U.S. Department of Veterans Affairs

Veterans Community Care Program (VCCP) Care Coordination for Breast Cancer Screening Audit

Draft Audit Report - Management Response Template

(b)(3):38 U.S.C. 5705; (b)(5)

(b)(3):38 U.S.C. 5705; (b)(5)

(b)(3):38 U.S.C. 5705; (b)(5)

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U.S. Department of Veterans Affairs

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(b)(3):38 U.S.C. 5705; (b)(5)

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VCCP Care Coordination Audit Draft Report October 2020	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	3666751	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
	Office of the AUSH Operations	15	10/26/20	(b)(6)		10/26/20

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

From: Office of the AUSHO Communications
Sent: Wed, 16 Sep 2020 11:43:10 +0000
To: McDougall, Skye;McInerney, Joan E.;Lapuz, Miguel H.;Patterson, William P. (V15);Brandecker, John;Walton, Robert;Horsman, Sandra L.;Lloyd, Russell E.
Cc: (b)(6) (V15);Dominy, (b)(6) VHA 15 Operations SS; (b)(6) (b)(6)
Subject: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report
Attachments: FY20_VCCP Care Coordination Audit Report_ Draft_2020-09-10.docx, VCCP Audit Mgmt Comments Template_2020-09-10.docx

Good Morning,

The Office of the Assistant Under Secretary for Health for Operations is requested by the Internal Audit Office to review and comment on VISN and Medical Center Recommendations #7-10 of the attached Veterans Community Care Coordination Audit draft report. Comments will be scanned and inserted directly into the final report appendices. Please assist 10N with the following action:

ACTION:

1. Review the attached draft report titled VETERANS COMMUNITY CARE PROGRAM CARE COORDINATION FOR BREAST CANCER SCREENING AUDIT
2. Provide comments on **Recommendations #7-10** using the attached management comments template
3. Submit the completed comment template to ***VHA CO 10N Support Staff*** (b)(6) @va.gov) by the due date

DUE DATE:
September 23, 2020

QUESTIONS:
For questions regarding this request, please contact (b)(6) (b)(6) @va.gov).

We appreciate your support and look forward to the outcomes.

Thank you,
VHA 10N Support Staff

U.S. Department of Veterans Affairs

VETERANS HEALTH ADMINISTRATION

VETERANS COMMUNITY CARE PROGRAM CARE COORDINATION FOR BREAST CANCER SCREENING AUDIT DRAFT REPORT

IA-20-PXXX | Performance Audit Report
September 2020

(b)(3):38 U.S.C. 5705; (b)(5)

(b)(3):38 U.S.C. 5705; (b)(5)

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U.S. Department of Veterans Affairs

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Draft Audit Report - Management Response Template

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(b)(3):38 U.S.C. 5705; (b)(5)

(b)(3):38 U.S.C. 5705; (b)(5)

From: (b)(6)
Sent: Wed, 23 Sep 2020 15:28:16 +0000
To: Horsman, Sandra L.
Cc: VHA 15 Operations SS
Subject: RE: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report

Hello Ms. Horsman, Thanks for your call and commitment to providing your perspective. Monday September 28th COB extension for your management comments is fine with our office. I'm copying 10N so they know to wait on your reply and incorporate into 10N's consolidated reply to IA.

10N Support Staff, IA will look for 10N's consolidated response on Tuesday September 29th instead of the 24th so that Ms. Horsman's input can be incorporated into your single consolidated response to IA.

Regards,

(b)(6)
Veterans Health Administration
(b)(6)

From: (b)(6)
Sent: Wednesday, September 23, 2020 7:52 AM
To: Horsman, Sandra L. (b)(6)@va.gov>
Cc: mailto:(b)(6)@va.gov
Subject: RE: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report

Ms. Horsman,

Many thanks to you and your staff for providing care in this difficult time! Please consider yourself exempt from the request below. We appreciate and support your focus staying on patient care.

Also please don't feel it's necessary to attend today's ARCC meeting. Your staff and patients need all of your energy.

I'm copying 10N Correspondence mailgroup so they know to remove you from this response item tracking.

May everyone there stay safe!

