



September 2020

# VETERANS COMMUNITY CARE PROGRAM

## Improvements Needed to Help Ensure Timely Access to Care

Accessible Version

# GAO Highlights

Highlights of [GAO-20-643](#), a report to congressional requesters

## Why GAO Did This Study

In June 2019, VA implemented its new community care program, the VCCP, as required by the VA MISSION Act of 2018. Under the VCCP, VAMC staff are responsible for community care appointment scheduling; their ability to execute this new responsibility has implications for veterans receiving community care in a timely manner.

GAO was asked to review VCCP appointment scheduling. This report examines, among other issues, the VCCP appointment scheduling process VA established and VA's monitoring of that process.

GAO reviewed documentation, such as scheduling policies, and referral data related to the VCCP and assessed VA's relevant processes. GAO conducted site visits to five VAMCs in the first region to transition to VA's new provider network, and interviewed VAMC staff and a non-generalizable sample of community providers receiving referrals from those VAMCs. GAO also interviewed VA and contractor officials.

## What GAO Recommends

GAO recommends that Congress consider requiring VA to establish an overall wait-time measure for the VCCP. GAO is also making three recommendations to VA, including that it align its monitoring metrics with the VCCP appointment scheduling process. VA did not concur with one of GAO's recommendations related to aligning monitoring metrics to VCCP scheduling policy time frames. GAO continues to believe this recommendation is valid, as discussed in the report.

View [GAO-20-643](#). For more information, contact Sharon M. Silas at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov).

September 2020

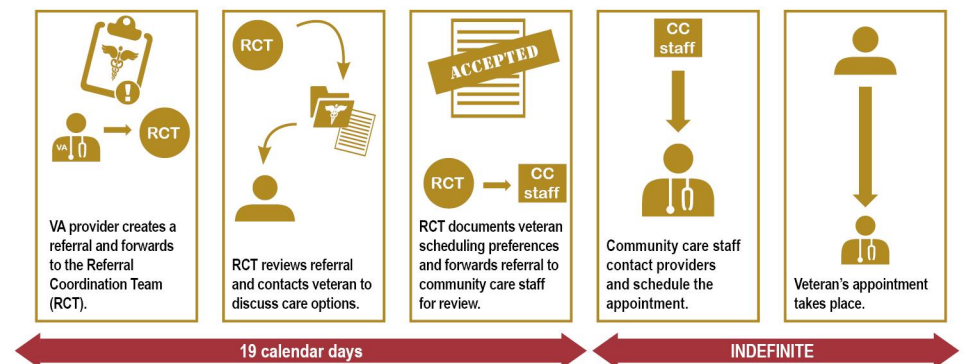
# VETERANS COMMUNITY CARE PROGRAM

## Improvements Needed to Help Ensure Timely Access to Care

### What GAO Found

The Department of Veterans Affairs (VA) established an appointment scheduling process for the Veterans Community Care Program (VCCP) that allows up to 19 days to complete several steps from VA providers creating a referral to community care staff reviewing that referral. However, as the figure shows, VA has not specified the maximum amount of time veterans should have to wait to receive care through the program. GAO previously recommended in 2013 the need for an overall wait-time measure for veterans to receive care under a prior VA community care program. Subsequent to VA not implementing this recommendation, GAO again recommended in 2018 that VA establish an achievable wait-time goal as part of its new community care program (the VCCP).

Potential Allowable Wait Time to Obtain Care through the Veterans Community Care Program



Source: GAO illustration based on analysis of Department of Veterans Affairs (VA) documentation. | GAO-20-643

Note: This figure illustrates potential allowable wait times in calendar days for eligible veterans who are referred to the VCCP through routine referrals (non-emergent), and have VA medical center staff—Referral Coordination Team (RCT) and community care staff (CC staff)—schedule the appointments on their behalf.

VA has not yet implemented GAO's 2018 recommendation that VA establish an achievable wait-time goal. Under the VA MISSION Act, VA is assigned responsibility for ensuring that veterans' appointments are scheduled in a timely manner—an essential component of quality health care. Given VA's lack of action over the prior 7 years implementing wait-time goals for various community care programs, congressional action is warranted to help achieve timely health care for veterans.

Regarding monitoring of the initial steps of the scheduling process, GAO found that VA is using metrics that are remnants from the previous community care program, which are inconsistent with the time frames established in the VCCP scheduling process. This limits VA's ability to determine the effectiveness of the VCCP and to identify areas for improvement.

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**Abbreviations**

CCN	Community Care Network
HSRM	HealthShare Referral Manager
RCT	Referral Coordination Team
TPA	third-party administrator
VA	Department of Veterans Affairs
VAMC	VA medical center
VCCP	Veterans Community Care Program
VISN	Veterans Integrated Service Network

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September 28, 2020

The Honorable Jon Tester  
Ranking Member  
Committee on Veterans' Affairs  
United States Senate

The Honorable Mark Takano  
Chairman  
Committee on Veterans' Affairs  
House of Representatives

The Honorable Julia Brownley  
Chairwoman  
Subcommittee on Health  
Committee on Veterans' Affairs  
House of Representatives

Since 1945, the Department of Veterans Affairs (VA) has allowed eligible veterans to receive care from community providers when they faced challenges accessing care at VA medical facilities, which include VA medical centers (VAMC) and outpatient facilities. In the last decade, Congress has taken steps to expand the availability of community care for veterans, including establishing the temporary Veterans Choice Program (Choice Program) in 2014.<sup>1</sup> While veterans still receive most of their care from VA medical facilities, the number of veterans that have received community care has increased 77 percent from 2014 through 2019, and in fiscal year 2019, VA obligated approximately \$15.5 billion for community care services.<sup>2</sup>

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<sup>1</sup>The Choice Program was created by the Veterans Access, Choice and Accountability Act of 2014. Pub. L. No. 113-146, §§ 101, 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

<sup>2</sup>The amount of obligations reflects community care services for both veterans and other eligible beneficiaries. In fiscal year 2019, VA obligated approximately \$64.3 billion for services provided at VA medical facilities.

We and others have identified challenges VA faced in implementing and administering prior community care programs.<sup>3</sup> For example, external reviews and congressional hearings held over the course of the Choice Program's implementation and operation highlighted programmatic weaknesses, including insufficient community provider networks, significant delays in scheduling appointments, and a lack of timely payment of claims to community providers. In addition, we reported in 2018 that under the Choice Program, veterans still experienced lengthy wait times when using community care and that VA had a limited ability to monitor veterans' access to community care.<sup>4</sup> Based on these findings, we made several recommendations to VA for it to incorporate lessons learned from the Choice Program to avoid similar challenges as it developed and implemented its future community care program.<sup>5</sup>

On June 6, 2019, VA implemented that program—the Veterans Community Care Program (VCCP)—as required under the VA MISSION Act of 2018 (VA MISSION Act).<sup>6</sup> The VCCP is a permanent program, and

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<sup>3</sup>See GAO, *Veterans Health Care: VA Needs to Address Challenges as It Implements the Veterans Community Care Program*, [GAO-19-507T](#) (Washington, D.C.: Apr. 10, 2019); *Veterans Choice Program: Further Improvements Needed to Help Ensure Timely Payments to Community Providers*, [GAO-18-671](#) (Washington, D.C.: Sept. 28, 2018); *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, [GAO-18-281](#) (Washington, D.C.: June 4, 2018); and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013). See also Department of Veterans Affairs, Office of the Inspector General, *Veterans Health Administration, Review of the Implementation of the Veterans Choice Program*, Report No. 15-04673-333 (Washington, D.C.: Jan. 30, 2017) and *Veterans Health Administration, Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, Report No. 18-05121-36 (Washington, D.C.: Jan. 16, 2020).

<sup>4</sup>See [GAO-18-281](#). Due to these and other concerns, VA health care continues to be on our High Risk List, including its most recent publication in March 2019. GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. We added VA health care to the High Risk List in 2015. See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

<sup>5</sup>Specifically, in [GAO-18-281](#), we recommended that VA should design an appointment scheduling process for its new community care program with certain time frames, establish a wait-time goal for veterans to receive care in the community, and develop a comprehensive policy directive. VA agreed or agreed in principle with these recommendations, but has not implemented them.

<sup>6</sup>Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018).

consolidated or replaced VA's previous community care programs, including the Choice Program. The VA MISSION Act established criteria under which a veteran may be eligible for the VCCP. Veterans are eligible to receive care under the VCCP, for example, when services are not available at the VAMC, VA cannot furnish care within its designated access standards, or a VA provider deems it is in the veteran's best medical interest. Additionally, under the VCCP, VA contracted with third-party administrators (TPA) to build regional networks of community providers and to pay those providers' claims for services delivered to veterans. The new contracts also removed appointment scheduling responsibilities from the TPAs, which had previously done this task, to VAMC staff.<sup>7</sup>

You asked us to review VA's implementation of the VCCP and the extent to which VAMCs were prepared to perform appointment scheduling responsibilities. In this report, we examine

1. the appointment scheduling process that VA established for veterans to obtain care through the VCCP;
2. the metrics VA uses to monitor the timeliness of VCCP appointment scheduling;
3. VA's efforts to prepare VAMC staff for VCCP appointment scheduling; and
4. VA's efforts to determine VAMC staffing needs for the VCCP.

To examine the appointment scheduling process that VA established for veterans to obtain care through the VCCP, and the metrics VA uses to monitor the timeliness of VCCP appointment scheduling, we reviewed applicable VA policies, directives, and guidance, and VA's contracts with the TPAs. In addition, we interviewed officials from VA's Office of Community Care and Office of Veterans Access to Care about the development and implementation of the VCCP scheduling and monitoring

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<sup>7</sup>Under the Choice Program, two TPAs were responsible for scheduling appointments with community providers for eligible veterans, in addition to establishing community provider networks and paying claims. Staff at some VAMCs began scheduling veterans' community care appointments before implementation of the VCCP in June 2019, because VA's contract with one of its Choice Program TPAs ended on September 30, 2018. For information on the TPAs' scheduling process and timeliness metrics under the Choice Program, see [GAO-18-281](#). The contracts for VA's new community provider network contain an optional task for the TPA to schedule appointments, however, as of June 2020, VA has not exercised this option.



processes, and the types of guidance provided by VA to VAMCs. We also reviewed data that VA uses to monitor VCCP appointment scheduling timeliness, and observed a demonstration of VCCP appointment scheduling by community care staff at one VAMC.<sup>8</sup> (See app. II for analysis of the timeliness of appointment scheduling actions and of veterans obtaining care for a sample of VCCP referrals from selected VAMCs.) We reviewed the data for completeness and to identify any obvious errors, and interviewed VA officials about the data. On this basis, we determined these data were sufficiently reliable for the purpose of our objective. We reviewed actions VA has taken to address previous recommendations, and assessed VA's scheduling and monitoring processes against VA guidance, the VA MISSION Act's requirement to implement the VCCP, and against federal internal control standards for control activities, information and communication, and monitoring.<sup>9</sup>

To examine VA's efforts to prepare VAMC staff for VCCP appointment scheduling and determine VAMC staffing needs for the VCCP, we reviewed VA policy and guidance, various implementation documents related to the VCCP and community provider networks, and TPA contract documents. We analyzed VA data on community care staffing levels from July 2019, the month following VCCP implementation, through February 2020—the most recent update to the data at the time of our review—for VAMCs located in VA's first region to transition to the new community provider network.<sup>10</sup> We reviewed the data for completeness and to identify

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<sup>8</sup>A referral is an electronic request entered into VA's electronic health record by a VA provider who is seeking an opinion, advice, or expertise regarding evaluation or management of a veteran's condition. VA used to refer to this request as a "consult," but is now using the term "referral" to describe specialty care requests in order to align with industry standards.

<sup>9</sup>See [GAO-18-281](#).

Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

<sup>10</sup>We reviewed information obtained from the staffing tool, such as recommended and reported staffing levels, but did not assess the tool itself and whether it accurately predicts the number of staff needed.

VA is deploying its new community provider network in a phased approach across six established regions. We focused on the first region as its deployment schedule of the new community provider network, July 2019 through December 2019, best aligned with our reporting time frames.

any obvious errors, and interviewed VA officials about the data. On this basis, we determined these data were sufficiently reliable for the purpose of our objective.

In addition, we conducted site visits to five VAMCs between September 2019 and February 2020 that are located in VA's first region to transition to the new community provider network. We selected VAMCs with varying facility complexity, rurality, implementation dates of the new community provider network, related Veterans Integrated Service Networks (VISN), and status of whether VAMC staff were scheduling community care appointments prior to VCCP implementation.<sup>11</sup> The VAMCs we selected were located in White River Junction, Vermont (VISN 1); Bath, New York (VISN 2); Bronx, New York (VISN 2); Philadelphia, Pennsylvania (VISN 4); and Washington, D.C. (VISN 5). We interviewed officials from VA's Office of Community Care, selected VISNs, leadership and community care staff from the selected VAMCs, and TPAs about VCCP implementation, staffing, and related technology.<sup>12</sup> We also reviewed VA provided data on overtime hours from June 2019—the month VCCP was implemented—through March 2020—the most recent data we requested—for community care schedulers at the selected VAMCs. The information we obtained from the selected VAMCs and VISNs cannot be generalized. We assessed the information we gathered from site visits and interviews against relevant VA documentation, and federal internal control standards for risk assessments and external communication.<sup>13</sup>

We conducted this performance audit from May 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our

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<sup>11</sup>VA's health care system is divided into areas called VISNs, each responsible for managing and overseeing the VA medical facilities within a defined geographic area.

<sup>12</sup>Although we did not conduct any site visits to VAMCs located in VISN 6, we interviewed officials from that VISN to ensure we spoke with all VISNs located in the first region of the new community provider network. We also interviewed a non-generalizable sample of six community providers from a TPA-provided list of the largest referral volume from the selected VAMCs to identify any challenges following VCCP implementation. The providers we interviewed included an academic health system and a home care provider.

We also made attempts to reach out to local representatives of Veteran Service Organizations associated with the selected VAMCs; however, we received only one response.

<sup>13</sup>[GAO-14-704G](#).

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findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

The VA MISSION Act was enacted in June 2018 to strengthen and improve VA's health care system for veterans and their caregivers. Among other things, such as introducing a new urgent care benefit, the VA MISSION Act required VA to implement within 1 year of the law's enactment a permanent community care program to help ensure that veterans have access to timely, quality care.<sup>14</sup> In response, VA implemented the VCCP on June 6, 2019, and issued regulations, including defining certain eligibility criteria, to carry out the new program.<sup>15</sup> The VCCP consolidated VA's previous community care programs, including the Choice Program and Patient-Centered Community Care.<sup>16</sup>

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### VCCP Eligibility Criteria

Under the VCCP, eligible veterans may choose to obtain health care services from community providers rather than from a VA provider when the veteran is enrolled in VA's health care system, or is not enrolled but otherwise entitled to care under 38 U.S.C. § 1705(c)(2), and receives VA's approval for community care due to any of the following criteria:<sup>17</sup>

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<sup>14</sup>Pub. L. No. 115-182, tit. I, §§ 101, 105, 132 Stat. 1393, 1395-1404, 1412-1413 (2018).

