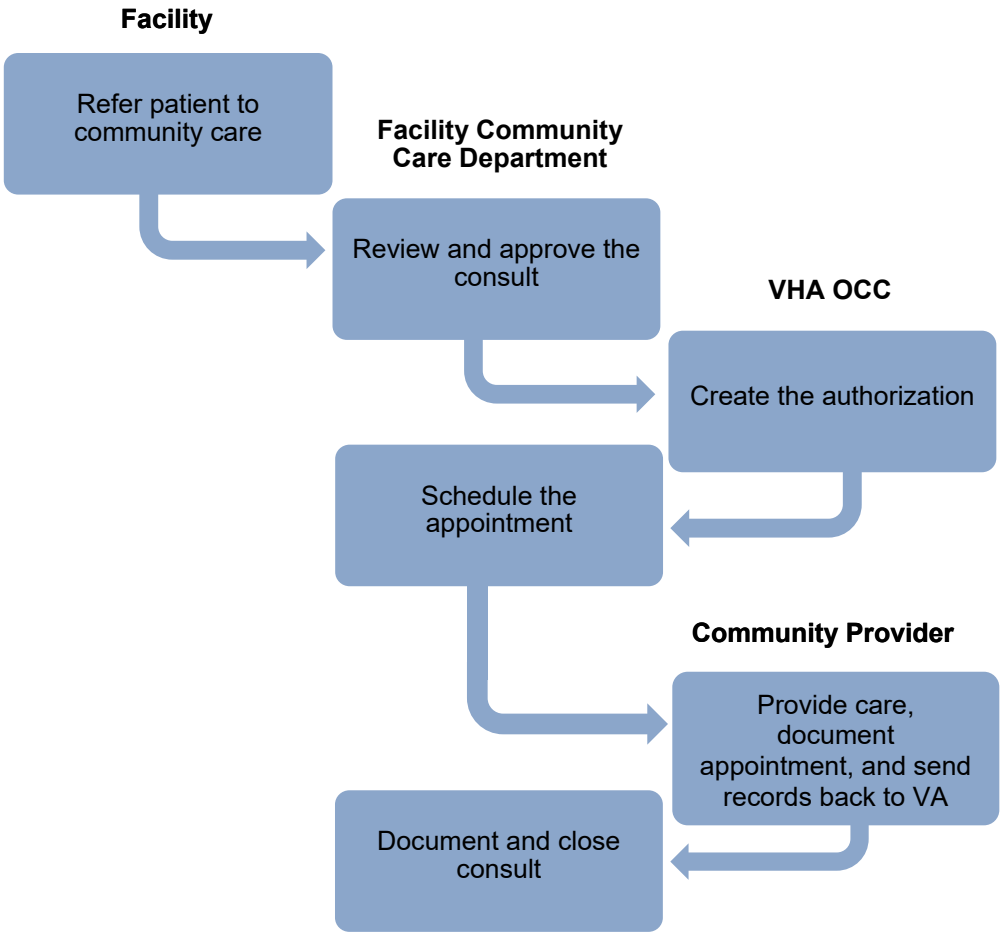

***Figure 4**. Community care consult process prior to the OCC returning authorization responsibilities to the facilities in July 2018*
Source: VA OIG analysis of criteria and interviews with VISN 8 community care department personnel

A VISN 8 operations council review of consult processing determined that assigning authorization duties to the OCC contributed to delays in creating authorizations for community care consults across VISN 8. Although they made this determination in November 2017, the authorization processing task—and respective staff—did not return to the facility community

care departments from the OCC until July 2018. According to the VISN 8 business development officer, the delay in transferring the authorization task back to the facilities was due to concerns regarding concurrence from the OCC on the validation of FTEs to be transferred, the transition of VISN 8's director, and union notification and approval.

According to the *VHA Office of Community Care Operating Model Implementation Guide* published in December 2017, VA facility leaders were required to consolidate their community care department to increase access to care and improve the experience of patients and internal stakeholders. This included centralizing community care tasks and enhancing community provider relations. Further, OCC's guidance states that implementing best practices ensures quality care is provided to the patients in a timely manner.

The OCC's deputy executive director of clinical integration and the nurse executive of clinical integration stated that they recommend the same administrative staff perform authorization and scheduling tasks because it would encourage an active partnership between the patient and community care staff. The facility's community care staff member who receives the consult would contact the patient, coordinate scheduling with community care provider, and create the authorization. This would confirm that patients were scheduled to receive the requested care.