Regards,

(b)(6)
Veterans Health Administration
(b)(6)

From: Horsman, Sandra L. (b)(6) @va.gov>
Sent: Tuesday, September 22, 2020 4:23 PM
To: (b)(6) @va.gov>
Subject: FW: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report

(b)(6)

We've had a rather significant increase in COVID activity within our HCS. Is it possible to get an extension on this since we've been very busy creating containment zones and moving patients?

Sandra

Sandra L. Horsman
Sandra L. Horsman, Director
VA Black Hills Health Care System
113 Comanche Road
Fort Meade SD 57741-1099

Phone: (b)(6)
Fax:

From: Office of the AUSHO Communications (b)(6) @va.gov>
Sent: Tuesday, September 22, 2020 10:12 AM
To: McDougall, Skye (b)(6) @va.gov>; Lapuz, Miguel H. (b)(6) @va.gov>; Patterson, William P. (V15) (b)(6) @va.gov>; Brandecker, John (b)(6) @va.gov>; Walton, Robert (b)(6) @va.gov>; Horsman, Sandra L. (b)(6) @va.gov>; Lloyd, Russell E. (b)(6) @va.gov>; (b)(6) @va.gov>
Cc: (b)(6) (VISN 16) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (V15) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; VHA CO 10N Support Staff (b)(6) @va.gov>; (b)(6) @va.gov>
Subject: RE: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report

Good Afternoon,

This is just a friendly reminder. The request below is due, **Wednesday, September 23, 2020**
.

Thank you

From: Office of the AUSHO Communications (b)(6) @va.gov>
Sent: Wednesday, September 16, 2020 9:20 AM
To: McDougall, Skye (b)(6) @va.gov>; McInerney, Joan E. (b)(6) @va.gov>; Lapuz, Miguel H. (b)(6) @va.gov>; Patterson, William P. (V15) (b)(6) @va.gov>; Brandecker, John (b)(6) @va.gov>; Walton, Robert (b)(6) @va.gov>; Horsman, Sandra L (b)(6) @va.gov>; Lloyd, Russell E. (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Cc: (b)(6) (VISN 16) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov> (b)(6) (V15) (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov> (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov> (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; VHA CO 10N Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Subject: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report

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DUE DATE:
September 23, 2020

QUESTIONS:
For questions regarding this request, please contact (b)(6) (b)(6) @va.gov).

We appreciate your support and look forward to the outcomes.

Thank you,
VHA 10N Support Staff

(b)(6)

From: Office of the AUSHO Communications
Sent: Wednesday, September 16, 2020 7:43 AM
To: McDougall, Skye; McInerney, Joan E.; Lapuz, Miguel H.; Patterson, William P. (V15); Brandecker, John; Walton, Robert; Horsman, Sandra L.; Lloyd, Russell E.
Cc: (b)(6) (VISN 16); (b)(6) (V15); (b)(6) VHA CO 10N Support Staff; (b)(6)
Subject: ACTION Due Date 9-23-2020: REQUEST for MANAGMENT COMMENT: VCCP Care Coordination Audit Draft Report
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DUE DATE:
September 23, 2020

QUESTIONS:
For questions regarding this request, please contact (b)(6) @va.gov).

We appreciate your support and look forward to the outcomes.

Thank you,
VHA 10N Support Staff

In **October 2020**, Internal Audit published its findings of the VA Care Coordination for Breast Cancer Screening Audit (VA Care Coordination Audit) to determine whether VA was coordinating Veterans' next stage in care following abnormal breast cancer screening performed at a VA medical facility.

Based on these findings they made two recommendations to Veterans Integrated Service Network (VISN) Directors, VISN Chief Medical Officers, VA Medical Facility Directors and Medical Facility Chiefs of Staff to improve the care coordination process and ensure Veterans receive timely and appropriate care.