<sup>15</sup>38 C.F.R. §§ 17.4000 - 17.4040.

<sup>16</sup>VA fully implemented Patient-Centered Community Care in 2014, and awarded contracts to two TPAs to develop regional networks of community providers to deliver care when such care was not feasibly available from a VA medical facility. To implement the Choice Program in 2014, VA modified its Patient-Centered Community Care contracts to establish networks of community providers, schedule appointments with community providers for veterans, and pay community providers for their services. The existing Patient-Centered Community Care network will transition out from a VAMC when the new network of community providers under the VCCP is live at that facility.

<sup>17</sup>See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018), codified at 38 U.S.C. § 1703(d), (e), and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040. See also VA, *Veterans Health Administration Office of Community Care Field Guidebook* (May 21, 2020); *Veterans Health Administration: Referral Coordination Initiative Implementation Guidebook* (Jan. 10, 2020); and *Fact Sheet: Veteran Community Care Eligibility* (Aug. 30, 2019).

- the veteran needs a service that is not available at any VAMC;
- the veteran lives in a U.S. state without a full-service VAMC;<sup>18</sup>
- the veteran qualifies under the grandfather provision related to distance eligibility for the Choice Program and resides in certain states;
- the veteran cannot receive care within VA's designated access standards, which occurs when the veteran's average drive time to a VA provider is more than 30 minutes for primary care or more than 60 minutes for specialty care, or the next available appointment with a VA provider is not available within 20 days for primary care or 28 days for specialty care of the date of request of care unless a later date has been agreed upon;<sup>19</sup>
- the care is in the veteran's best medical interest as determined by the veteran and his or her VA provider;<sup>20</sup> or
- the care or services the veteran is seeking at their VAMC does not comply with VA's standards for quality.

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## Community Care Networks

The VCCP allows VA various options to purchase community care, including through regional contracts called Community Care Networks (CCN) and direct agreements with community providers for care not included in those contracts, known as Veterans Care Agreements.<sup>21</sup> VA is using TPAs to develop and administer the CCN—specifically, TPAs are responsible for recruiting and building networks of licensed health care

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<sup>18</sup>This includes Alaska, Hawaii, New Hampshire, and the U.S. territories of Guam, American Samoa, the Northern Mariana Islands, and the U.S. Virgin Islands.

<sup>19</sup>In this report, "days" refers to calendar days, unless otherwise indicated.

<sup>20</sup>The "best medical interest" criteria is used for the purpose of achieving improved clinical outcomes for the veteran based on one or more of the following factors, as applicable: the distance between the veteran and the VA medical facility providing the care, the nature of the needed care, the frequency of the needed care, the timeliness of available appointments for the needed care, the potential for improved continuity of care, the quality of the care provided, or whether the veteran faces an unusual or excessive burden in accessing a VA medical facility.

<sup>21</sup>VA also has the option to refer veterans to other federal health care facilities with whom VA has an agreement, such as a Department of Defense or other federal health care facility.

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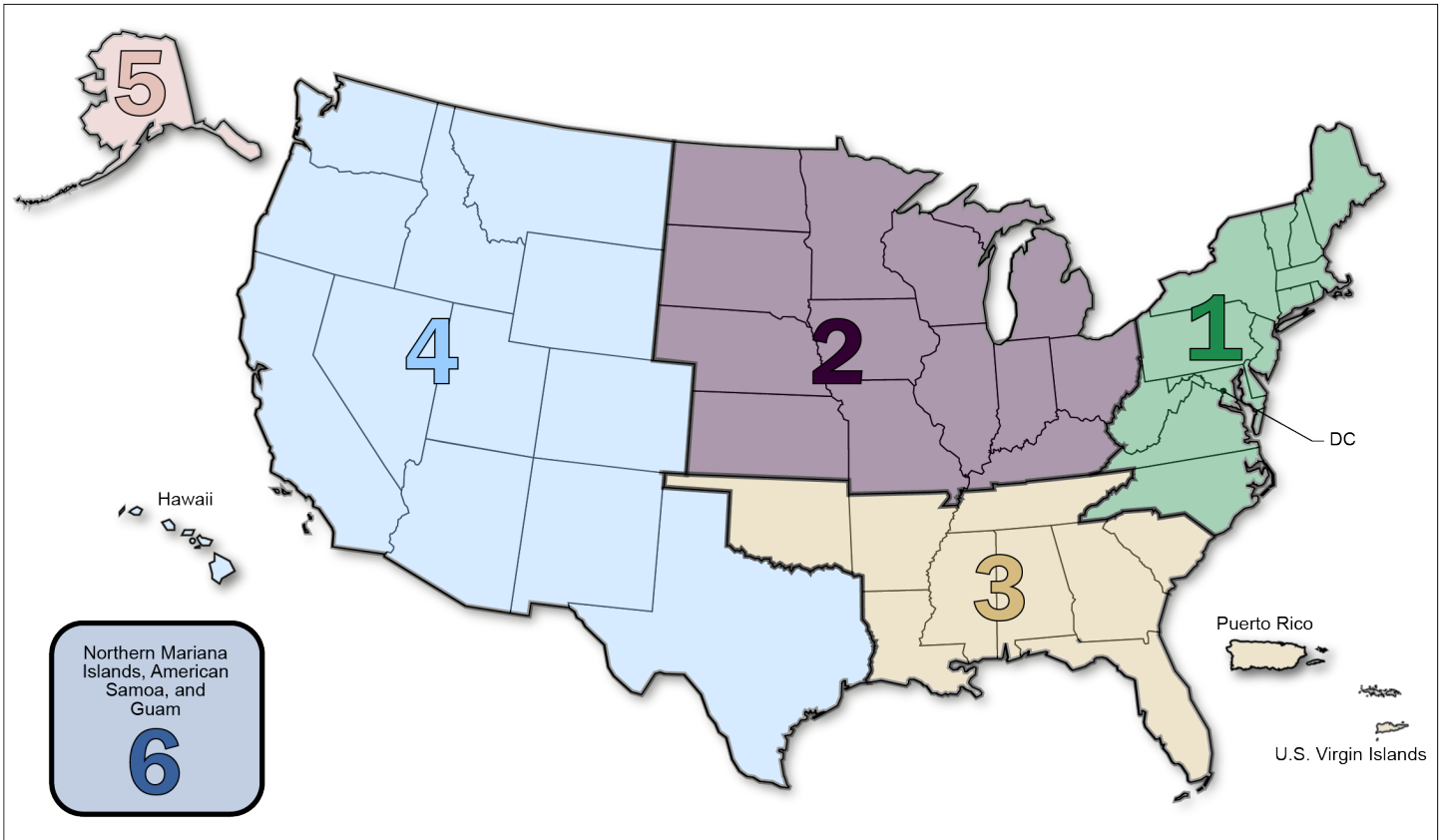
community providers and paying community provider claims.<sup>22</sup> Contracts for Regions 1 through 3 were awarded to Optum Public Sector Solutions (Optum) in December 2018, and the contract for Region 4 was awarded to TriWest Healthcare Alliance (TriWest) in August 2019.<sup>23</sup> (See fig. 1.) As of September 2020, the contracts for Regions 5 and 6 had not been awarded.

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<sup>22</sup>VA issued a request for proposals for the CCN contracts in December 2016, prior to the enactment of the VA MISSION Act.

<sup>23</sup>TriWest was one of VA's TPAs for both Patient-Centered Community Care and the Choice Program. Though the contracts for CCN Regions 2 and 3 were awarded in 2018, the first stages of their phased implementations were not deployed at the time we started our review.

**Figure 1: Map of Community Care Networks and Awarded Third-Party Administrators (TPA) for the Veterans Community Care Program, as of September 2020**



<b>1</b> Optum	<b>2</b> Optum	<b>3</b> Optum	<b>4</b> TriWest	<b>5</b> Pending award	<b>6</b> Pending award
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Source: GAO analysis of Department of Veterans Affairs information (data); Map Resources (map). | GAO-20-643

Note: The awarded TPAs include Optum Public Sector Solutions (Optum) and TriWest Healthcare Alliance (TriWest).

VA implemented the CCN contracts for the VCCP region-by-region in a phased approach by VAMC, beginning with VAMCs in CCN Region 1. For VAMCs in Regions 1, 2 and 3, VA allowed VAMCs to continue using the existing Patient-Centered Community Care network for a designated time frame during the transition to the CCN while Optum continued to grow the CCN to meet each VAMC’s provider network needs.

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## VA's Appointment Scheduling Process for the VCCP Does Not Specify the Maximum Amount of Time Veterans Should Have to Wait to Receive Care

VA established its appointment scheduling process for the VCCP using various guidance and policy. As described in VA's *Referral Coordination Initiative Implementation Guidebook*, the VCCP appointment scheduling process involves actions from two groups of staff at VAMCs: 1) staff that make up Referral Coordination Teams (RCT), and 2) staff in the community care office.<sup>24</sup> According to VA guidance, the process for VAMC staff to schedule a VCCP appointment begins when a VA provider creates a referral and informs the veteran that someone from the RCT will follow up with that veteran to discuss the available options for their care. (See Step 1 below in fig. 2.) After receiving the referral, based on VA guidance, the RCT is responsible for completing several actions, which include:

- reviewing the referral and determining if the veteran is eligible for community care;
- if at least one eligibility criteria is met, attempting to contact the veteran to discuss available options for care both within VA and in the community;
- if the veteran cannot be reached by telephone, sending the veteran a letter asking them to contact the RCT;

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<sup>24</sup>The RCTs are based by specialty care type, though officials from VA's Office of Community Care stated that there is flexibility in the way the RCT can be designed by the VAMC, and one RCT could be responsible for multiple care types. According to VA guidance, the RCT should be made up of administrative and clinical staff. The clinical staff recommendations for RCT members includes positions such as nurses, physician assistants, and social workers. The administrative staff recommendations for RCT staff includes schedulers and other clinical administrative roles such as registered nurses, and health care technicians.

- if the veteran chooses to receive community care, collecting and documenting in the referral the veterans' preferences, including their preferred community provider;<sup>25</sup> and
- sending the referral to staff in the VAMC's community care office.

Once received, VAMC community care staff are responsible for reviewing the referral to ensure all required elements are documented.<sup>26</sup> According to VA guidance, once that review is complete, community care staff then must take several actions to schedule an appointment:

- contact community providers;
- create and send the authorization for community care and information about the veteran to the community provider for review and approval;<sup>27</sup>
- schedule the veteran's appointment with the community provider; and
- communicate appointment details to the veteran.<sup>28</sup>

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<sup>25</sup>If the veteran chooses to receive their care within the VA, the RCT schedules their appointment with a VA provider and communicates appointment details to the veteran.

<sup>26</sup>VAMC community care staff may have up to 4 days if the referral is received on Friday. If there are holidays, the maximum number of days permitted to elapse may be greater than 4 days. Prior to contacting community providers, VAMC community care staff must confirm the referral is complete, and includes types of information like clear documentation of eligibility, documentation that the referral was reviewed for clinical appropriateness and approved for scheduling in the community, and documentation of the veteran's community care appointment scheduling preferences, communication preferences, and mileage the veteran is willing to travel. If the veteran's community care scheduling preferences are not documented, community care staff will contact the veteran to document preferences and proceed with the scheduling process.

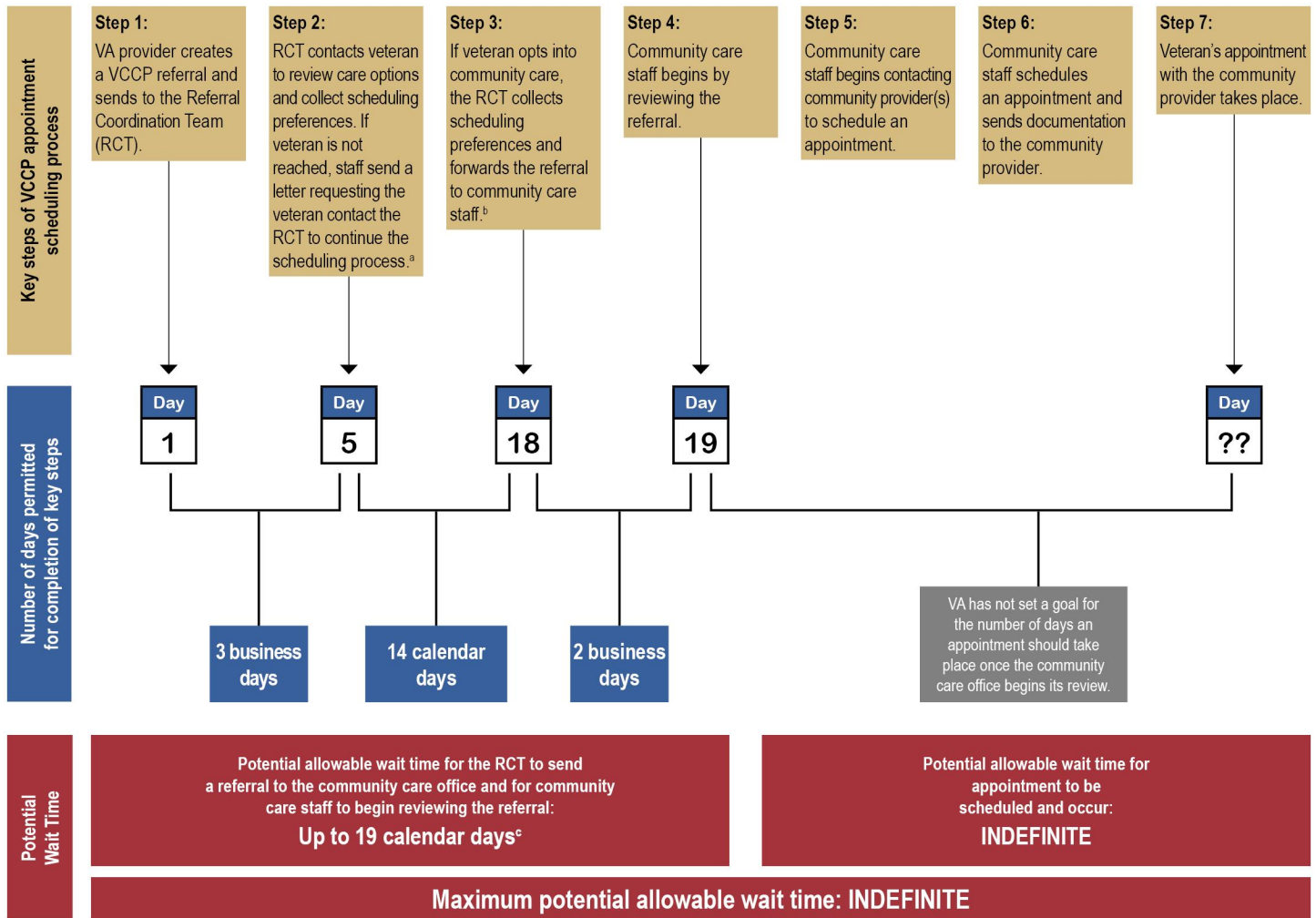
<sup>27</sup>The information sent to the community provider includes the veteran's community care referral and any other medical documentation that the community provider would need to review and accept the referral.