In July 2018, however, after the authorization duties and staff were realigned under the facilities, only one of the seven community care departments merged the scheduling and authorization tasks. Prior to the transition of authorization duties and staff back to the facilities' community care departments, community care staff were not cross-trained or assigned to conduct the scheduling and authorization functions. Community care department leaders and staff also stated they did not have adequate resources to consistently call and follow up with providers and patients to determine if patients scheduled care. As a result, patients could be at risk of delayed care.

OCC guidance states that the community care staff should contact the patient and community provider to schedule the patient's appointment before creating the authorization.[18] VHA OCC personnel stated that scheduling the appointment first is more efficient, and it will confirm that the community provider will accept the patient prior to authorizing payment. However, the audit team found that VISN 8 community care departments routinely created authorizations before they contacted the patients and scheduled the appointments with the community providers.

The audit team determined that creating an authorization before scheduling a patient's appointment contributed to delays in VISN 8 facilities because they experienced backlogs at the point of authorization. For example, if the authorization clerk received a consult on the first of the month and created the authorization on the 15th of the month, then it would have been

[18] The OCC *Transition Field Guidebook* includes guidance for VA facilities in a pre-Community Care Network state, post-Community Care Network transition state, or as applicable to both. It provides guidance on how to perform the work coordinating care for veterans in the community.

14 days before the consult was available for the scheduler to begin contacting the patient and provider to coordinate scheduling the appointment. As noted earlier, an average of 18 days elapsed while staff worked to authorize the care.

The audit team observed a disconnection between OCC guidance and what VA facility staff stated they could perform.[19] For example, a VISN staff member stated that community providers often would not schedule a VA patient without an authorization, which makes it difficult for staff to follow this OCC guideline. One community care department chief also stated that community providers would not schedule VA patients without an authorization because they risk not getting paid and VA cannot schedule an appointment without allocating funds using the authorization. The audit team concluded that merging the scheduling and authorization tasks within the community care departments could allow scheduling attempts to begin promptly. The same staff would create associated authorizations, alleviating provider concerns about not obtaining authorizations.

Recommendation 4 addresses the need for VISN 8 to ensure that community care administrative staff are effectively cross-trained to carry out applicable administrative consult processing duties to streamline scheduling and authorization, and to implement a control to monitor whether facilities are processing community care consults in accordance with the OCC's guidance and recommendations.

Community Care Consult Workload Update

As of July 2019, VHA data shows that VISN 8 community care departments had over 74,500 open consults. This generally meant these patients were not yet scheduled; were scheduled and waiting for their appointment; or they already completed care, but the VA facility had yet to receive and record the non-VA provider medical documentation.

Two of the VISN 8 facility community care departments accounted for over half of that total—Gainesville had nearly 30,000 open consults and Orlando had over 13,000. The audit team's assessment of VHA data shows that the number of open community care consults increased overall in VISN 8 compared to the number of open consults in December 2018—most significantly in Orlando (79 percent increase), Tampa (44 percent increase), and Gainesville (30 percent increase).

VISN 8 facilities started to address community care staffing needs in response to the memo sent by the DUSHOM on September 27, 2018. In addition, VISN 8 personnel conducted site visits to facilities' community care departments from November 2018 through January 2019 to evaluate

[19] The agreement between the VHA and community providers does not require the providers to accept patients without an authorization. Therefore, community providers requesting an authorization prior to scheduling is a permissible practice.

the community care operations. While those site visits resulted in action plans to address backlogs, including hiring more staff, the significant number of open consults affects the timeliness of patients accessing community care. Furthermore, according to data provided by VISN 8, the average number of consults sent to community care departments increased from an average of about 3,350 consults per month to about 4,430 per month.[20] VISN 8 facilities in Bay Pines, Gainesville, and Orlando each had more than a 25 percent increase in monthly community care consult referrals since the MISSION Act was implemented in June 2019.

Recommendation 5 addresses the need for VISN 8 to develop and implement specific facility plans to address the backlog of open consults and the growing number of new consults.

Conclusion

VISN 8 facilities were not sufficiently staffed and could improve how they process community care consults to meet VHA's timeliness metrics. Delays primarily occurred during the authorization of care and appointment scheduling. Heavier workloads also contributed to lengthy consult processing times. On average in FY 2018, services within the VA medical facilities took about 10 days to refer patients to their community care departments. Community care staff then took an average of three days to accept the consults and an additional 43 days until the patients received care in the community. About 18 of those 43 days elapsed while staff completed the administrative function to authorize the care, at which point the scheduling process began. The number of patients eligible to receive care in the community is expected to increase dramatically under the MISSION Act. Therefore, it is essential that VISN 8 and community care departments address consult processing delays and staffing needs in a timely manner.