The Assistant Under Secretary for Health for Operations offers the following consolidated responses to these four recommendations:

Recommendation #1: (b)(5); (b)(3):38 U.S.C. 5705

(b)(5); (b)(3):38 U.S.C. 5705

Recommendation #2: (b)(5); (b)(3):38 U.S.C. 5705

(b)(5); (b)(3):38 U.S.C. 5705

U.S. Department of Veterans Affairs

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(b)(5); (b)(3):38 U.S.C. 5705

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(b)(5); (b)(3):38 U.S.C. 5705

KELLY LOEFFLER
GEORGIA

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(202) 224 3643

ONE OVERTON PARK
3625 CUMBERLAND BOULEVARD, SUITE 970
ATLANTA, GA 30339
(770) 661-0999

United States Senate
WASHINGTON, DC 20510-1010

AGRICULTURE, NUTRITION, AND FORESTRY
VETERANS' AFFAIRS
HEALTH, EDUCATION, LABOR, AND PENSIONS
JOINT ECONOMIC COMMITTEE

October 14, 2020

Richard A. Stone, M.D.
Executive in Charge
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Stone,

Thank you for your commitment to caring for the men and women who have served and sacrificed for our country, over 700,000 of whom call Georgia home. Under the current administration, the U.S. Department of Veterans Affairs (VA) has taken significant steps to improve the way in which veterans receive the care they need and benefits they deserve. However, I write today to express concern over recent reports that many veterans in Georgia are facing significant wait times for care under the new Veterans Community Care Program (VCCP).

In 2018, Congress worked with the administration to significantly reform the way in which the VA provides care to our nation's veterans through the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. One of the primary goals of the VA MISSION Act was to ensure that every veteran has access to quality care in the communities where they live. To accomplish this goal, the bill authorized the creation of the VCCP to consolidate existing community care programs under the VA into a single program, in order to improve efficiency and ensure that veterans receive care when they need it.

The VA officially launched the VCCP in June 2019 and began the process of rolling out a new community care network (CCN) across six regions. Under the VA MISSION Act, third-party administrators are responsible for building and maintaining the network of non-VA providers in each region. VA medical centers (VAMCs) are responsible for determining patient eligibility for community care and for the coordination and scheduling of such care. In June 2020, the new CCN in Georgia was deployed through the third-party administrator Optum.

Although the VCCP was created to improve patient choice and ensure timely access to care, a recent report from the Atlanta Journal-Constitution suggests that as of late September 2020, 4,632 veterans in Georgia waited at least 180 days for a community care appointment to be scheduled through the Atlanta VAMC. The report also suggests that "an additional 5,458 requests" for community care had not been scheduled within 30 days.[1] Several weeks ago, the Government Accountability Office (GAO) reported that although the VA has established a

[1] https://www.ajc.com/news/georgia-veterans-wait-times-for-medical-help skyrocket/IDN4Z5JYRRDMBNVFXVY5PESJNY/

"maximum potential allowable wait time"[2] of approximately 19 days for routine referrals to be submitted for scheduling, the VA has not established a time frame by which an appointment should occur.[3]

I understand that COVID-19 has created delays across our healthcare system, including at the Veterans Health Administration (VHA), and that the formal rollout of the CCN is still occurring across the country. However, I believe you would agree with me that no veteran should have to wait six months to receive care. Therefore, I respectfully ask that you provide answers to the following questions:

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?

2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?

3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

Thank you again for your commitment to our nation's veterans. I look forward to continuing to work together on this important issue.

Sincerely,

Kelly Loeffler
United States Senator

[2] According to GAO, the "maximum potential allowable wait time" of approximately 19 days refers to the time it should take for a VA provider to submit a routine (not urgent) referral for community care to the VAMC's Referral Coordination Team (RCT) and for the RCT to then submit the referral to the VAMC's community care staff for scheduling.

[3] https://www.gao.gov/assets/710/709804.pdf

From: (b)(6)
Sent: Tue, 3 Nov 2020 23:48:05 +0000
To: (b)(6)
Cc: Czarnecki, Tammy;VHA CO 15 Operations Correspondence
Subject: FW: 3767978 Loeffler Letter to Dr. Stone re VCCP
Attachments: 3767978 INCOMING 10-14-20 Loeffler Letter to Stone re VCCP Wait Times.pdf, 3767978 DRAFT RESP.docx, RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response, RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response, 110320 VIEWS 3767978 .pdf

Good Afternoon

The signed C&S sheet is attached. See minor edit below

Thank you

Dear Senator Loeffler:

Thank you for your inquiry to the Department of Veterans Affairs (VA) regarding your concerns with VA Community Care. I appreciate this opportunity to respond on behalf of the Veterans Health Administration.