<sup>28</sup>According to VA guidance, community care referrals are closed once the VAMC community care staff confirms the veteran attended the appointment and the community provider submits medical documentation from the appointment to the VAMC. Further, if the provider does not submit clinical documentation, VAMC community care staff must make at least one attempt to collect these documents before closing the referral. Community providers are not required to submit clinical documentation of the veteran's appointment to receive payment for authorized care, based on VA guidance.



See figure 2 below for an illustration of the scheduling process and potential allowable wait time for veterans to receive care through the VCCP when VAMC staff schedule on their behalf.<sup>29</sup>

**Figure 2: Potential Allowable Wait Time to Obtain Care through the Veterans Community Care Program (VCCP) Appointment Scheduling Process (effective February 2020)**



Source: GAO illustration based on analysis of Department of Veterans Affairs (VA) documentation. | GAO-20-643

<sup>29</sup>Under the VCCP, eligible veterans can also self-schedule their community care appointments or use VA's online scheduling capabilities to request an appointment for primary care and select specialty care with community providers, which may involve different steps by VAMC staff. Our review focuses on the scheduling process when VAMC staff schedule on behalf of the veteran for community care obtained through routine referrals and does not reflect the scheduling process for emergent referrals.

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Notes: This figure illustrates potential allowable wait times for eligible veterans who are referred to the VCCP through routine referrals (non-emergent), and have RCT and community care staff schedule the appointments on their behalf. The potential wait time reflects the days if RCT and community care staff take the maximum amount of time allowed by VA's process; VA does not have a wait-time measure for receipt of care. Under the VCCP, eligible veterans can also self-schedule their community care appointments or use VA's online scheduling capabilities to request an appointment for primary care and select specialty care with community providers, which may involve different steps by VA medical center staff.

<sup>a</sup>According to VA officials, the phone call and letter can occur on the same day.

<sup>b</sup>If a veteran is not eligible or does not opt into community care, the RCT will schedule an in-house appointment based on the veteran's scheduling preferences.

<sup>c</sup>The maximum potential allowable wait time is 19 calendar days if the veteran's need for care is identified on a Friday. If there are holidays, the total number of calendar days permitted to elapse may be greater than 19 calendar days.

VA introduced guidance on the RCTs and related VCCP scheduling process in December 2019, with, according to VA officials, RCT implementation starting in February 2020, to address challenges with the scheduling process that had been in place at the time of VCCP implementation in June 2019.<sup>30</sup> Specifically, VA officials stated that they found that under the previous process veterans were not aware early enough in the scheduling process of their care options inside VA and in the community. According to VA, the RCT concept attempts to address these challenges by adding a conversation with the veteran and RCT about the veteran's options for care both within VA and in the community earlier in the scheduling process to better support the veteran's ability to make an informed decision. In addition, according to VA guidance, the RCT and related scheduling process aim to relieve VA providers of administrative burdens, by shifting responsibility for determining veteran eligibility for community care to the RCT and away from providers.

In reviewing VA's scheduling process for obtaining care under the VCCP and related VA interviews, directives, and guidance, we identified three weaknesses, including that (1) VA lacks an overall wait-time performance measure; (2) VA's scheduling process does not reflect scheduling steps with related time frames that are consistent with an overall wait-time performance measure; and (3) VA lacks a comprehensive policy directive

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<sup>30</sup>See app. II for a figure of the VCCP scheduling process prior to February 2020. According to VA guidance, the RCTs are one part of VA's Referral Coordination Initiative to support efforts to streamline the referral process, both within VA and with community providers. According to VA officials, VA began phasing in the RCTs by implementing them in a minimum of one specialty in 100 percent of VAMCs by February 29, 2020, and planned to implement RCTs in all specialties in 100 percent of VAMCs by July 2020. However, in May 2020, VA officials said that these plans were postponed because of Coronavirus Disease 2019.

for the VCCP. These weaknesses may limit VA's ability to achieve its goal of reducing veterans' wait times for care.

**VA lacks a wait-time performance measure for the VCCP.** Through analysis of relevant VA guidance and policy, we determined that VA established maximum allowable wait times for part of the appointment scheduling process – up to 19 days to complete several steps between when a VA provider creates a VCCP referral and when community care staff review the referral (see fig. 2 above). However, according to VA officials, VA does not have an overall wait-time performance measure specifying the maximum amount of time it should take veterans to receive care from community providers under the VCCP. According to VA officials, the VCCP lacks a wait-time performance measure because there is no statutory requirement and wait-times vary based on the community provider and location.<sup>31</sup>

We previously identified the lack of an overall wait-time measure for veterans to receive care as a deficiency under prior VA community care programs. Specifically, we reported in May 2013 that under the Fee Basis Program (VA's previous name for community care), VA did not have a timeliness measure for veterans to receive care through the program, and recommended that VA apply the same wait-time measure to that care that it uses to monitor wait times for care at VAMCs. Although VA agreed with our recommendation, the department never implemented it.<sup>32</sup>

In our June 2018 report we found that under the Choice Program VA did not track or monitor how long it took VAMCs to refer veterans to the community.<sup>33</sup> Further, in our June 2018 report we recommended that as VA developed and implemented its new community care program (the VCCP), it should implement an achievable wait-time goal for veterans to

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<sup>31</sup>According to VA officials, the current wait-time goal for scheduling appointments with VA providers does not apply to the VCCP. VA's goal is to schedule appointments with VA providers within 30 days of the veteran's documented clinically indicated date (the date an appointment is deemed clinically appropriate by the referring provider), or in the absence of a clinically indicated date, the veteran's preferred date. See VA Directive 1230(1) *Outpatient Scheduling Processes and Procedures* (July 15, 2016, amended July 12, 2019).

<sup>32</sup>See [GAO-13-441](#).

<sup>33</sup>See [GAO-18-281](#).

receive care.<sup>34</sup> VA agreed with our recommendation for the new community care program, and in October 2019, VA officials stated that they were considering options for a wait-time measure, including potentially mirroring the designated access standards VA developed under the VA MISSION Act.<sup>35</sup> However, the VCCP has been operational since June 2019 and VA has not implemented our recommendation that was intended to be in place as part of the implementation of the new program.

The absence of an overall performance measure specifying the maximum amount of time veterans should have to wait to receive care through the VCCP is problematic as VA has historically struggled to administer its community care programs effectively. Consequently, veterans have not always received timely care in the community. Under the VA MISSION Act, VA is assigned responsibility to oversee the VCCP, including ensuring that veterans' appointments are scheduled in a timely manner. Appointment timeliness is an essential component of quality health care; delays in care have been shown to negatively affect patients' morbidity, mortality, and quality of life. Without implementing an achievable wait-time performance measure for receiving community care, VA cannot determine whether the VCCP has helped to achieve its goal of reducing veterans' wait times for receiving care. Given VA's lack of action over the prior 7 years in implementing a wait-time goal, absent congressional action, it is uncertain whether VA will implement a wait-time performance measure for the VCCP.

**VA's scheduling process does not reflect steps or time frames consistent with an overall wait-time performance measure.** Without an established wait-time measure, VA is unable to structure its appointment scheduling process to account for the entire time it takes for veterans to obtain care. We reported in 2018 that the previous scheduling process VA developed for the Choice Program may have resulted in veteran wait times that exceeded statutory requirements for veterans to

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<sup>34</sup>In addition, in April 2020, we reiterated the importance of this recommendation in our Priority Open Recommendations Letter for the Department of Veterans Affairs. See *GAO Priority Open Recommendations: Department of Veterans Affairs*, [GAO-20-537PR](#) (Washington, D.C.: Apr. 20, 2020).

<sup>35</sup>VA officials noted challenges to developing a wait-time measure for community care, including that it would require changes to its CCN contracts.

receive care through the program.<sup>36</sup> We recommended that as VA develops and implements the VCCP, it design an appointment scheduling process for the VCCP that sets forth time frames within which (1) veterans' referrals must be processed, (2) veterans' appointments must be scheduled, and (3) veterans' appointments must occur, which are consistent with a wait-time goal VA establishes for the program. VA agreed with our recommendation; however, VA has not implemented this recommendation.<sup>37</sup> We maintain our recommendation that VA establish an appointment scheduling process that aligns with an overall wait-time goal or measure. Without such a process, VA cannot ensure that the VCCP helps achieve the department's goal of reducing veterans' wait times for receiving care.

**VA lacks a comprehensive policy directive for the VCCP.** VA has not developed a comprehensive policy directive that would provide definitive, up to date information on VCCP scheduling policy for VAMC staff. Instead, the policies and guidance that outlines the VCCP scheduling processes and related time frames is found in a mix of VA documents. For example,

- VA officials confirmed that VA's directive for in-house referrals scheduled with VA providers establishes the timeliness requirement to change a VCCP referral from a pending to active status;<sup>38</sup>
- VA officials confirmed that VA's notice for outpatient scheduling establishes the timeliness requirements for contacting a veteran and sending a letter;<sup>39</sup>

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<sup>36</sup>See [GAO-18-281](#).

<sup>37</sup>For example, as fig. 2 shows, VA has established a maximum allowable wait time of 19 days for a VA provider to create a referral and have it reviewed by VAMC staff responsible for scheduling; however, for the completion of the VCCP scheduling process, in which VAMC staff schedule an appointment with community providers and the appointment occurs, VA has not established a maximum allowable wait time.

<sup>38</sup>A referral in pending status means the request for care has been sent, but not yet acted on by the receiving service. A referral in active status occurs when the referral is received and efforts are underway to fulfill the referral. See VA Directive 1232(2) *Consult Processes and Procedures* (June 28, 2019).

<sup>39</sup>See VA Notice 2019-09(2) *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VA Directive 1230 and VA Directive 1232(1)* (Apr. 24, 2019, amended May 8, 2019).

- VA's Office of Community Care Field Guidebook establishes the responsibilities of VAMC community care staff and describes actions staff must take to schedule and coordinate community care; and
- VA's Referral Coordination Initiative Implementation Guidebook establishes the responsibilities of the RCTs, and describes actions RCTs must take before they forward a referral to community care staff.

The use of different documents could make it difficult for VAMC staff to know which guidance to follow to appropriately schedule veterans' care. For example, the most recent version of VA's *Office of Community Care Field Guidebook* does not include comprehensive responsibilities of the RCT, and officials confirmed that certain timeliness requirements included in the guidebook do not apply to the VCCP. We reported in 2018 that under the Choice Program, VA lacked a comprehensive policy directive and operations manual, and recommended that VA issue such a document for the VCCP.<sup>40</sup> VA agreed in principle with our recommendation; however, VA has not implemented it. In May 2020, VA officials told us they were working on a directive, but according to them it was not available at the time of VCCP implementation because they prioritized developing regulations to implement the VA MISSION Act by June 2019. We maintain our recommendation that VA develop a comprehensive up-to-date source on VCCP scheduling policy. Without one, VA increases the risk that VAMC staff may be unaware of VA's policies and related timeliness requirements for veterans seeking care under the program.

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## VA Is Using Prior Community Care Program Metrics to Monitor VCCP Appointment Scheduling Timeliness, Which Are Inconsistent with Current Policy

VA's policy establishes two metrics that VA, VISN, and VAMC officials can use to monitor and assess timeliness of VCCP appointment scheduling: VAMC community care staff should (1) review referrals within 7 days of referral creation, and (2) schedule appointments within 30 days

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<sup>40</sup>See [GAO-18-281](#).

of referral creation.<sup>41</sup> According to VA officials, these metrics were originally developed by VA to monitor appointment scheduling under prior community care programs. Our review of the data used to monitor timeliness of VCCP appointment scheduling showed that, as of February 13, 2020,

- 26 of 39 VAMCs (67 percent) in CCN Region 1 successfully moved at least 90 percent of referrals from pending to active within 7 days, and
- seven of 39 VAMCs (18 percent) in CCN Region 1 successfully scheduled at least 90 percent of appointments within 30 days.<sup>42</sup>

Officials from VA's Office of Community Care said they review these metrics on a weekly basis to identify VAMCs that need additional guidance, and that there could be multiple reasons for VAMCs not meeting these metrics, including VAMC staff adjusting to program and process changes under the VCCP. For example, officials from VA's Office of Community Care said that if a VAMC is struggling to meet the timeliness metrics, VA field support staff will reach out to the VAMC to try and identify the cause. In addition to VA's monitoring efforts, each VAMC is required to have an oversight council, which meets monthly and reviews data on VCCP referral management, among other things. Office of Community Care officials said the VAMC oversight councils are also able to run more granular data reports than the 7- and 30-day metrics. During our site visits, community care staff at the 5 VAMCs we visited said they use the 7- and 30-day metrics to monitor referral timeliness, and did not mention using the more granular reports used by VAMC oversight councils.

We found that the metrics VA uses to assess the timeliness of VCCP appointment scheduling are inconsistent with the time frames found in VA's guidance for its scheduling process, which VAMC staff are instructed to follow. Specifically, the metrics differ in two main ways from

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<sup>41</sup>VA also has a metric that occurs after the appointment scheduling process—closing 90 percent of referrals within 90 days. A referral is closed when the veteran has received care and VAMC staff have received, or attempted to retrieve, medical records from the community provider.

<sup>42</sup>The data we reviewed were as of February 13, 2020. There are 40 VAMCs in CCN Region 1 (the first region to implement the new community provider network under the VCCP), however, according to VA officials, data for two VAMCs in CCN Region 1 are combined and reported as one integrated health care system as of December 2019. VA officials said these data change daily, as referrals age each day.

the time frames laid out in VA scheduling guidance that VAMC staff follow to schedule VCCP appointments, with one metric longer than guidance specifies and with no guidance related to the second metric. (See table 1.)

**Table 1: VA’s Performance Metrics for Selected Scheduling Actions under the Veterans Community Care Program as Compared to VA’s Guidance for VA Medical Center Staff Responsible for These Actions**

Scheduling actions	VA scheduling guidance time frames <sup>a</sup>	VA performance metrics
VA medical center community care staff begin reviewing the referral once it is received	Two business days	90 percent of referrals acted on within 7 calendar days of referral creation
Veteran’s appointment is scheduled <sup>b</sup>	No guidance	90 percent of referrals have an appointment scheduled within 30 calendar days of referral creation

Source: GAO analysis of Department of Veterans Affairs (VA) documentation. | GAO-20-643

<sup>a</sup>VA scheduling guidance time frames are from VA’s Office of Community Care Field Guidebook

<sup>b</sup>A referral is in a scheduled status when an appointment has been created.