Recommendations 1–5

The OIG recommends that the VISN 8 director conduct the following:

1. Develop and implement a mechanism for VA facilities and their respective VA community care departments to routinely identify and exchange wait time data to help make decisions that reduce patient wait times.
2. Routinely monitor the timeliness of each distinct stage of the community care consult process so Veterans Integrated Service Network 8 facilities can identify specific delays.
3. Ensure facilities routinely monitor the Office of Community Care staffing tool and take appropriate actions to confirm actual staffing levels are sufficient to meet workloads in a timely manner.

[20] This average was measured using data from October 2018 through May 2019 (prior to the MISSION Act implementation) and compared to data from June 2019 through August 2019 (after the MISSION Act was implemented on June 6, 2019).

4. Ensure community care administrative staff are effectively cross-trained to carry out applicable administrative consult processing duties to streamline scheduling and authorizations, and implement a control to monitor whether facilities are processing community care consults in accordance with Office of Community Care guidance and recommendations.
5. Develop and implement specific facility plans to address the backlog of open consults and the growing number of new consults.

Management Comments

The VISN 8 network director stated he recognized the need for improvements in the community care consult process, concurred with the five recommendations, and provided responsive corrective action plans.

For recommendation 1, the network director stated that VISN 8 is developing a report that all VISN 8 facilities will use to identify VA referral processing times and community care wait times. The director stated that the report will be used by VHA staff in communicating the total community care wait time to patients so they can make an informed decision as to where they wish to receive care.

For recommendation 2, the network director stated that VISN 8 is developing a report that will utilize HealthShare Referral Manager data and will be utilized as an interim solution until a national report is released. This report will allow facilities to monitor the timeliness of the distinct stages of the referral process, and to report improvements or barriers to the VISN.

For recommendation 3, the network director stated facilities will complete the most recent version of the OCC staffing tool upon release in December 2019. The director stated that the VISN 8 facilities will complete the staffing tool on a quarterly basis to assess staffing needs, and act as needed.

For recommendation 4, the network director indicated that all administrative staff have been trained on the utilization of HealthShare Referral Manager. The director stated that VISN 8 facilities began utilizing the HealthShare Referral Manager to refer and authorize community care referrals, and stated that the system is designed to ensure compliance with the process to authorize and then schedule.

For recommendation 5, the network director stated that VISN 8 has taken steps to eliminate the backlog of community care consults, including hiring additional staff, leveraging voluntary/mandatory overtime, realigning teams, using nursing and administrative staff from other services, and scheduling assistance from the third-party administrator. The director also stated that VISN 8 will implement a Referral Coordination Team model and the new community care scheduling process, and that VISN 8 will monitor the data and actions of the backlog reduction and community care utilizations through the VISN 8 Community Care Subcommittee.

OIG Response

The VISN 8 network director's comments and corrective action plans are responsive to the intent of the recommendations. The director stated that VISN 8 considers recommendation 4 fully implemented and requested closure. VISN 8 provided support of community care administrative staff training on the HealthShare Referral Manager, and the director stated that facilities began using it in November 2019. Prior to closing this recommendation, the OIG requests that VISN 8 provide evidence that VISN 8 facilities are utilizing HealthShare Referral Manager and that VISN 8 is monitoring whether facilities are appropriately processing community care consults in accordance with OCC guidance and recommendations. The OIG will monitor implementation of all recommendations and planned actions, and will close the recommendations when VISN 8 provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. The full text of the responses from the VISN 8 network director is in Appendix B.

Appendix A: Scope and Methodology

Scope

The audit team conducted this audit from July 2018 through August 2019 to assess whether VISN 8 facilities were effectively and efficiently managing the community care needs of patients. The audit team reviewed the life cycle data for community care consults submitted in FY 2018 and completed by community care staff as of November 29, 2018, to identify delays in the various phases of community care consult processing at each facility. Specifically, the audit team assessed processing time for community care services. It also reviewed community care consult data as of July 2019 to determine any change in open consults during the audit. To measure overall demand, the audit team reviewed community care consults and Veterans Choice List entries.