VA launched the Veterans Community Care Program (VCCP) on June 6, 2019, implementing portions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which both ended the Veterans Choice Program and established a new Veterans Community Care Program.

Under the VCCP Veterans can work with their VA health care provider or other VA staff to determine eligibility for community care based on eligibility criteria. Eligible Veterans can choose to have VA provide their care or may elect to receive care in the community.

Our responses to your three specific questions are listed on the attachment included with this response. VA is working with all of our partners to ensure the program is a viable and efficient option for all eligible Veterans. If you have any additional questions, please have a member of your staff contact Mx. XXXX XXXXXX at 202-XXX-XXXX, or XXXX.XXXXXX@va.gov.

Thank you for your continued support of our mission.

Sincerely,

Richard A. Stone, M.D.
Executive in Charge

Department of Veterans Affairs (VA)
Responses to Senator Loeffler's Questions Regarding VCCP Wait Times

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?

- VHA is taking several steps to reduce wait times for community care under the Veterans Community Care Program (VCCP) by implementing processes that will streamline and expedite the community care scheduling process.
- VHA recently began implementing Referral Coordination Teams at VA Medical Centers (VAMCs) across the country to assist Veterans in making new appointments with specialists. This effort should reduce the time it takes to schedule and complete an appointment with a specialist in VA or in the community and provide Veterans with information they need to advocate for their own care. A key focus for these Referral Coordination Teams is to implement a streamlined referral and consult management process with attempts at more "real-time" scheduling while the Veteran is available on the phone or in clinic. By empowering Veterans with key information to help them make an informed decision about their options for care and decreasing the administrative burden, VHA is successfully demonstrating the ability to reduce the average wait times to schedule appointments. Presently, nearly 80% of our VAMCs have at least three Referral Coordination Teams in place , with a goal to have all specialists included by January of 2021.
- The need to execute multiple contact attempts to Veterans to establish a scheduled appointment was identified as the rate limiting step in community care scheduling. VHA is implementing a process to collect Veteran community care scheduling preferences prior to leaving their internal VHA appointment when a consult is forwarded or entered directly to community care. This new streamlined process to collect this information with the Veteran face to face will minimize delays and help to ensure the Veteran receives timely care.
  In addition, VHA is exploring alternative ways to contact Veterans, such as texting or email to expediate communication regarding appointment scheduling with Veterans.
- As of October 1, 2020, VHA has implemented Department of Veterans Affairs Online Scheduling (VAOS) for certain specialty community care appointments. VAOS gives Veterans the ability to request specific services online and quickly expedite the ability to obtain appointments electronically with community providers. VAOS allows Veterans to (1) request initial primary care appointments, routine exams for podiatry, optometry, and audiology; (2) request hearing aid support and nutrition visits; (3) view community care provider appointment details through the VAOS app; and (4) receive notifications about community care appointments.

2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?

- VHA has sent out announcements and memoranda, held office hours, presented on national conference calls, provided end to end training and updated the Field Guidebook on specific policies and procedures. IT solutions have been updated to include Veterans eligibility to assist the field. VHA staff have collaborated to ensure these trainings and office hours reach the intended audience.
- VHA provides a community care staffing calculator to assist local VAMC leadership with making informed resource decisions.

3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

- VHA is committed to meeting Veterans' care needs with excellence and monitors referral timeliness metrics closely for both VA services and community care. VHA established a thoughtfully designed scheduling process for when a consult reaches a facility's community care office. The current scheduling standards are depicted in the chart outlined below. VHA is currently reviewing these standards to assure they continue to meet the health care needs of our Veterans.