Officials from VA’s Office of Community Care said they informed VAMC staff to follow the 2-day time frame for reviewing a referral once it is received (see step 4 in fig. 2), and felt that VAMC staff knew to do so. However, while staff at two of the five VAMCs we visited said they followed the 2-day time frame, staff at the other three VAMCs said they had up to 7 days to move a referral from pending to active.

VA officials said these differences exist because the metrics reflect monitoring policies in effect before the VCCP was implemented. According to VA officials, these metrics were built into VA’s monitoring tools for prior community care programs, and officials did not have the time or could not make changes to those tools prior to VCCP implementation. As of May 2020, Office of Community Care officials said they plan to update their monitoring metric for pending referrals to 2 business days to align with the time frame in scheduling policy once a comprehensive policy directive for the VCCP is released and the CCN is implemented nationwide. However, even if VA makes this proposed change, there will still be an inconsistency between the monitoring metric VA uses for scheduling an appointment and the process followed by VAMC staff.

VA’s metrics for monitoring the timeliness of the VCCP appointment scheduling process are not consistent with federal internal control standards regarding the use of quality information and monitoring



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activities.<sup>43</sup> According to VA officials, monitoring the timeliness of the VCCP appointment scheduling process is essential because delays in referral management may lead to extended wait times for veterans to receive care. However, monitoring metrics that are inconsistent with the time frames in VA policy, which are used by staff to schedule appointments, limits VA's ability to identify high and low performing VAMCs. The use of inconsistent metrics also affects VA's ability to work with VAMCs to identify problems and implement corrective actions to improve the timeliness of veterans' appointments as needed.

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## VA Has Taken Steps to Prepare VAMCs for VCCP Scheduling but Reports That Few Providers Have Opted to Exchange Information Electronically

VA took steps to prepare VAMC staff for appointment scheduling under the VCCP and implementation of the CCN, but at selected VAMCs we visited between September 2019 and February 2020, VAMC staff identified difficulties with VA's software tools, the CCN, and community provider education.<sup>44</sup> VA is working to address these challenges, but few community providers have signed up to use VA's new software system to manage referrals and electronically exchange information with VAMCs.

To prepare VAMC staff for appointment scheduling responsibilities and implementation of the CCN, VA (1) developed a readiness assessment to implement the VCCP, (2) developed software tools for VAMC staff to manage VCCP referrals, (3) developed training materials related to various VCCP topics, and (4) assisted VAMCs during deployment of the CCN at a VAMC.

**Readiness assessment:** VA developed a readiness assessment in August 2018 and assigned each VAMC a numerical score to quantify its

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<sup>43</sup>[GAO-14-704G](#).

<sup>44</sup>We conducted site visits to the VAMCs located in White River Junction and Philadelphia in September 2019, the VAMC located in the Bronx in December 2019, the VAMC located in Bath in January 2020, and the VAMC located in Washington, DC in February 2020.

preparedness to implement the VCCP.<sup>45</sup> VA calculated the readiness scores using pre-VCCP data from each VAMC including, among other things<sup>46</sup>

- the percentage of community care referrals already scheduled by VAMC staff;
- the percentage of community care referrals processed within VA's timeliness goals; and
- a readiness assessment from the VAMC's related VISN.

Officials from VA's Office of Community Care said the percentage of pre-VCCP community care referrals scheduled by VAMC staff was most directly related to the VAMC's readiness to implement VCCP appointment scheduling, because staff scheduling appointments were already familiar with the process. VA data shows that as of July 2019, most of the VAMCs in CCN Region 1 (36 of 40) were already scheduling at least some community care appointments using VAMC staff.<sup>47</sup> To determine the extent to which VAMC's were meeting referral timeliness goals, VA calculated, based on status, the percentage of community care referrals that were pending no more than 7 days, active no more than 30 days, and scheduled no more than 90 days. VA recommended that VAMCs that were not meeting these timeliness goals add community care staff ahead of VCCP implementation. VA officials also said they used VISN assessments of VCCP readiness to provide additional insight on a VAMC's preparedness that could not be obtained through quantitative means, such as identifying whether a VAMC had past success with community care process or technology changes.

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<sup>45</sup>In addition to assessing how prepared VAMCs were to implement VCCP appointment scheduling, the readiness assessment also looked at VAMCs' preparedness to transition to using the CCN.

<sup>46</sup>The readiness score also included data on processes that are not directly related to, and occur after, an appointment has been scheduled, such as whether community care referrals and provider claims have a corresponding authorization.

<sup>47</sup>Under the Choice Program, two TPAs were responsible for scheduling appointments with community providers for eligible veterans. Staff at some VAMCs began scheduling veterans' community care appointments before implementation of the VCCP in June 2019, as VA's contract with one of its Choice Program TPAs ended on September 30, 2018, before the VCCP was implemented.

### VA software systems to support the VCCP

VA developed three software systems that VA medical center (VAMC) staff can use to manage and schedule appointments for the Veterans Community Care Program (VCCP):

- Provider Profile Management System:** VA's master database of community providers, including Community Care Network providers, that was deployed at the end of fiscal year 2018. The system receives and stores information from multiple sources about each provider such as demographic information and the types of services the provider is authorized to deliver.
- Decision Support Tool:** Deployed at all VAMCs on June 6, 2019, for VAMC staff to use to help determine and document veteran eligibility for the VCCP. The system includes information about the availability and average wait times for services at VAMCs, and, as of June 2020, community care wait times, as well as average drive times from a veteran's address to VAMCs that offer a needed service.
- HealthShare Referral Manager:** Deployed at all VAMCs as of June 24, 2019, for VAMC staff to use to manage VCCP referrals, including creating authorizations, searching for community providers, documenting appointments, and reviewing referral timeliness data. The system also allows VAMC staff and community providers to electronically share referrals and documentation with each other.

Source: GAO analysis of Department of Veterans Affairs (VA) documentation. | GAO-20-643

VA Office of Community Care officials said they conducted site visits to VAMCs that had lower readiness scores and thus were less prepared ahead of VCCP implementation. Officials also said they used the readiness scores to help inform the roll-out of the CCN, although other factors (like availability of providers in the TPA's existing network) were more important. VA officials said the readiness scores will no longer be needed after the CCNs are implemented nationwide, but they plan to continue monitoring the timeliness metrics for referral processing.

**Software systems:** According to VA documentation we reviewed, VA developed three software systems for VAMC staff to use to manage VCCP referrals in preparation for the VCCP: (1) the Provider Profile Management System to search for community providers, (2) the Decision Support Tool to help determine veteran's VCCP eligibility, and (3) the HealthShare Referral Manager (HSRM) to manage VCCP referrals and share documentation with community providers. However, at the time of our site visits, staff from all five VAMCs discussed challenges they faced when using these systems, including glitches with the HSRM or community providers not showing up in the Provider Profile Management System despite being enrolled in the CCN.<sup>48</sup> Staff from four of the five VAMCs also discussed issues with interoperability among the multiple systems community care staff need to use to schedule referrals, and staff from three VAMCs expressed frustration at the number of systems and screens that needed to be open simultaneously to schedule a community care appointment.

VA officials confirmed that there have been challenges with their software systems, but said they worked closely with their technology teams to resolve issues as they arise.<sup>49</sup> VA officials added that their primary goal is to have community care appointments documented through the HSRM. To accomplish this, in April 2020, VA released a software patch for the HSRM to link appointments back into VA's electronic medical record system.

<sup>48</sup>For example, the HSRM prepopulating a veteran's authorization form with 999 visits, which requires VAMC staff to edit the form to the correct number of authorized visits. Officials from VA's Office of Community Care stated that it was a system's development requirement to enter in a number of visits, so they used 999 as to not limit the number of visits an authorization can have.

<sup>49</sup>VA officials stated that they used a process of running lists of actions and issues to track major software systems to make sure they followed up with resolutions.

In addition to VAMC staff using the HSRM to internally manage referrals, community providers can also sign up to use the system to exchange information, including sharing medical documentation electronically with VAMC staff. However, staff from all five VAMCs stated that very few, if any, community providers had signed up for, or were using, the HSRM for this purpose. As of June 2020, VA officials stated that nationally, approximately 10,000 community providers had signed up to use the HSRM out of the approximately 1.7 million community providers enrolled in the CCN.<sup>50</sup> Staff from one VAMC detailed the challenges of community providers not using the HSRM as a care coordination portal, including that VAMC staff had to receive veterans' medical documentation by fax or mail, which then had to be scanned into VA's electronic medical record system.<sup>51</sup> This, in turn, created backlogs.

Community provider use of the HSRM, according to VA and its HSRM user guide, allows VA to better manage community care and reduce the time it takes to process referrals by transitioning the department away from a largely manual referral management process to an electronic one. As such, VA officials said they intend for the HSRM to be the primary tool used by VAMC staff to manage community care referrals and interact with community providers. However, VA officials stated that they do not require community provider use of the HSRM to participate in the VCCP, because VA wants to offer flexibility to providers and not mandate a single system for use under the program.<sup>52</sup> Further, VA officials stated that there are no guidance or goals related to recruitment of community providers to use the HSRM. The limited use of the HSRM by community providers is a risk to VA successfully meeting its goal of using the system as its main tool to exchange information and manage referrals with community providers. For example, VAMC staff may have to continue to rely on manual document exchange with community providers, which could result in delayed scheduling, lost documentation, or delays in VA

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<sup>50</sup>VA officials stated that multiple providers could access the HSRM from one office, and that the estimated 10,000 community providers able to use the HSRM were located at approximately 4,000 unique locations.

<sup>51</sup>We previously reported in 2018 that VA struggled with manual referral processes under the Choice Program, and that VA's ability to coordinate care with community providers was limited. See [GAO-18-281](#).

<sup>52</sup>According to VA officials, there is a risk that requiring community providers to use the HSRM as a condition of VCCP participation could result in fewer providers participating in the program.

providers reviewing community provider notes if there are document scanning backlogs.

**VCCP training courses.** VA developed several training courses for VAMC staff to complete in May 2019, the month prior to VCCP implementation. Based on our review of training materials, the courses covered information on community care, VCCP eligibility, the Decision Support Tool, the HSRM, and additional components of the VA MISSION Act.<sup>53</sup> In November 2019, VA released a training course that covered the appointment scheduling process from beginning to end, based on feedback it received from VAMC staff in CCN Region 1, according to VA officials. Additionally, according to VA officials, each VAMC assigned a “champion” who was responsible for overseeing the training courses that staff needed to complete before VCCP implementation and communicating information about the program, among other things.

Staff at three of the five VAMCs we visited said they generally felt prepared, but some staff felt it was a challenge to learn a large volume of information in the 1-year preparation time frame. Officials from one VAMC and one VISN said that they felt the VCCP implementation went more smoothly than that of the Choice Program in 2015.

**CCN deployment actions.** VA and TPA officials stated that they took several actions to prepare VAMC staff for the implementation of the new provider networks under the CCN at their facilities, including:

- developing training courses covering different aspects of the CCN and the TPA’s CCN portal,
- establishing national and regional transition teams comprised of various staff to ensure consistent and timely implementation of the CCN across all regions, and
- providing virtual or onsite command centers with VA and TPA staff the week the CCN goes live at a facility so that both parties could collaborate and resolve issues in real time.

Despite these actions, VAMC staff we spoke with identified challenges with the CCN after the network went live at their facilities. First, at the time

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<sup>53</sup>VA officials stated that staff primarily completed training courses through online modules, although VA and VISN officials said they also provided an on-site training course at VAMCs ahead of implementation. VA officials said they provided additional virtual training courses to VAMCs who were not previously scheduling community care appointments.

of our site visits, staff from all five VAMCs stated that they felt the CCN provider network was not adequate. Staff from four of the VAMCs discussed major community providers they usually refer care to that were not in the network the day the CCN went live at their facilities, though staff from three VAMCs discussed that they had provided the names of these providers in advance to the TPA responsible for building the network. At another VAMC, staff stated that 10 large hospital systems were still not in the network more than three months after the CCN went live. Staff from two VAMCs felt that part of the reason why their CCN provider networks were not adequate was due to the criteria that VA uses to assess CCN provider network adequacy, which could allow for drive times of up to 180 minutes for certain types of care in rural areas.<sup>54</sup>

Second, staff from all five VAMCs cited issues with community provider education, including community providers not knowing they were enrolled in the CCN, or community providers unsure of certain requirements, like where to send claims documentation. For example, staff from one VAMC stated that despite a community provider showing up in VA's Provider Profile Management System as active in the CCN, when they attempted to schedule with that provider, the provider did not know they were enrolled in the CCN, which delayed appointment scheduling. In addition, staff from two VAMCs stated that they felt, out of necessity, it was their responsibility to conduct outreach and recruitment of community providers into the CCN, despite this responsibility falling under the TPAs' contract requirements. With the limited number of providers at the time the CCN went live at their facilities, staff from four of the VAMCs felt concerned that they had inundated those community providers with VCCP referrals.

VA officials stated that they have taken actions to address VAMCs' concern about inadequate CCN provider networks, including

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<sup>54</sup>VA's contract for CCN Region 1 states that network adequacy will be determined for each VAMC and by specific categories of care utilizing two primary factors: (1) geographic accessibility to a provider based on drive times, and (2) appointment availability. VA's drive-time access standards to determine a veteran's eligibility for the VCCP are an average drive time of more than 30 minutes for primary care or 60 minutes for specialty care to a VA provider, while VA's drive-time standards in the CCN contracts allow for 30 to 180 minute drive times based on care type and rurality. VA officials stated that as of March 2020, the TPA for CCN Region 1 was meeting its contractual standards for drive times, and they are not measuring appointment availability yet due to the inherent delays in claims' data. Officials only recently started reviewing claims data for those VAMCs in CCN Region 1 that went live in the earliest implementation phase.

- extending some VAMCs' access to the Patient-Centered Community Care provider network so VAMC staff could continue to schedule appointments with that network's providers after the CCN went live at their facilities in order to temporarily resolve challenges they were facing with the adequacy of the CCN;<sup>55</sup>
- educating facility staff about the CCN's contractual requirements, like drive time standards, and how VAMC staff can better use the Provider Profile Management System to identify available community providers in the CCN;<sup>56</sup> and
- working with the TPA to address system issues, including how to report and validate community provider addresses, which staff from four VAMCs sometimes found to be outdated or incorrect.<sup>57</sup>

In addition, regarding community provider education, VA officials stated that they hold monthly calls for community providers, but that community provider education responsibilities ultimately lie with the TPA, and that claims submission requirements are included in authorization and referral documentation. As of June 2020, TPA officials stated that they have provided numerous training courses to community providers, including webinars, in-person training courses, and through information expos, and developed and proactively sent communications to community providers to support their transition to the CCN. TPA officials stated these communications included information on claims processing and contact information for additional provider questions.