The audit team conducted interviews with staff from the seven primary facilities in VISN 8 from August through January 2019:

- C.W. Bill Young VA Medical Center (Bay Pines, Florida)
- North Florida/South Georgia Veterans Health System (Gainesville, Florida)
- Miami VA Healthcare System (Miami, Florida)
- Orlando VA Medical Center (Orlando, Florida)
- VA Caribbean Healthcare System (San Juan, Puerto Rico)
- James A. Haley Veterans Hospital (Tampa, Florida)
- West Palm Beach VA Medical Center (West Palm Beach, Florida)

Methodology

To accomplish its objective, the audit team identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to VHA's community care process. The audit team interviewed managers and employees from the seven primary VISN 8 facilities, VISN 8 headquarters, and VHA's OCC. The audit team reviewed prior audits and reviews related to VHA access to health care completed by the OIG and the Government Accountability Office.

The audit team used VHA's web-based tracking database, the VHA Support Service Center, and VHA's Corporate Data Warehouse to obtain the relevant data required to assess the wait times for patients using community care. The audit team discussed the methodology of selecting consult data for review with VISN 8 officials. This audit focused on the management of community care consults by examining staffing levels and the procedures used to best determine

how to meet patients' care needs in the facilities or in the community during FY 2018 and throughout VISN 8. The audit team conducted the following tasks:

- Identified and reviewed criteria pertaining to timeliness of care, including VA policies, procedures, and programs regarding appointment scheduling and consult management.
- Assessed staffing tools at each facility, including the facilities' determination of deficiencies of clinical and administrative staff in community care offices.
- Examined each facility's procedures for evaluating the ability of in-house clinicians and staff to provide selected specialty care services versus obtaining that care in the community.
- Analyzed data of community care consults submitted in FY 2018 and completed as of November 29, 2018, to identify delays in each phase of consult processing at the VISN 8 facilities. The audit team measured consult processing timeliness for the approximately 104,000 community care consults that were submitted in FY 2018 and completed as of November 29, 2018. Of those approximately 104,000 consults submitted, 97 percent were accepted by community care staff and 64 percent had a scheduled appointment linked to a consult.[21]
- Interviewed managers and staff for three specialty care services per facility.

Table A.1 identifies the three services for each VISN 8 facility, with the corresponding number of submitted consults for each service.

[21] The audit team was not able to remove delays that resulted from a patient canceling an appointment or a patient failing to attend a scheduled appointment. This was because patients may have canceled an appointment directly with the community provider, and the community care department staff were not always directly involved in this process.

Table A.1 Submitted Consults for Three Specialty Services at Each VISN 8 Facility

Bay Pines	Gainesville	Miami	Orlando	San Juan	Tampa	West Palm Beach
Dermatology (4,128)	Physical therapy (3,849)	Chiropractic (738)	Physical therapy (1,224)	Physical therapy (801)	Physical therapy (3,855)	Orthopedic (1,272)
Orthopedic (2,201)	Ophthalmology (2,484)	Sleep disorder (352)	Cardiology (5,511)	Physical med & rehab (637)	Pain management (2,823)	Physical therapy (655)
Physical therapy (1,871)	Orthopedic (2,073)	Neurology (200)	Urology (1,102)	Sleep disorder (516)	Ophthalmology (2,040)	Dermatology (1,119)

Source: VA OIG analysis of VHA Support Service Center data of the consults for three specialty care services submitted to community care—as of August 2018 (all VISN 8 facilities)

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The team exercised due diligence in staying alert to any fraud by taking actions such as soliciting the OIG's Office of Investigations for indicators and requesting a review of relevant OIG hotline complaints and concerns that might point to potential fraudulent activity. The audit team did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

To support the findings, conclusions, and recommendations for this audit, the audit team used computer-processed data from VHA's Support Service Center, electronic health records review in VA's Compensation and Pension Record Interchange, and information provided by the VISN 8 community care staff. The audit team reviewed consult activity of a random sample of 30 community care consults from VHA's Support Service Center and compared it against electronic health records in VA's Compensation and Pension Records Interchange to determine whether any data were missing from key fields, included any calculation errors, or were outside the timeframe requested. Testing of the data did not disclose any problems with data reliability. Therefore, the audit team concluded that the data obtained and relied upon were sufficiently reliable for the purposes of this audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions

based on the audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Management Comments

Department of Veterans Affairs Memorandum

Date: November 22, 2019

From: Network Director, VISN 8 (10N8)

Subj: Healthcare Inspection—Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities

To: Director, OIG, Office of Audits & Evaluations; Access to Care Division (52AD)

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

1. Thank you for the opportunity to review the draft report of your analysis of the Community Care Consult process at the VISN 8 facilities. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and are committed to ensuring high quality care is provided to each Veteran.