Appointment Scheduling Standards

	Initiate Referral processing	**Time to schedule**	**Time to appointment**
	Days from consult receipt in facility community care office to initiate scheduling	Days from consult receipt in facility community care office to appointment scheduled	Days from consult receipt in facility community care office to community appointment date CCN
Target Days from community care consult entry	Within 2 days	Within 21 days	Within 30 days

From: (b)(6) @va.gov>
Sent: Tuesday, November 3, 2020 4:46 PM
To: (b)(6) @va.gov>
Cc: VHA CO 15 Operations Correspondence (b)(6) @va.gov>
Subject: 3767978 Loeffler Letter to Dr. Stone re VCCP

Hello (b)(6)

Please review and provide 15 OPNS AUSO clearance on the above attached DRAFT RESPONSE

Thank you

(b)(6)

VACO/AUSHO (15)
Ofc (b)(6)
Iphone (b)(6)

KELLY LOEFFLER
GEORGIA

131 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224 3643

ONE OVERTON PARK
3625 CUMBERLAND BOULEVARD, SUITE 970
ATLANTA, GA 30339
(770) 661-0999

United States Senate
WASHINGTON, DC 20510-1010

AGRICULTURE, NUTRITION, AND FORESTRY
VETERANS' AFFAIRS
HEALTH, EDUCATION, LABOR, AND PENSIONS
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October 14, 2020

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Although the VCCP was created to improve patient choice and ensure timely access to care, a recent report from the Atlanta Journal-Constitution suggests that as of late September 2020, 4,632 veterans in Georgia waited at least 180 days for a community care appointment to be scheduled through the Atlanta VAMC. The report also suggests that "an additional 5,458 requests" for community care had not been scheduled within 30 days.[1] Several weeks ago, the Government Accountability Office (GAO) reported that although the VA has established a

[1] https://www.ajc.com/news/georgia-veterans-wait-times-for-medical-help skyrocket/IDN4Z5JYRRDMBNVFXVY5PESJNY/

"maximum potential allowable wait time"[2] of approximately 19 days for routine referrals to be submitted for scheduling, the VA has not established a time frame by which an appointment should occur.[3]

I understand that COVID-19 has created delays across our healthcare system, including at the Veterans Health Administration (VHA), and that the formal rollout of the CCN is still occurring across the country. However, I believe you would agree with me that no veteran should have to wait six months to receive care. Therefore, I respectfully ask that you provide answers to the following questions:

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?

2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?

3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

Thank you again for your commitment to our nation's veterans. I look forward to continuing to work together on this important issue.

Sincerely,

Kelly Loeffler
United States Senator

[2] According to GAO, the "maximum potential allowable wait time" of approximately 19 days refers to the time it should take for a VA provider to submit a routine (not urgent) referral for community care to the VAMC's Referral Coordination Team (RCT) and for the RCT to then submit the referral to the VAMC's community care staff for scheduling.
[3] https://www.gao.gov/assets/710/709804.pdf

The Honorable Kelly Loeffler
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

Dear Senator Loeffler:

Thank you for your inquiry to the Department of Veterans Affairs (VA) regarding your concerns with VA Community Care. I appreciate this opportunity to respond on behalf of the Veterans Health Administration.

VA launched the Veterans Community Care Program (VCCP) on June 6, 2019, implementing portions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which both ended the Veterans Choice Program and established a new Veterans Community Care Program.

Under the VCCP Veterans can work with their VA health care provider or other VA staff to determine eligibility for community care based on eligibility criteria. Eligible Veterans can choose to have VA provide their care or may elect to receive care in the community.

Our responses to your three specific questions are listed on the attachment included with this response. VA is working with all of our partners to ensure the program is a viable and efficient option for all eligible Veterans. If you have any additional questions, please have a member of your staff contact Mx. XXXX XXXXXX at 202-XXX-XXXX, or XXXX.XXXXXX@va.gov.

Thank you for your continued support of our mission.

Sincerely,

Richard A. Stone, M.D.
Executive in Charge

Department of Veterans Affairs (VA)
Responses to Senator Loeffler's Questions Regarding VCCP Wait Times

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?