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## VA Developed a Tool to Help VAMCs Determine Community Care Staffing Needs, but VAMCs

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<sup>55</sup>For VAMCs in CCN Regions 1, 2 and 3, VA implemented a process for VAMCs to continue using the existing Patient-Centered Community Care network for a designated timeframe until the CCN was more fully in place for those facilities. Officials from three of the five VAMCs where we conducted site visits stated that they extended their access to Patient-Centered Community Care providers for this purpose.

<sup>56</sup>In addition, under the RCT scheduling process, the RCTs are to hold discussions with veterans about their care options before moving forward with scheduling with community providers, including appointment availability and drive times.

<sup>57</sup>We have ongoing work reviewing community provider data in the Provider Profile Management System.

## May Still Face Challenges Scheduling VCCP Appointments in a Timely Manner

VA developed a staffing tool in May 2017 to help VAMCs determine the number of community care staff needed to operate VA’s future community care program.<sup>58</sup> VA has made several updates to the staffing tool since then and recommended that VAMCs increase staffing levels in preparation for appointment scheduling responsibilities under the VCCP. (See table 2.) However, as of February 2020 most VAMCs in CCN Region 1 do not have the number of staff recommended by the tool and are not meeting timeliness metrics for appointment scheduling. While VA has taken some action to address challenges to timely appointment scheduling, VAMCs may face risks that they have not identified or addressed.

**Table 2: Timeline of VA Staffing Tool Developments and Veterans Community Care Program (VCCP) Implementation**

Year	Month	Event
2017	May	VA developed a staffing tool to assist VA medical centers in determining the number of community care staff needed to operate VA’s future community care program.
2018	June	The VA MISSION Act was enacted on June 6, 2018 and required VA to implement a new permanent community care program within 1 year.
2018	September	VA issued guidance recommending that VA medical centers not meeting certain community care referral timeliness metrics increase staffing to at least within 15 percent of what the staffing tool recommended in preparation for the new community care program.
2018	November	VA updated the staffing tool with new referral volume data from fiscal year 2018.
2019	June	VA implemented the VCCP on June 6, 2019 and issued regulations that set the designated access standards for VCCP eligibility, among other things.
2019	November	VA conducted time studies of the referral management process under the VCCP, including the use of new software systems, at 11 VA medical centers.
2019	December	VA updated the staffing tool again to incorporate changes that occurred under the VCCP, including increased volume of community care referrals and the results of the November 2019 time studies. VA asked VA medical centers to report updated staffing data by Feb. 13, 2020.
2020	February	All 40 VA medical centers in Community Care Network Region 1 reported updated staffing data to VA.

<sup>58</sup>The staffing tool includes information entered by VA and VAMC staff, such as the average time it takes VAMC staff to complete referral management tasks, community care referral volume from the previous fiscal year, and expected referral volume growth for the current year. Using these data, the staffing tool outputs a recommended number of administrative and clinical staff each VAMC’s community care office needs to meet timeliness metrics for processing community care referrals and scheduling appointments.



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Source: GAO analysis of Department of Veterans Affairs (VA) documentation and discussions with VA officials. | GAO-20-643

VA made its first staffing recommendations using the tool in September 2018 to prepare VAMCs for appointment scheduling responsibilities under the VCCP. The first iteration of the tool, however, did not include updated referral data or sufficiently account for the growth in referral volume that would occur under the VCCP.<sup>59</sup> While the staffing tool incorporates a standard 10 percent growth in referral volume, during the time of our site visits, staff from all five VAMCs stated that their facilities saw a larger increase in community care referrals since June 6, 2019, with staff from four VAMCs stating increases in referrals ranged from 40 to 72 percent since VCCP implementation.<sup>60</sup> As a result, the staffing tool may have recommended staffing levels that were too low for VAMC staff to manage the growing referral workload under VCCP in a timely manner. Staff from two VAMCs described their workload at that time as “unsustainable,” and some staff felt frustrated that they were unable to keep up with the referral workload. Staff from one VAMC speculated whether VAMCs could have staffed up appropriately prior to VCCP implementation, had they known there would be an increase in workload.

At the time the VCCP was implemented, several VAMCs in CCN Region 1 had fewer than the recommended number of staff. According to VA data, as of July 2019,

- 26 of the 40 VAMCs in CCN Region 1 reported updated data to the staffing tool, and 15 of those VAMCs were within 15 percent of the recommended level of administrative staff, clinical staff, or both.
- 14 of the 40 VAMCs did not report updated staffing data to VA at that time, so it is unknown whether those VAMCs had the recommended level of staff.<sup>61</sup>

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<sup>59</sup>A report from VA’s Office of the Inspector General reported that a VA official stated that VAMCs in the VISN being reviewed were not adequately staffed for the future of community care. See Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration, Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities, Report No. 18-05121-36 (Washington, D.C.: Jan. 16, 2020)*.

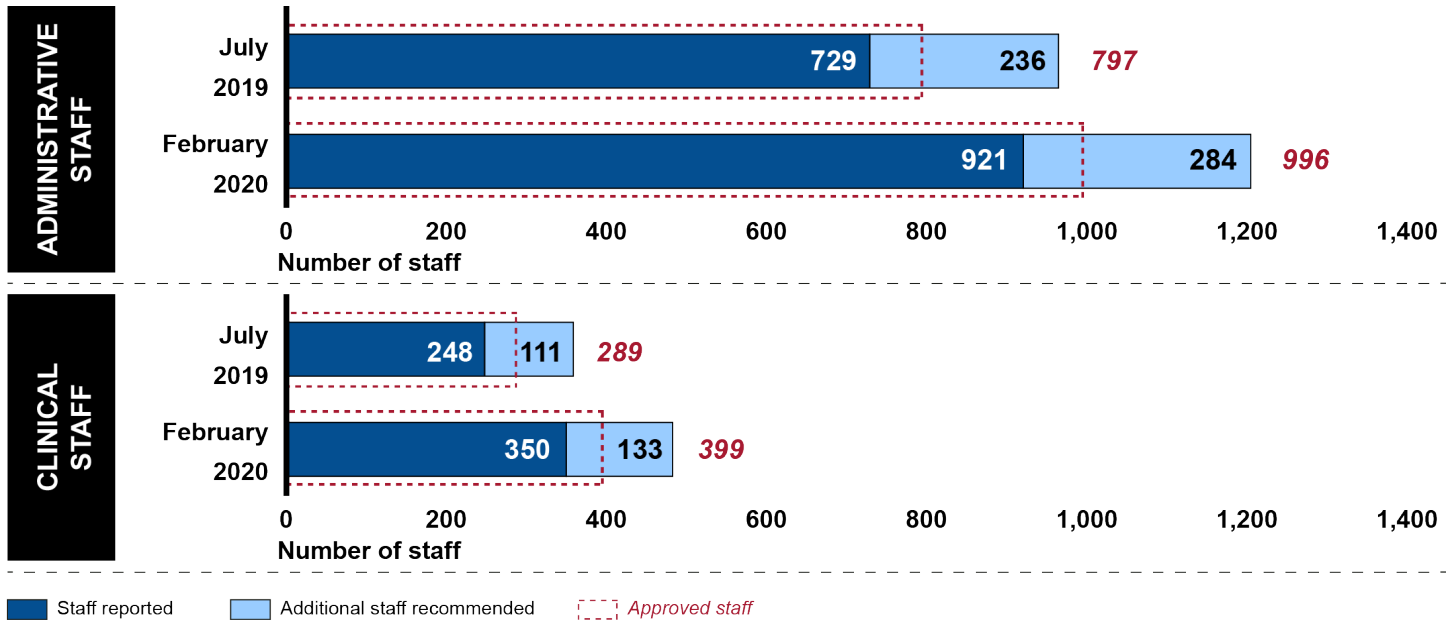
<sup>60</sup>Staff provided various reasons for the increase, including expanded eligibility criteria under the VA MISSION Act.

<sup>61</sup>VA Office of Community Care officials said they cannot require VAMCs to use the tool or report staffing data, as they do not have organizational authority over VAMC community care offices.

VA updated the staffing tool in December 2019, after VCCP implementation, to account for changes stemming from the VCCP, such as increased referral workload. As a result, the staffing tool recommended more community care staff overall for VAMCs in CCN Region 1. However, VA data show that while VAMCs in CCN Region 1 added community care staff overall, most still did not have the full amount recommended by the updated staffing tool. (See fig. 3.) As of February 2020, of the 40 VAMCs in CCN Region 1,

- 37 VAMCs had fewer administrative staff than VA recommended in the staffing tool (24 VAMCs were not within 15 percent), and
- 32 VAMCs had fewer clinical staff than VA recommended in the staffing tool (28 VAMCs were not within 15 percent).

**Figure 3: Community Care Staffing Levels in Community Care Network Region 1 VA Medical Centers (VAMC), July 2019 and February 2020**



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-20-643

Notes: Staff are measured in full time employee equivalents. "Staff reported" is the number of staff VAMCs reported to VA; "Additional staff recommended" is the difference between what the staffing tool recommended and what VAMCs reported; and "Approved staff" is the number of staff VAMC leadership approved for their facility. There are 40 VAMCs in Community Care Network Region 1.

(See app. III for VAMC level staffing data in CCN Region 1.)

In addition, according to VA data, VAMC leadership has not approved the full amount of staff recommended by the tool for their community care

offices as of February 2020—though the approved amount did increase from what VAMCs reported as of July 2019. Of the 40 VAMCs in CCN Region 1, 10 VAMCs were approved to have the amount of administrative staff recommended by the tool, and 15 VAMCs were approved to have the amount of clinical staff recommended by the tool, according to VA data. VA Office of Community Care officials acknowledged they do not have organizational authority over VAMC community care staffing decisions and cannot require facilities to approve the recommended number of staff. As a result, approved staffing levels may not match recommended amounts. VA Office of Community Care and VAMC officials said there are several reasons why VAMC leadership might not approve the recommended amount. For example, VA officials stated that leadership at some VAMCs felt the staffing tool recommended more staff than the facility needed.<sup>62</sup> In addition, officials at three of the five VAMCs we visited said VAMC leadership must balance community care staffing needs against various priorities within their facilities, including staffing for facility based care.

VA and VAMC officials also noted challenges with filling approved positions in VAMC community care offices, resulting in vacancies at some VAMCs. Specifically, of the 40 VAMCs in CCN Region 1, 16 VAMCs had administrative staff vacancies, and 19 VAMCs had clinical staff vacancies, according to VA data. VAMC staff mentioned vacancies at their VAMCs that included a range of positions, including a community care office chief, scheduler supervisors, schedulers, social workers, and program support assistants. They said medical centers can face difficulties recruiting and retaining community care schedulers, including the perception of low salaries given the complexity and volume of work, the availability of less stressful scheduler positions for facility based care, and little opportunity for advancement.<sup>63</sup> VA Office of Community Care

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<sup>62</sup>In contrast, some VAMC and VISN staff we spoke with thought the staffing tool did not consider all of the responsibilities staff had in managing community care referrals, and did not account for various differences across VAMCs (such as complexity of referrals), or delays caused by challenges staff faced with using the new VA software systems.

<sup>63</sup>We have previously reported on recruitment and retention challenges across VA. See GAO, *Department of Veterans Affairs: Improved Succession Planning Would Help Address Long-Standing Workforce Problems*, [GAO-20-15](#). (Washington, D.C.: Oct. 10, 2019), *Veterans Health Administration: Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain*, [GAO-18-623T](#) (Washington, D.C.: Jun. 21, 2018) and, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, [GAO-18-124](#). (Washington, D.C.: Oct. 19, 2017).

officials said they are aware of staffing challenges VAMCs face, and have taken action to address them, such as working to increase the salaries for scheduler positions and speed up the hiring and training process for new staff.

At the time of our site visits, staff from all five VAMCs stated that their community care offices were understaffed.<sup>64</sup> Community care managers from all five VAMCs discussed actions they were taking to address staffing shortages, including the use of overtime and temporarily reassigning staff within the VAMC to fill vacant positions. For example, community care schedulers from the selected VAMCs we visited used approximately 1,200 hours of overtime in July 2019, the month after VCCP implementation. (See app. IV for community care scheduler overtime hours at selected VAMCs.) Managers from one VAMC discussed using overtime for schedulers to call veterans after hours to gather appointment scheduling preferences for use by different schedulers the next day who would contact community providers.

According to VA Office of Community Care officials, VAMCs that meet the recommended amount of staff typically process more referrals within the timeliness metrics. As previously stated, only seven of the 39 VAMCs in CCN Region 1 were meeting VA's timeliness metrics for scheduling an appointment within 30 days of referral creation, according to VA data from February 13, 2020.<sup>65</sup> VA Office of Community Care officials stated that they continue to remind VAMC leadership about the staffing tool and the importance of timely referral management. Further, while the staffing tool provides one indicator of a VAMC's resource needs, VA officials also noted that staffing issues were not the only cause of delays in scheduling and poor performance on timeliness metrics. Other factors included staff adjusting to process changes and gaps in knowledge of available tools and resources to expedite their work. VA officials said they have issued clarified guidance and additional training courses to address knowledge gaps and help staff adjust to new processes.

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<sup>64</sup>According to the staffing tool data, all five VAMCs had fewer community care staff than the tool recommended as of February 2020.

<sup>65</sup>There are 40 VAMCs in CCN Region 1, however, according to VA officials, data for two VAMCs in CCN Region 1 are combined and reported as one integrated health care system as of December 2019. VA officials said these data change daily, as referrals age each day.

VA policy requires that VA medical center directors assess resource needs to ensure staff can adequately perform appointment scheduling tasks to meet the needs of veterans.<sup>66</sup> However, VA officials stated that while these assessments are required for care provided within VA facilities, they do not require such assessments for facilities' community care departments. As of February 2020, most VAMCs in CCN Region 1 were not meeting timeliness metrics for scheduling veterans' community care appointments. At the same time, VAMCs reported having fewer community care staff than recommended by VA's staffing tool, and facing other challenges, such as difficulties with hiring and retaining such staff. Federal internal control standards state that management should assess the risk facing the entity as it seeks to achieve its objectives, and develop an appropriate response.<sup>67</sup> If VAMCs do not assess the risks to their community care office's ability to schedule veterans' appointments in a timely manner, and take action to address such risks, it increases the likelihood that VAMCs will lack sufficient staffing and other resources to ensure that veterans receive timely care under the VCCP.

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## Conclusions

Many of the issues VA faces with its community care appointment scheduling and monitoring processes are longstanding and predate the VCCP. We made several recommendations to VA following our review of the Choice Program in 2018 to help VA avoid similar challenges as it developed and implemented its new program, including developing an achievable wait-time measure for veterans to receive care. Without such a measure, VA cannot determine if the new program is providing timely care to veterans. Our 2018 recommendation echoed a recommendation that we made in 2013 for VA to develop a wait-time measure for its community care program. VA agreed to implement both recommendations, but has not done so. Thus, absent congressional action, it is uncertain whether an achievable wait-time measure will be developed.