2. I have reviewed the corrective action plan and projected completion dates and concur. VISN 8 will assist facilities in reaching full compliance in a timely manner.

(Original signed by)

Miguel H. LaPuz, M.D., MBA

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities

Date of Draft Report: October 25, 2019

Recommendations/ Actions	Status	Target Completion Date

The OIG recommends the VISN 8 Director conducts the following:

Recommendation 1: Develops and implements a mechanism for VA facilities and their respective VA community care department to routinely identify and exchange wait time data to help make decisions that reduce patient wait times.

VHA Comments: Concur

VISN 8 is developing a report that all VISN 8 facilities will utilize to assist VHA staff in communicating the total community care wait time to Veterans so they can make an informed decision where they wish to receive their care. This will be an interim solution until a national report is released. The report will identify VA referral processing times and community care wait times that will be used by VA staff to communicate to the veteran the total wait time for the community appointment. VISN 8 facilities will also develop a process and scripts to assist staff in this communication. This report will be implemented along with the implementation of the Referral Coordination Initiative. The completion of the report is targeted for December 2019 with implementation by the end of January 2020. Each facility in VISN 8 will certify to the implementation and utilization of the report and then report to the VISN 8 Community Care Subcommittee its continued use and success/barriers as a result of its implementation.

VISN 8 will provide the following documentation at completion of this action:

- Facility certifications of implementation and utilization of the report.
- VISN 8 Community Care Subcommittee minutes documenting discussion and actions of the utilization of the report.

Status: In Progress

Target Completion Date: April 2020

Recommendation 2: Routinely monitors the timeliness of each distinct stage of the community care consult process so Veterans Integrated Service Network 8 facilities can identify specific delays.

VHA Comments: Concur

VISN 8 is developing a report that will monitor the timeliness of the distinct stages of the referral process. The report will utilize HealthShare Referral Manager (HSRM) data and will be utilized as an interim solution until a national report is released. Facilities will review the data monthly and will report improvements and/or barriers to the VISN 8 Community Care Subcommittee.

VISN 8 will provide the following documentation at completion of this action:

- VISN 8 Community Care Subcommittee minutes documenting discussion and actions of the utilization of the report.

Status: In Progress

Target Completion Date: April 2020

Recommendation 3: Ensures facilities routinely monitor the Office of Community Care staffing tool and take appropriate actions to confirm actual staffing levels are sufficient to meet workloads in a timely manner.

VHA Comments: Concur

The VA Community Care Staffing Tool is designed to enable each site to quantify resource needs necessary to successfully operate and execute the operating model. The tool utilizes average task times, workload data, type of role (administrative or clinical), other tasks (community care work that doesn't involve processing consults or coordinating care such as meetings, training, congressional research, etc.) and leave replacement factors to calculate resource needs. The Office of Community Care plan to release the latest version of the staffing tool in December 2019. Once released, the VISN 8 facilities will complete the staffing tool on a quarterly basis to assess staffing needs and act as needed.

VISN 8 will provide the following documentation at completion of this action:

- VISN 8 Community Care Subcommittee minutes documenting discussion and actions that result from the completion of the staffing tool.

Status: In Progress

Target Completion Date: July 2020

Recommendation 4: Ensures community care administrative staff are effectively cross-trained to carry out applicable administrative consult processing duties to streamline scheduling and authorizations and implement a control to monitor whether facilities are processing community care consults in accordance with Office of Community Care guidance and recommendations.

VHA Comments: Concur

Authorization staff transitioned to the VISN 8 facilities in July 2019, from the now Payment Operations and Management Office. At the time of the OIG review, authorizations were created by staff using Fee Basis Claim System (FBCS) by administrative staff. Since the review, all facilities have implemented HealthShare Referral Manager (HSRM) which is an industry-standard referral and authorization system. Authorizations are auto-assigned to a community care referral when the referral is pushed to HSRM. All administrative staff have been trained on the utilization of HSRM.