- VHA is taking several steps to reduce wait times for community care under the Veterans Community Care Program (VCCP) by implementing processes that will streamline and expedite the community care scheduling process.
- VHA recently began implementing Referral Coordination Teams at VA Medical Centers (VAMCs) across the country to assist Veterans in making new appointments with specialists. This effort should reduce the time it takes to schedule and complete an appointment with a specialist in VA or in the community and provide Veterans with information they need to advocate for their own care. A key focus for these Referral Coordination Teams is to implement a streamlined referral and consult management process with attempts at more "real-time" scheduling while the Veteran is available on the phone or in clinic. By empowering Veterans with key information to help them make an informed decision about their options for care and decreasing the administrative burden, VHA is successfully demonstrating the ability to reduce the average wait times to schedule appointments. Presently, nearly 80% of our VAMCs have at least three Referral Coordination Teams in place , with a goal to have all specialists included by January of 2021.
- The need to execute multiple contact attempts to Veterans to establish a scheduled appointment was identified as the rate limiting step in community care scheduling. VHA is implementing a process to collect Veteran community care scheduling preferences prior to leaving their internal VHA appointment when a consult is forwarded or entered directly to community care. This new streamlined process to collect this information with the Veteran face to face will minimize delays and help to ensure the Veteran receives timely care.
  In addition, VHA is exploring alternative ways to contact Veterans, such as texting or email to expediate communication regarding appointment scheduling with Veterans.
- As of October 1, 2020, VHA has implemented Department of Veterans Affairs Online Scheduling (VAOS) for certain specialty community care appointments. VAOS gives Veterans the ability to request specific services online and quickly expedite the ability to obtain appointments electronically with community providers. VAOS allows Veterans to (1) request initial primary care appointments, routine exams for podiatry, optometry, and audiology; (2) request hearing aid support and nutrition visits; (3) view community care provider appointment details through the VAOS app; and (4) receive notifications about community care appointments.

2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?

- VHA has sent out announcements and memoranda, held office hours, presented on national conference calls, provided end to end training and updated the Field Guidebook on specific policies and procedures. IT solutions have been updated to include Veterans eligibility to assist the field. VHA staff have collaborated to ensure these trainings and office hours reach the intended audience.
- VHA provides a community care staffing calculator to assist local VAMC leadership with making informed resource decisions.

3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

- VHA is committed to meeting Veterans' care needs with excellence and monitors referral timeliness metrics closely for both VA services and community care. VHA established a thoughtfully designed scheduling process for when a consult reaches a facility's community care office. The current scheduling standards are depicted in the chart outlined below. VHA is currently reviewing these standards to assure they continue to meet the health care needs of our Veterans.

Appointment Scheduling Standards

	Initiate Referral processing	**Time to schedule**	**Time to appointment**
	Days from consult receipt in facility community care office to initiate scheduling	Days from consult receipt in facility community care office to appointment scheduled	Days from consult receipt in facility community care office to community appointment date CCN
Target Days from community care consult entry	Within 2 days	Within 21 days	Within 30 days

From: (b)(6)
Sent: Tue, 3 Nov 2020 19:09:30 +0000
To: (b)(6)
Cc: VHA 13 Community Care Support Staff
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

yes

(b)(6)
(b)(6) to the Assistant Under Secretary
for Health for Community Care
Office of Community Care
P (b)(6)
C
Email: (b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Tuesday, November 3, 2020 1:51 PM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

If you are ok with the edits I will move forward, CI didn't have any opposition.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (OCC CI) (b)(6) @va.gov>
Sent: Tuesday, November 3, 2020 1:32 PM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Hi (b)(6)

Yes, we're good with their edits.

Thank you,
(b)(6)
(b)(6) to the Executive Director, Clinical Integration and Field Operations
VHA Office of Community Care
(b)(6) Office
Mobile
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Tuesday, November 3, 2020 9:07 AM
To: (b)(6) (OCC CI) (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) <(b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning (b)(6)
OVAC provides the following edits, are you good with the edits?

Please respond by COB today.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (JBVAMC) (b)(6) @va.gov>
Sent: Monday, November 2, 2020 3:52 PM
To: (b)(6) @va.gov>; VHA 15ACC OVAC Action (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon – see edits attached. 15ACC clears.

Thanks,

(b)(6)
Office of Veterans Access to Care (OVAC) (15ACC)
Cell: (b)(6)
Email: (b)(6) @va.gov

VA | U.S. Department of Veterans Affairs

"The way we treat our Veterans today will be why they Choose VA in the future"

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:28 AM
To: VHA 15ACC OVAC Action (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning OVAC,

For review and clearance.