In addition, VA has not implemented our 2018 recommendations to develop an appointment scheduling process with related time frames to meet the overall wait-time measure that VA establishes for the VCCP, nor has it developed a comprehensive policy directive for staff to follow when

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<sup>66</sup>VA Directive 1230(1).

<sup>67</sup>[GAO-14-704G](#).

scheduling VCCP appointments. We maintain the importance of these actions and reiterate that VA should implement these recommendations.

Further, the timeliness metrics VA and others use to monitor VCCP appointment scheduling are remnants of previous community care programs and are inconsistent with the time frames found in the scheduling process VA developed for the VCCP. While these metrics sometimes allow for more days than what is in policy, most VAMCs are still not meeting these goals. The deficiencies in VA's appointment scheduling and monitoring processes limit VA's ability to determine the effectiveness of the VCCP and identify areas for improvement.

Additionally, although VA took actions to prepare VAMC staff for appointment scheduling responsibilities, including developing a software system to allow for document exchange electronically with community providers, few community providers are signed up to use the system for that purpose. Limited participation in the use of this system has resulted in manual exchange of documentation with VAMCs, which could result in additional delays in scheduling veterans' appointments, lost documentation, or scanning backlogs. Further, while VA developed a staffing tool to help VAMCs determine the number of staff needed to process referrals and schedule appointments, it does not require VAMCs to assess its staffing and resource needs for community care appointment scheduling. Meanwhile, most VAMCs in CCN Region 1 did not have the staffing tool's recommended number of staff and were not hitting timeliness metrics, and VAMC staff we spoke with faced challenges with recruitment and retention.

Addressing these challenges provides an opportunity for VA to mitigate ongoing concerns about veterans' access to care and improve its administration of the VCCP, including VAMC staff's ability to schedule timely appointments consistent with VA policy.

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## Matter for Congressional Consideration

Congress should consider requiring VA to establish an overall wait-time performance measure for veterans to receive care under the VCCP that will permit VA to measure and monitor the timeliness of VCCP appointments and compare timeliness to that of VA medical facilities. (Matter for Consideration 1)

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## Recommendations for Executive Action

We are making the following three recommendations to VA:

The Under Secretary of Health should align its monitoring metrics with the time frames established in the VCCP scheduling process. (Recommendation 1)

The Under Secretary of Health should conduct a review of community provider enrollment and use of the HSRM to include identifying and taking steps to remove any challenges to community provider enrollment and use; and, if determined appropriate, establish a requirement for community providers to use the HSRM; and (Recommendation 2)

The Under Secretary of Health should direct VAMC leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed. (Recommendation 3)

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## Agency Comments and Our Evaluation


We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix I, VA concurred with recommendations 2 and 3 and identified actions it is taking to implement our recommendations. This includes addressing any challenges to provider enrollment in the HSRM and addressing VCCP staff and resource needs.

VA did not concur with recommendation 1 to align its monitoring metrics with the time frames established in the VCCP scheduling process. VA stated that it already monitors key steps in the VCCP scheduling process that align with policy; specifically, that the department monitors the time from referral placement to when the appointment is created, as well as the time from referral placement to when the veteran receives care. However, we continue to believe that VA should review, and if needed, update the time frames in its VCCP scheduling process and align its monitoring metrics accordingly. First, VA's response does not address an inconsistency we note in this report related to reviewing referrals. Specifically, VA monitors a metric that measures whether staff review a referral within 7 days; however, VA guidance states that VAMC staff

should follow a time frame of 2 days. Secondly, VA has not established time frames to account for the entire VCCP appointment scheduling process, including specifying the maximum time allowed for a veteran to obtain care. Therefore, VA is unable to align any of its metrics to effectively monitor the extent to which veterans receive care within such specified time frames. Without taking these steps, VA cannot ensure it is achieving its goal of reducing veterans' wait times in receiving care.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. This report is also available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.

A handwritten signature in black ink, appearing to read "Sharon Silas". The signature is fluid and cursive, with the first name "Sharon" and the last name "Silas" clearly distinguishable.

Sharon M. Silas  
Director, Health Care



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# Appendix I: Comments from the Department of Veterans Affairs

Appendix I: Comments from the Department of  
Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON

September 8, 2020

Ms. Sharon M. Silas  
Director  
Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VETERANS COMMUNITY CARE PROGRAM: Improvements Needed to Help Ensure Timely Access to Care*** (GAO-20-643).

The enclosure contains general comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink that reads "Brooks D. Tucker".

Brooks D. Tucker  
Acting Chief of Staff

Enclosure

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**Appendix I: Comments from the Department of  
Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to  
Government Accountability Office (GAO) Draft Report  
**VETERANS COMMUNITY CARE PROGRAM: Improvements Needed to Help  
Ensure Timely Access to Care**  
(GAO-20-643)

**General Comments:**

The Veterans Health Administration (VHA) appreciates the Government Accountability Office's recommendations, and we are committed to delivering health care for Veterans when and where they need it. We are focused on meeting Veterans' care needs with excellence, and we closely monitor and act upon referral timeliness metrics for both VA direct care and community care. VHA uses these metric reports to prioritize care by clinical necessity, track requests for care and follow up on any outliers to ensure Veterans receive the care requested.

Clinical needs must necessarily dictate the urgency of care, and VHA is ensuring that urgent referrals are completed in under 2 days, both in VA direct care as well as in community care. It would not be appropriate to set a defined endpoint for all types of routine care, as some preventive care may be appropriately scheduled 3 or 6 months in advance. While we are grateful to have a strong network of very dedicated community providers, we cannot mandate that community providers give priority placement to VHA enrollees ahead of other patients. VHA does actively monitor this and engages both internal and community stakeholders on an ongoing basis to optimize services and timeliness.

As above, VHA leads the industry in delivery of care regarding urgent referrals. Among active efforts to continue to enhance the timeliness of routine care, VA is implementing the Referral Coordination Initiative, designed to streamline and unify scheduling processes and further empower Veterans with knowledge of their care options. Further, VHA continues to thoughtfully assess staffing, policies and procedures to ensure in alignment with the aims of timeliness and optimal Veteran experience.

VHA is also conducting outreach to educate and encourage community providers to use HealthShare Referral Manager (HSRM) to securely exchange records and improve the efficiency and timeliness of care coordination. VA does not mandate use of HSRM to maintain flexibility in dealing with community providers who use alternative methods of secure information exchange.

VHA understands that lasting, positive change is achieved through sustained, active attention to the moments that matter to Veterans, including the timeliness of scheduling and delivering care. The aforementioned efforts, among others, demonstrate VA's commitment to deliver best-in-class care for Veterans.

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**VETERANS COMMUNITY CARE PROGRAM: Improvements Needed to Help  
Ensure Timely Access to Care**  
(GAO-20-643)

**Recommendation 1: The Under Secretary for Health should align its monitoring metrics with the time frames established in the VCCP scheduling process.**

**VA Response:** Non-Concur. The Veterans Health Administration (VHA) is committed to meeting Veterans' care needs with excellence and already monitors referral timeliness metrics closely for both VA services and community care. As recommended by GAO in the past, VHA closely monitors the key steps in the Veterans Community Care Program scheduling process and aligns these metrics with policy and guidance. VHA uses these metric reports to prioritize care, track requests for care and follow up on outliers to ensure Veterans receive the care requested. VHA's monitoring ability has also been purposefully enhanced through process and technology modernization, including with the use of tools such as HealthShare Referral Manager (HSRM).

Specifically, VHA measures and closely monitors the time from consult placement to the time care is scheduled, as well as the time from consult placement to the time care is delivered. These metrics are aligned with the moments in the process that matter most to Veterans, and data are collectively reviewed on a daily basis by leaders at multiple levels of the organization. VHA continues to advance accelerated action to achieve timeliness goals across the enterprise, including during the response to the COVID-19 pandemic.

Notably, clinical needs must necessarily dictate the urgency of care. For this reason, VHA tracks urgent referrals separately from routine referrals. Urgent referrals are completed in under 2 days both in VA services and in community care, which is consistently better than the private sector. It would not be appropriate to set a defined endpoint for all routine care, as some preventive care may be scheduled 3 or 6 months in advance.

For these reasons, and as VHA is already actively monitoring and enhancing the timeliness of care delivery across the enterprise, VHA non-concurs with this recommendation and recommends its closure.

**Recommendation 2: The Under Secretary for Health should conduct a review of community provider enrollment and use of the HSRM to include identifying and taking steps to remove any challenges to community provider enrollment and use; and, if determined appropriate, establish a requirement for community providers to use the HSRM.**

**VA Response:** Concur. VHA tracks the number of providers using HSRM and therefore can develop a percent users metric which today would be 1.5 percent. In VHA Office of Community Care's (OCC) discussions with community providers, one of the most

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significant concerns with adoption of the HSRM tool has been the security requirements necessary for their employees to access the tool. OCC is working collaboratively with our partners within VA to improve the provider experience while also preserving the security of Veteran data. VHA agrees that it needs to maximize the ability to exchange electronic information with as many community providers as possible, even those unwilling or unable to use HSRM. Due to the multiple ways VHA can receive medical documents, we have not made the use of HSRM a requirement as that would potentially adversely affect network adequacy. Future solutions including health information exchange and medical record interoperability are arguably more efficient and effective tools for clinical care coordination; however, there will not be a guarantee of our community partners selecting to use any of these tools. We, and our Third Party Administrators, continue to encourage the use of HSRM, to increase the value it provides by adding features and functions such as the ability to view the entire VHA medical record for the duration of the Episode of Care, and to mitigate the challenges community providers have with access without compromising VHA security requirements. VA requests closure of this recommendation.

**Recommendation 3: The Under Secretary for Health should direct VAMC leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed.**

**VA Response:** Concur. VHA is committed to defining and implementing the most efficient methods and composition of both OCC and Referral Coordination Teams (RCT) at each VA Medical Center (VAMC), including the potential for cross-training these respective teams at their individual facilities and potentially more globally. Both teams are comprised of administrative and clinical staff who possess knowledge of the types of services (specialties, telehealth and face-to-face) offered both within VA and in the community. Given the variability in size, complexity and needs of the local Veteran population and the variability of availability of care within the community care network, each VAMC will have a different staffing composition relative to those staff with expertise pertaining to in-house and community care. The recommended resource

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(GAO-20-643)

assessment is underway through the Referral Coordination Initiative (RCI), which is a joint effort between OCC and VHA's Office of Veterans Access to Care. Attached is the RCI Guidebook for more information.

Target Completion Date: December 31, 2020.

  
Referral  
Coordination Initiat

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# Appendix II: Appointment Timeliness for a Non- Generalizable Sample of VCCP Referrals from Selected VAMCs in CCN Region 1

To examine the timeliness of appointment scheduling actions and selected veterans' overall wait times to receive care through the Veterans Community Care Program (VCCP), we took four key steps. We (1) selected a random, non-generalizable sample of 150 routine VCCP referrals for care from three Department of Veterans Affairs (VA) medical centers (VAMC) to conduct a medical record review; (2) reviewed VA's VCCP appointment scheduling process and identified timeliness metrics; (3) performed analysis on the sample of referrals against VA's timeliness metrics; and (4) interviewed VAMC officials to understand reasons behind any scheduling delays.

**VCCP referral sample, methodology, and medical record review.** The random, non-generalizable sample of 150 routine referrals from three VAMCs was selected from a list of veterans who were scheduled for, and received, specialty care from community providers under the VCCP.<sup>1</sup> We reviewed referrals from three of the five VAMCs from Community Care Network (CCN) Region 1 that we conducted site visits to located in White River Junction, Vermont; Philadelphia, Pennsylvania; and Bath, New York. We selected VAMCs based on varying facility complexity, rurality, implementation date of the CCN, related Veterans Integrated Service Networks (VISN), and whether VAMC staff were scheduling community care appointments prior to the implementation of the VCCP. We reviewed

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<sup>1</sup>A routine referral indicates that the veteran should be seen by a date indicated by that veteran's provider. Our review examined the scheduling actions of VAMC community care staff when receiving, reviewing, and scheduling VCCP referrals to understand the length of time it took to complete those actions and for the veteran to receive care. We did not evaluate if veterans were eligible for the VCCP.

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**Appendix II: Appointment Timeliness for a  
Non-Generalizable Sample of VCCP Referrals  
from Selected VAMCs in CCN Region 1**

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VCCP referrals that were scheduled by VAMC staff on behalf of the veteran, with referrals created by VA providers at those facilities between the times the CCN went live at those VAMCs through December 31, 2019.<sup>2</sup> We reviewed 50 referrals from each of the three VAMCs, for a total of 150 referrals.

For all 150 referrals, we manually reviewed the veterans' VA electronic health records to track the number of business and calendar days that elapsed at each step of the VCCP appointment scheduling process through when the veteran received care from the community provider. The findings from our review of VCCP referrals cannot be generalized beyond the veterans' VCCP referrals we reviewed.

**VCCP appointment scheduling process.** For the time frame of our medical record review, we reviewed two timeliness metrics found in VA's appointment scheduling process to obtain care under the VCCP:

- VAMC community care staff had 2 business days to change the status of the referral from a pending to active status and to begin contacting the veteran to gather scheduling preferences.
- Once staff collected a veteran's scheduling preferences, staff had 1 business day to begin contacting community providers to schedule the veteran's appointment. (See fig. 4.)