Status: Complete

Target Completion Date: November 2019

Beginning November 15, 2019, VISN 8 facilities began utilizing the HealthShare Referral Manager (HSRM) to refer and authorize community care referrals. HSRM is an industry-standard referral and authorization system that incorporates portal functionality to prepare and complete all referrals and authorizations. There is a distinct pathway for each referral to follow until the episode of care is complete. Once the community care consult is 'sent' to HSRM, the system auto-assigns an authorization number to that referral. Once the referral is authorized and the community provider is identified and has accepted

the referral, then the appointment is scheduled. HSRM is designed to ensure compliance with the process, authorize and then schedule. VISN 8 considers this recommendation fully implemented and requests closure.

Status: Complete

Target Completion Date: November 2019

Recommendation 5: Develop and implement specific facility plans to address the backlog of open consults and the growing number of new consults.

VHA Comments: Concur

The VISN 8 Business Development Office staff conducted site visits to each facility community care office from November 2018, through January 2019. At each site visit, the community care backlog was identified as a finding in the final report. Each facility developed an action plan to eliminate their consult backlog. Following the site visits, the VISN 8 Business Development Office staff conducted monthly meetings with each site to discuss the status of actions and assist with any barriers that were identified. All actions and barriers were documented in the VISN 8 Site Visit Tracker. Actions facilities have taken include hiring additional staff, voluntary/mandatory overtime, realigning teams, nursing and administrative staff from other services, and scheduling assistance from TriWest. The VISN 8 Business Development Office staff will continue to hold monthly calls with the facilities to discuss actions plans and assist with any barriers to working down the consult backlogs and will continue to document actions and barriers in the VISN 8 Site Visit Tracker.

To address increased workload (and the consult backlog if the new processes prove to be more efficient), VISN 8 will implement the new Referral Coordination Team model and the new community care scheduling process that were developed during a national sequester and VISN 8 Rapid Process Improvement Workshop (RPIW). VISN 8 hosted a RPIW at the Orlando VAMC to identify efficiencies in the referral process to reduce the burden for additional human resources and to realign existing resources to eliminate the consult backlogs. In addition to the VISN 8 RPIW, there was a national 2-week sequester convened with participants from the Office of Community Care and the Office of Veterans Access to Care, as well as VISN and facility representation, to review the in-house specialty care referral process and identify pathways for Veterans to continue to receive the quality care that VA provides. At the time of this response, the proposal was presented to the Governance Board and approved. Implementation of the process will begin January 2020 and each facility will certify to its implementation. Once VISN 8 sites implement the new processes, sites will continue to work the backlog with all sites having a consult readiness score of 100 by September 2020. VISN 8 will monitor the data and actions of the backlog reduction and community care utilizations through the VISN 8 Community Care Subcommittee.

VISN 8 will provide the following documentation at completion of this action:

- Facility certifications of implementation and utilization of the report.
- VISN 8 Community Care Subcommittee minutes documenting discussion and actions of the utilization of the report.

Status: In Progress

Target Completion Date: September 2020

VHA General Comments

OIG Draft Report, Improvements Are Needed in the

Community Care Consult Process at VISN 8 Facilities

Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Improvements are Needed in the Community Care Consult Process at Veterans Integrated Service Network (VISN) 8 Facilities. I concur with the report's recommendations and provide the attached action plans.

VISN 8 is the nation's largest system of Veterans Affairs (VA) hospitals and clinics that provided services for 622,851 Veterans and provided 8.9 million visits in fiscal year (FY) 2019. In FY19, VISN 8 facilities completed 178,341 community care consults. VISN 8 realized a 24 percent increase in community care consults from FY18 to FY19. However, when comparing June 2019–September 2019 (launch of the MISSION Act) to the same period in 2018, the workload increase was 46 percent in VISN 8, nearly doubling community care workload. In addition to staffing and space constraints, other contributors to the continued backlogs were the multiple transitions between third party administrators, the end of individual authorizations, and the change in legislation.

Despite these changes, the VA Caribbean Health Care System was able to achieve a consult score of 100 and has been able to sustain their progress. Additional improvements in VISN 8 include the percentage of open community care consults that met one of the 3 requirements improved from 37 percent in January 2019 to 55 percent in October 2019. Consult processing time also has improved. The average days from File Entry (date the consult was created) to the completion date decreased from 125 days to 59 days (excluding GEC consults). Through the VISN 8 Community Care Subcommittee, we will ensure that actions are taken to eliminate the consult backlogs and improve consult processing timeliness.

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

OIG Contact and Staff Acknowledgments

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