Thank you,

(b)(6)

AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 12:17 PM
To: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Here are my redlines

(b)(6)
(b)(6) Assistant Under Secretary
for Health for Community Care
Office of Community Care
P (b)(6)
C
Email: (b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:48 AM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Hi (b)(6)
If you are ok with the attached response I will move it to OVAC to get their clearance.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:07 AM
To: (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Morning (b)(6) and Greetings from Colorful Colorado!

Here is the response for Senator Loeffler. It has been approved by Policy. CI provided the responses to the three questions which were approved by Dr. Greenstone. Thank you.

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

BOA (Congressional Correspondence) Customer Survey

From: (b)(6) @va.gov>
Sent: Monday, November 02, 2020 7:02 AM
To: (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Hi (b)(6)
Any chance you can complete this response today?

Thank you,

(b)(6)

AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (OCC CI) (b)(6) @va.gov>
Sent: Friday, October 30, 2020 9:37 AM
To: (b)(6) @va.gov>; (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Attached is the response approved by Dr. Greenstone with one edit made in the table of 21 days instead of 14.

Thank you,

(b)(6)
(b)(6) to the Executive Director, Clinical Integration and Field Operations
VHA Office of Community Care
(b)(6) Office
Mobile
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 3:14 PM
To: (b)(6) (OCC CI) (b)(6) @va.gov>; (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Thank you (b)(6)

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)
BOA (Congressional Correspondence) Customer Survey

From: (b)(6) (OCC CI) (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 1:07 PM
To: (b)(6) @va.gov>; (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

No, (b)(6) is OOO today and the CI proposed response is with Dr. Greenstone for review now and I expect he will complete by COB today and then we will be able to send to you.

(b)(6)
(b)(6) to the Executive Director, Clinical Integration and Field Operations
VHA Office of Community Care
(b)(6) Office
Mobile
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 2:37 PM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Afternoon (b)(6) and Greetings from Colorful Colorado!

Do you have the requested responses to the three questions. We'll actually go ahead and put the final response together and forward it to OCC leadership for review. In addition to Dr. Greenstone it will need to go through Policy and Dr. Upton's office as well before it is sent to the SECVA's office. Thank you.

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

From: (b)(6) @va.gov>
Sent: Tuesday, October 27, 2020 4:05 PM

To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good evening,
Our team has prepared and submitted our draft responses for Dr. Greenstone's review and concurrence. Once he reviews, our action team will send to you. I'm pushing for the request by COB tomorrow.

Thank you!
(b)(6)

From: (b)(6)
Sent: Friday, October 23, 2020 9:50 AM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov> (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,
Yes, absolutely- We will have a response to you by next Wednesday.

Thanks,
(b)(6)

(b)(6)
(b)(6) Clinical Integration Field Support
Clinical Integration [10D1D1]
VHA Office of Community Care – Clinical Network and Management
U.S. Department of Veterans Affairs
(b)(6)
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 9:41 AM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response
Importance: High

Good Morning (b)(6) and Greetings from Colorful Colorado!

Are you able to assist on behalf of CI with these three questions?

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?

2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

DC would like our response back by next Friday. If possible, we need your input by COB on Wednesday, October 28th in order to finish the response and have leadership review it. Thank you.

Sincerely,

(b)(6)
(b)(6)
Congressional Correspondence (10D1A6)
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

BOA (Congressional Correspondence) Customer Survey

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 7:34 AM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,

CI has submitted (b)(6) @va.gov) to serve as the SME on this response.

Thank you,

--

(b)(6)
(b)(6)
AUSH for Community Care (VHA 13)

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 9:27 AM
To: (b)(6) @va.gov>

Cc: VHA 13 Community Care Support Staff (b)(6)@va.gov>; (b)(6)
(b)(6)@va.gov>; VHA 13CHIFO Clinical Integration Action
(b)(6)@va.gov>; (b)(6)@va.gov>; (b)(6)
(b)(6)@va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Morning,

Clinical Integration submits (b)(6) as the SME to work with (b)(6) on this response.