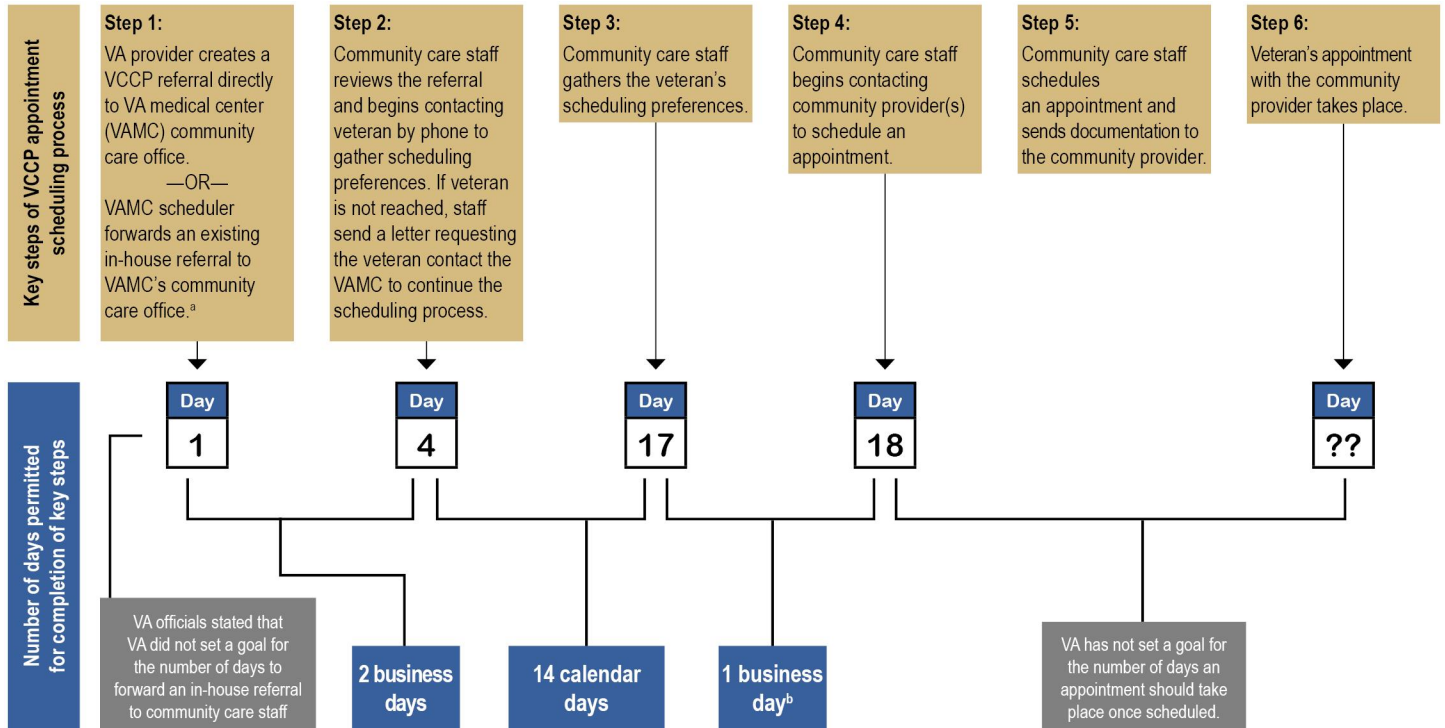
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<sup>2</sup>The VAMCs located in White River Junction and Philadelphia went live with the CCN on July 29, 2019, and the VAMC located in Bath went live on November 19, 2019. We did not review referrals from the VAMC in Washington, D.C. because the CCN went live at that facility in mid-December 2019 and was too close to our cut-off date of December 31, 2019. In addition, we did not review referrals from the VAMC located in the Bronx due to the small number of referrals (less than 10) that fit our review parameters.



**Appendix II: Appointment Timeliness for a  
Non-Generalizable Sample of VCCP Referrals  
from Selected VAMCs in CCN Region 1**

**Figure 4: Appointment Scheduling Process to Receive Care under the Veterans Community Care Program (VCCP), July 2019—February 2020**



Source: GAO illustration based on analysis of Department of Veterans Affairs (VA) documentation and interviews with VA officials. | GAO-20-643

Note: This figure illustrates scheduling actions and timeliness metrics for eligible veterans who were referred to the VCCP through routine referrals (non-emergent), and had community care staff schedule the appointments on their behalf.

<sup>a</sup>VA providers can directly enter or create a community care referral if needed services are unavailable at a VA facility. VA schedulers can forward an existing in-house referral to community care if an in-house appointment is not available within designated wait-time standards.

<sup>b</sup>VA removed this requirement in February 2020.

**Medical record review results.** Our review found that of the 150 VCCP referrals in our sample, 40 referrals met the timeliness metric to change a referral to active and initiate contact with a veteran, and 133 met the timeliness metric to initiate contact with a community provider. (See table 3.)

**Appendix II: Appointment Timeliness for a  
Non-Generalizable Sample of VCCP Referrals  
from Selected VAMCs in CCN Region 1**

**Table 3: Timeliness of Appointment Scheduling Actions at Three Selected VA Medical Centers (VAMC) for a Sample of 150 Veterans Community Care Program Referrals**

na	na	2 business days to change a referral from pending to active and to initiate contact with veteran	1 business day to initiate contact with community providers
Category 1	Category 2	40 (27 percent) (Total number of referrals meeting metric)	133 (89 percent) (Total number of referrals meeting metric)
Range	VAMC A	1-44 business days	1-8 business days
Range	VAMC B	1-53 business days	1-26 business days
Range	VAMC C	1-16 business days	1-13 business days
Average	VAMC A	8 business days	1 business day
Average	VAMC B	14 business days	2 business days
Average	VAMC C	7 business days	2 business days

Source: GAO analysis of Department of Veterans Affairs (VA) medical record information. | GAO-20-643

Notes: For some referrals in our sample, VAMC staff began contacting community providers prior to receiving a veteran's scheduling preferences. In those instances, we measured the timeliness of that action as 1 business day.

The average number of days for community care staff to begin work on a referral and initiate contact with the veteran and to initiate contact with community providers varied by VAMC, with the lowest averages being 7 business days and 1 business day, respectively. Officials from all three VAMCs indicated that one of the main reasons behind these scheduling delays was having staffing issues in their community care offices and increased VCCP referral workloads.

In addition, our review found that the average number of days and range of days the (1) referral spent with VAMC community care staff prior to the appointment being scheduled, and (2) the veterans' overall wait time varied by VAMC. (See table 4.).

**Table 4: Timeliness of Appointment Scheduling and Overall Wait Times at the Three Selected VA Medical Centers (VAMC) for a Sample of 150 Veterans Community Care Program (VCCP) Referrals**

Category 1	Category 2	Time spent with VAMC staff to schedule a VCCP referral <sup>a</sup>	Overall veteran wait time <sup>b</sup>
Range	VAMC A	1-116 calendar days	1-117 calendar days
Range	VAMC B	1-108 calendar days	3-130 calendar days
Range	VAMC C	2-37 calendar days	1-61 calendar days
Average	VAMC A	37 calendar days <sup>c</sup>	34 calendar days
Average	VAMC B	31 calendar days	38 calendar days
Average	VAMC C	18 calendar days	25 calendar days

Source: GAO analysis of Department of Veterans Affairs (VA) medical records. | GAO-20-643

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**Appendix II: Appointment Timeliness for a  
Non-Generalizable Sample of VCCP Referrals  
from Selected VAMCs in CCN Region 1**

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<sup>a</sup>This is measured from the date the VA provider created the referral to the date the community care staff scheduled an appointment.

<sup>b</sup>This is measured from the date the VA provider created the referral to the date the veteran received care.

<sup>c</sup>VAMC A's sample of referrals included instances where staff recorded the appointment date in the veteran's medical record after the appointment had already occurred.

# Appendix III: Reported and VA Recommended Community Care Staffing Levels for VAMCs in CCN Region 1

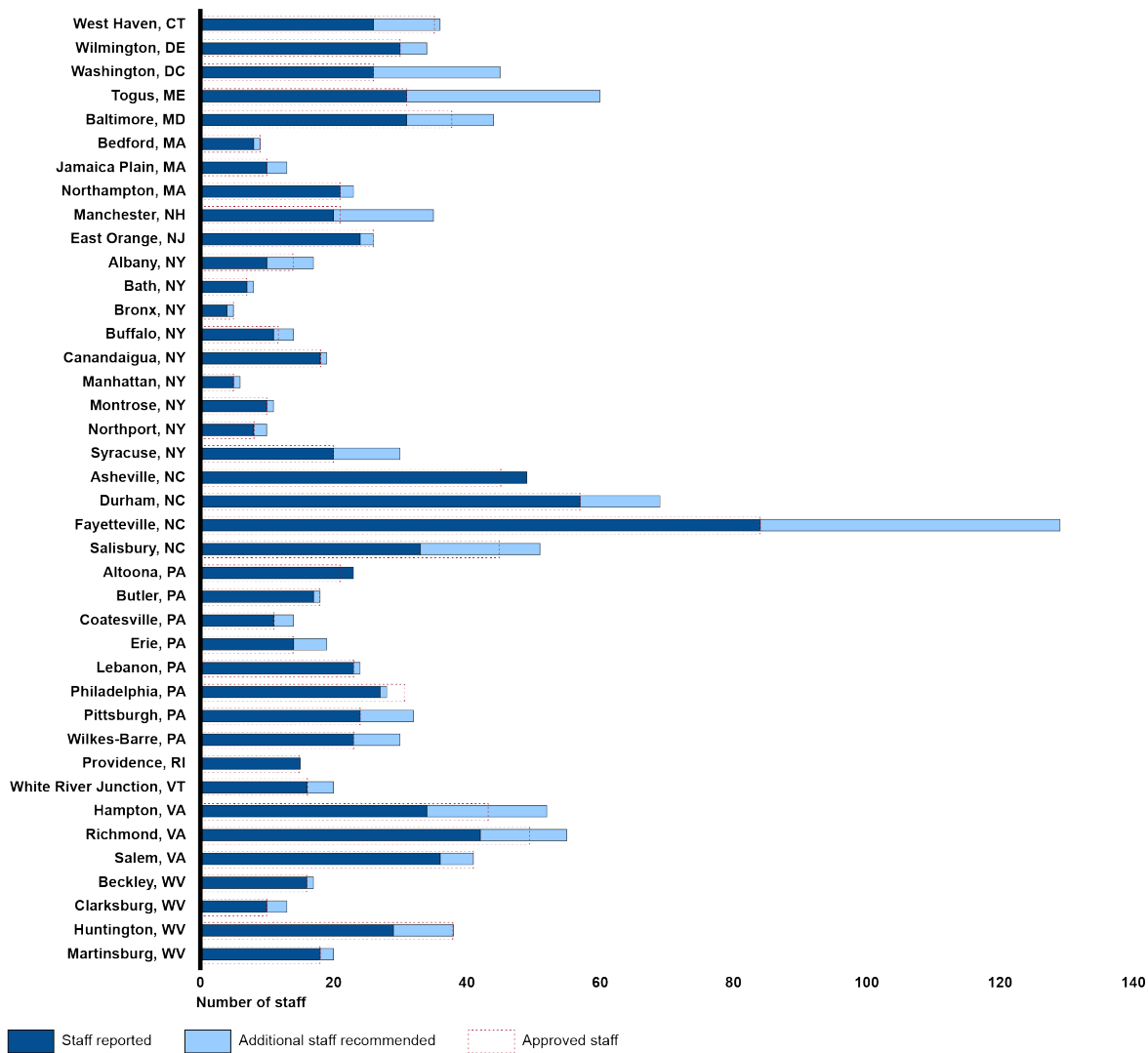
The Department of Veterans Affairs (VA) developed a staffing tool in May 2017 to assist VA medical centers (VAMC) in determining the number of community care staff needed to successfully operate their community care programs. In December 2019, VA released an updated staffing tool, which incorporated changes that occurred under the Veterans Community Care Program (VCCP), such as increased referral volume, and the results of time studies VA conducted at VAMCs under the VCCP using new software systems. The staffing tool also included updated staffing data reported by VAMCs as of February 2020.

The figures below show the number of administrative staff (e.g. schedulers) and clinical staff (e.g. nurses) that

- each VAMC in Community Care Network (CCN) Region 1 reported having;
- the VA staffing tool recommended each VAMC have; and
- each VAMC approved for its community care office.

Appendix III: Reported and VA Recommended  
Community Care Staffing Levels for VAMCs in  
CCN Region 1

Figure 5: Reported and Recommended Administrative Staffing Levels at VA Medical Centers in Community Care Network Region 1, February 2020

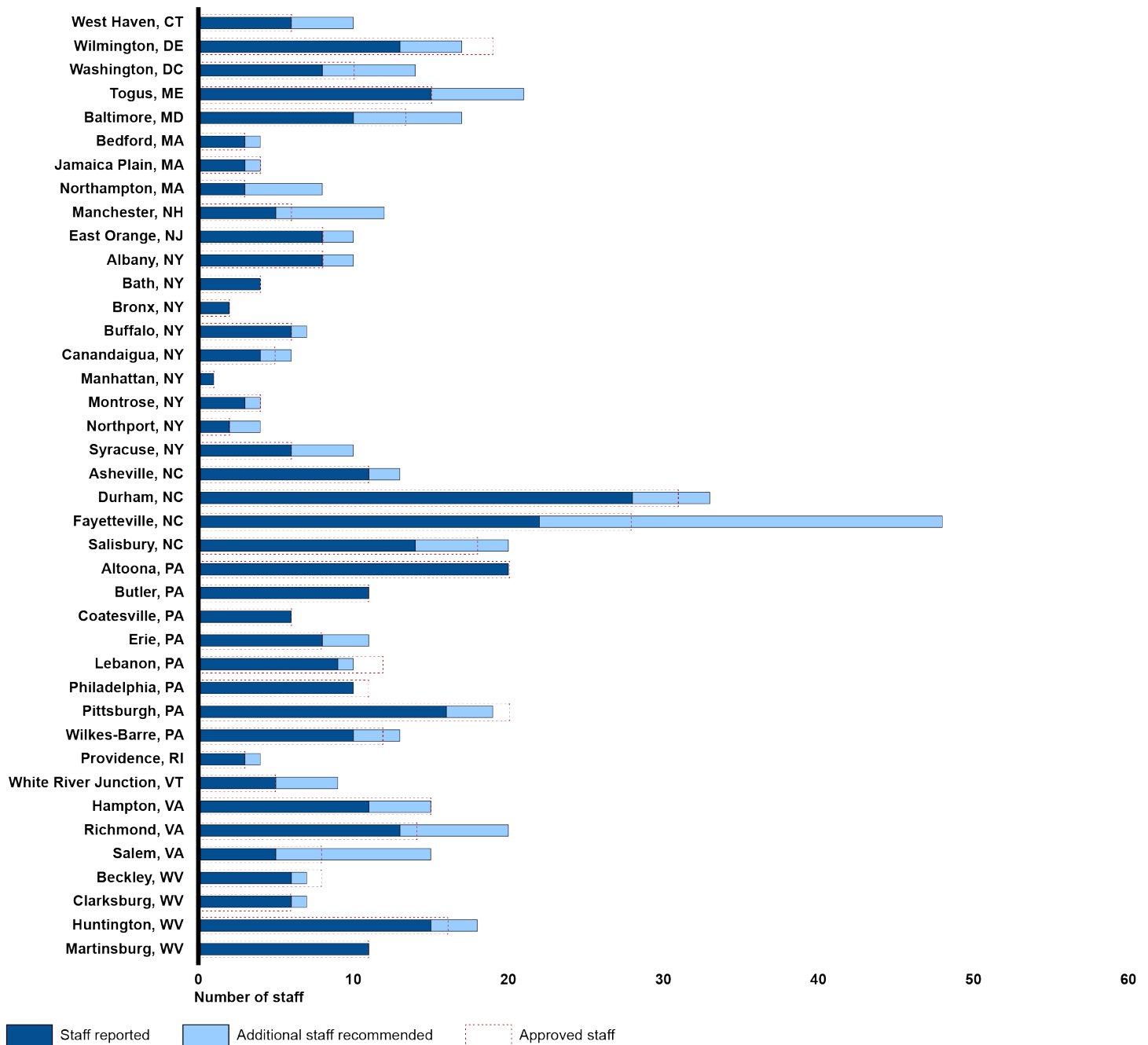


Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-20-643

Notes: Administrative staff are measured in full time employee equivalents, and include positions such as an appointment scheduler. "Staff reported" is the number of staff VA medical centers (VAMC) reported to VA; "Additional staff recommended" is the difference between what the staffing tool recommended and what VAMCs reported; and "Approved staff" is the number of staff VAMC leadership approved for the department. There are 40 VAMCs in Community Care Network (CCN) Region 1.

Appendix III: Reported and VA Recommended  
Community Care Staffing Levels for VAMCs in  
CCN Region 1

Figure 6: Reported and Recommended Clinical Staffing Levels at VA Medical Centers in Community Care Network Region 1, February 2020



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-20-643

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**Appendix III: Reported and VA Recommended  
Community Care Staffing Levels for VAMCs in  
CCN Region 1**

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Notes: Clinical staff are measured in full time employee equivalents, and include positions such as a nurse. "Staff reported" is the number of staff VA medical centers (VAMC) reported to VA; "Additional staff recommended" is the difference between what the staffing tool recommended and what VAMCs reported; and "Approved staff" is the number of staff VAMC leadership approved for the department. There are 40 VAMCs in Community Care Network (CCN) Region 1.

# Appendix IV: Community Care Scheduler Overtime Hours at Selected VAMCs

The table below shows Department of Veterans Affairs (VA) provided data of overtime hours for community care schedulers at five VA medical centers (VAMC) from June 2019, the month the Veterans Community Care Program was implemented, through March 2020, the most recent data we requested. The Bath and Bronx VAMCs are located in New York, the Philadelphia VAMC is located in Pennsylvania, and the White River Junction VAMC is located in Vermont.

**Table 5: Overtime Hours for Community Care Schedulers by Selected VA Medical Center, June 2019 through March 2020**

VA Medical Center Location	June (2019)	July (2019)	Aug. (2019)	Sept. (2019)	Oct. (2019)	Nov. (2019)	Dec. (2019)	Jan. (2020)	Feb. (2020)	Mar. (2020)
Bath	80	38	55	85	85	106	47	96	80	14
Bronx	0	0	0	51	25	0	0	0	0	0
Philadelphia	89	83	42	59	90	264	77	12	172	127
Washington, D.C.	570	700	483	461	435	401	49	211	495	237
White River Junction	342	380	488	331	106	54	22	0	17	53
<b>Total</b>	<b>1,081</b>	<b>1,201</b>	<b>1,068</b>	<b>987</b>	<b>741</b>	<b>825</b>	<b>195</b>	<b>319</b>	<b>764</b>	<b>431</b>

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-20-643

Notes: Numbers are rounded to the closest whole number. The Bath and Bronx VAMCs are located in New York, the Philadelphia VAMC is located in Pennsylvania, and the White River Junction VAMC is located in Vermont. According to VAMC officials and documentation, White River Junction had 18 schedulers in May 2019, the Bronx had four schedulers in August 2019, Philadelphia had 24 schedulers in September 2019, Bath had seven schedulers in January 2020, and Washington, DC had 24 schedulers in February 2020. The number of schedulers may have changed over time.



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# Appendix V: GAO Contact and Staff Acknowledgments

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## GAO Contact

Sharon M. Silas at (202) 512-7114 or [silass@gao.gov](mailto:silass@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Kate Tussey (Analyst-in-Charge), Emily Bippus, Robert Dougherty, Erika Huber, and Diona Martyn made key contributions to this report. Also contributing were Jennie Apter, Jacquelyn Hamilton, and Vikki Porter.

# Appendix VI: Accessible Data

## Data Tables

**Accessible Data for Figure 1: Map of Community Care Networks and Awarded Third-Party Administrators (TPA) for the Veterans Community Care Program, as of September 2020**

Category	Contractor	States in region
Region 1	Optum	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, District of Columbia, Virginia, North Carolina
Region 2	Optum	North Dakota, South Dakota, Nebraska, Kansas, Missouri, Illinois, Indiana, Ohio, Kentucky, Michigan, Wisconsin, Iowa, Minnesota
Region 3	Optum	Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina
Region 4	TriWest	Texas, New Mexico, Colorado, Utah, Arizona, Nevada, California, Oregon, Washington, Idaho, Montana, Wyoming
Region 5	Pending award	Alaska
Region 6	Pending award	Northern Mariana Islands, American Samoa, and Guam

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Appendix VI: Accessible Data

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**Accessible Data for Figure 3: Community Care Staffing Levels in Community Care Network Region 1 VA Medical Centers (VAMC), July 2019 and February 2020**

Category	Month/Year	Staff reported	Additional staff recommended	Approved staff
Administrative staff	July 2019	729	236	797
Administrative staff	February 2020	921	284	996
Clinical staff	July 2019	248	111	289
Clinical staff	February 2020	350	133	399

Appendix VI: Accessible Data

**Accessible Data for Figure 5: Reported and Recommended Administrative Staffing Levels at VA Medical Centers in Community Care Network Region 1, February 2020**

VAMC	Staff Reported	Total Staff Recommended	Approved Staff
West Haven, CT	26	36	35
Wilmington, DE	30	34	30
Washington, DC	26	45	26
Togus, ME	31	60	31
Baltimore, MD	31	44	38
Bedford, MA	8	9	9
Jamaica Plain, MA	10	13	10
Northampton, MA	21	23	21
Manchester, NH	20	35	21
East Orange, NJ	24	26	26
Albany, NY	10	17	14
Bath, NY	7	8	7
Bronx, NY	4	5	5
Buffalo, NY	11	14	12
Canandaigua, NY	18	19	18
Manhattan, NY	5	6	5
Montrose, NY	10	11	10
Northport, NY	8	10	8
Syracuse, NY	20	30	20
Asheville, NC	49	46	51
Durham, NC	57	69	57
Fayetteville, NC	84	129	84
Salisbury, NC	33	61	45
Altoona, PA	23	21	23
Butler, PA	17	18	18
Coatesville, PA	11	14	11
Erie, PA	14	19	14
Lebanon, PA	23	24	23
Philadelphia, PA	27	28	31
Pittsburgh, PA	24	32	24
Wilkes-Barre, PA	23	30	23
Providence, RI	15	13	15
White River Junction, VT	16	20	16

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Appendix VI: Accessible Data

<b>VAMC</b>	<b>Staff Reported</b>	<b>Total Staff Recommended</b>	<b>Approved Staff</b>
Hampton, VA	34	52	42
Richmond, VA	42	55	50
Salem, VA	36	41	41
Beckley, WV	16	17	16
Clarksburg, WV	10	13	10
Huntington, WV	29	38	38
Martinsburg, WV	18	20	18

Appendix VI: Accessible Data

**Accessible Data for Figure 6: Reported and Recommended Clinical Staffing Levels at VA Medical Centers in Community Care Network Region 1, February 2020**

VAMC	Staff Reported	Total Staff Recommended	Approved Staff
West Haven, CT	6	10	6
Wilmington, DE	13	17	19
Washington, DC	8	14	10
Togus, ME	15	21	15
Baltimore, MD	10	17	13
Bedford, MA	3	4	3
Jamaica Plain, MA	3	4	4
Northhampton, MA	3	8	3
Manchester, NH	5	12	6
East Orange, NJ	8	10	8
Albany, NY	8	10	8
Bath, NY	4	4	4
Bronx, NY	2	2	2
Buffalo, NY	6	7	6
Canandaigua, NY	4	6	5
Manhattan, NY	1	1	1
Montrose, NY	3	4	4
Northport, NY	2	4	2
Syracuse, NY	6	10	6
Asheville, NC	11	13	11
Durham, NC	28	33	31
Fayetteville, NC	22	48	28
Salisbury, NC	14	20	18
Altoona, PA	20	19	20
Butler, PA	11	11	11
Coatesville, PA	6	6	6
Erie, PA	8	11	8
Lebanon, PA	9	10	12
Philadelphia, PA	10	8	11
Pittsburgh, PA	16	19	20
Wilkes-Barre, PA	10	13	12
Providence, RI	3	4	3
White River Junction, VT	5	9	5

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Appendix VI: Accessible Data

VAMC	Staff Reported	Total Staff Recommended	Approved Staff
Hampton, VA	11	15	15
Richmond, VA	13	20	14
Salem, VA	5	15	8
Beckley, WV	6	7	8
Clarksburg, WV	6	7	6
Huntington, WV	15	18	16
Martinsburg, WV	11	11	11

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## Agency Comment Letter

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### Accessible Text for Appendix I Comments from the Department of Veterans Affairs

#### Page 1

September 8, 2020

Ms. Sharon M. Silas Director

Health Care

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: VETERANS COMMUNITY CARE PROGRAM: Improvements Needed to Help Ensure Timely Access to Care (GAO-20-643).

The enclosure contains general comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Brooks D. Tucker

Acting Chief of Staff

Enclosure

Page 2

General Comments:

The Veterans Health Administration (VHA) appreciates the Government Accountability Office's recommendations, and we are committed to delivering health care for Veterans when and where they need it. We are focused on meeting Veterans' care needs with excellence, and we closely monitor and act upon referral timeliness metrics for both VA direct care and community care. VHA uses these metric reports to prioritize care by clinical necessity, track requests for care and follow up on any outliers to ensure Veterans receive the care requested.

Clinical needs must necessarily dictate the urgency of care, and VHA is ensuring that urgent referrals are completed in under 2 days, both in VA direct care as well as in community care. It would not be appropriate to set a defined endpoint for all types of routine care, as some preventive care may be appropriately scheduled 3 or 6 months in advance. While we are grateful to have a strong network of very dedicated community providers, we cannot mandate that community providers give priority placement to VHA enrollees ahead of other patients. VHA does actively monitor this and engages both internal and community stakeholders on an ongoing basis to optimize services and timeliness.

As above, VHA leads the industry in delivery of care regarding urgent referrals. Among active efforts to continue to enhance the timeliness of routine care, VA is implementing the Referral Coordination Initiative, designed to streamline and unify scheduling processes and further empower Veterans with knowledge of their care options. Further, VHA continues to thoughtfully assess staffing, policies and procedures to ensure in alignment with the aims of timeliness and optimal Veteran experience.

VHA is also conducting outreach to educate and encourage community providers to use HealthShare Referral Manager (HSRM) to securely



exchange records and improve the efficiency and timeliness of care coordination. VA does not mandate use of HSRM to maintain flexibility in dealing with community providers who use alternative methods of secure information exchange.

VHA understands that lasting, positive change is achieved through sustained, active attention to the moments that matter to Veterans, including the timeliness of scheduling and delivering care. The aforementioned efforts, among others, demonstrate VA's commitment to deliver best-in-class care for Veterans.

### Page 3

Recommendation 1: The Under Secretary for Health should align its monitoring metrics with the time frames established in the VCCP scheduling process.

VA Response: Non-Concur. The Veterans Health Administration (VHA) is committed to meeting Veterans' care needs with excellence and already monitors referral timeliness metrics closely for both VA services and community care. As recommended by GAO in the past, VHA closely monitors the key steps in the Veterans Community Care Program scheduling process and aligns these metrics with policy and guidance. VHA uses these metric reports to prioritize care, track requests for care and follow up on outliers to ensure Veterans receive the care requested. VHA's monitoring ability has also been purposefully enhanced through process and technology modernization, including with the use of tools such as HealthShare Referral Manager (HSRM).

Specifically, VHA measures and closely monitors the time from consult placement to the time care is scheduled, as well as the time from consult placement to the time care is delivered. These metrics are aligned with the moments in the process that matter most to Veterans, and data are collectively reviewed on a daily basis by leaders at multiple levels of the organization. VHA continues to advance accelerated action to achieve timeliness goals across the enterprise, including during the response to the COVID-19 pandemic.

Notably, clinical needs must necessarily dictate the urgency of care. For this reason, VHA tracks urgent referrals separately from routine referrals. Urgent referrals are completed in under 2 days both in VA services and in community care, which is consistently better than the private sector. It

would not be appropriate to set a defined endpoint for all routine care, as some preventive care may be scheduled 3 or 6 months in advance.

For these reasons, and as VHA is already actively monitoring and enhancing the timeliness of care delivery across the enterprise, VHA non-concurs with this recommendation and recommends its closure.

Recommendation 2: The Under Secretary for Health should conduct a review of community provider enrollment and use of the HSRM to include identifying and taking steps to remove any challenges to community provider enrollment and use; and, if determined appropriate, establish a requirement for community providers to use the HSRM.

VA Response: Concur. VHA tracks the number of providers using HSRM and therefore can develop a percent users metric which today would be 1.5 percent. In VHA Office of Community Care's (OCC) discussions with community providers, one of the most

#### Page 4

significant concerns with adoption of the HSRM tool has been the security requirements necessary for their employees to access the tool. OCC is working collaboratively with our partners within VA to improve the provider experience while also preserving the security of Veteran data. VHA agrees that it needs to maximize the ability to exchange electronic information with as many community providers as possible, even those unwilling or unable to use HSRM. Due to the multiple ways VHA can receive medical documents, we have not made the use of HSRM a requirement as that would potentially adversely affect network adequacy. Future solutions including health information exchange and medical record interoperability are arguably more efficient and effective tools for clinical care coordination; however, there will not be a guarantee of our community partners selecting to use any of these tools. We, and our Third Party Administrators, continue to encourage the use of HSRM, to increase the value it provides by adding features and functions such as the ability to view the entire VHA medical record for the duration of the Episode of Care, and to mitigate the challenges community providers have with access without compromising VHA security requirements. VA requests closure of this recommendation.

Recommendation 3: The Under Secretary for Health should direct VAMC leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to

schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed.

VA Response: Concur. VHA is committed to defining and implementing the most efficient methods and composition of both OCC and Referral Coordination Teams (RCT) at each VA Medical Center (VAMC), including the potential for cross-training these respective teams at their individual facilities and potentially more globally. Both teams are comprised of administrative and clinical staff who possess knowledge of the types of services (specialties, telehealth and face-to-face) offered both within VA and in the community. Given the variability in size, complexity and needs of the local Veteran population and the variability of availability of care within the community care network, each VAMC will have a different staffing composition relative to those staff with expertise pertaining to in-house and community care. The recommended resource

Page 5

assessment is underway through the Referral Coordination Initiative (RCI), which is a joint effort between OCC and VHA's Office of Veterans Access to Care. Attached is the RCI Guidebook for more information.

Target Completion Date: December 31, 2020.

Referral Coordination Initiat

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