Thank You,

(b)(6)
Clinical Integration
VHA Office of Community Care
U.S. Department of Veterans Affairs
Ph: (b)(6)

From: (b)(6)@va.gov>
Sent: Thursday, October 22, 2020 12:02 PM
To: (b)(6)@va.gov>; (b)(6) (OCC CI) (b)(6)@va.gov>;
VHA 13CHIFO Clinical Integration Action (b)(6)@va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6)@va.gov>; (b)(6)
(b)(6)@va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon (b)(6) looks like OVAC is deferring to CI on all the questions. Are you going to be the SME for this response. (b)(6) is waiting to get an SME **today**.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (ERPi) (b)(6)@va.gov>
Sent: Thursday, October 22, 2020 11:52 AM
To: (b)(6)@va.gov>; VHA 15ACC OVAC Action
(b)(6)@va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6)@va.gov>; (b)(6)
(b)(6)@va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,

After discussing with Dr. Kirsh, OVAC is deferring to OCC. We are happy to review any draft responses though.

Thanks,
(b)(6)

1) What steps is the VHA taking to reduce wait times for community care under the VCCP? OCC
2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act? OVAC is deferring this to OCC as the question is around CC staffing.
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled? OVAC is deferring this to OCC as the question is around scheduling for community care under the VCCP.

(b)(6)
Contract support for Office of Veterans Access to Care (OVAC)
(b)(6)@va.gov | (b)(6)@erpi.net

From: (b)(6)@va.gov>
Sent: Monday, October 19, 2020 3:57 PM
To: VHA 15ACC OVAC Action (b)(6)@va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6)@va.gov>; (b)(6)
(b)(6)@va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon OVAC,
The attached letter was assigned to 13 OCC can you please review and provide your inputs by **COB 10/22.**

Following questions:
1) What steps is the VHA taking to reduce wait times for community care under the VCCP?
2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?
Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

-----Original Message-----
From: (b)(6) @va.gov>
Sent: Monday, October 19, 2020 1:04 PM
To: VHA OCC Congressional Inquiry Triage Team (Encrypted)
(b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; VHA 13CHIFO
Clinical Integration Actio (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon,
Can you please work with CI to develop a response to the attached letter from Senator Loeffler by COB October 30th.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

-----Original Message-----
From: (b)(6) @va.gov>
Sent: Friday, October 16, 2020 3:56 PM
To: (b)(6) @va.gov>
Subject: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

New Task Assignment Alert!

A new case task was created on: 2020-10-16 15:56:01 and assigned to VHA-10D DUSH for Community Care.

Please see details below.
Case Subject: FW: Loeffler Letter to Dr. Stone re VCCP Primary MOC: (b)(6) Signature Level: USH

Task Created By: (b)(6) @va.gov
Office: VHA-10BEXC Executive Correspondence
Organization: VHA

Task Name: LCT-249762
Due Date is on: 2020-10-30 17:00:00
Action Requested: Prepare Response
Requested Activity: Please see attached and provide a signed and dated letter to the Member of Congress with Appropriate Individual's signature. Upload into VIEWS and create a task back to 10B1 to close. Thank you.

To view case Task details and to provide response, please use the link below:
https://va.my.salesforce.com/a4at0000000GxoKAAS

Thank you!

From: (b)(6) (JBVAMC)
Sent: Mon, 2 Nov 2020 20:52:19 +0000
To: (b)(6) VHA 15ACC OVAC Action
Cc: VHA 13 Community Care Support Staff
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response
Attachments: Community Care-Sen.Loeffler-03767978_Response 13_15ACC edits.docx

Good afternoon – see edits attached. 15ACC clears.

Thanks,

(b)(6)
Office of Veterans Access to Care (OVAC) (15ACC)
Cell: (b)(6)
Email: (b)(6) @va.gov
VA | U.S. Department of Veterans Affairs

"The way we treat our Veterans today will be why they ChooseVA in the future"

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:28 AM
To: VHA 15ACC OVAC Action (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning OVAC,

For review and clearance.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 12:17 PM

To: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Here are my redlines

(b)(6)
(b)(6) to the Assistant Under Secretary
for Health for Community Care
Office of Community Care
P – (b)(6)
C –
Email: (b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:48 AM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Hi (b)(6)
If you are ok with the attached response I will move it to OVAC to get their clearance.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) @va.gov>
Sent: Monday, November 2, 2020 11:07 AM
To: (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Morning (b)(6) and Greetings from Colorful Colorado!

Here is the response for Senator Loeffler. It has been approved by Policy. CI provided the responses to the three questions which were approved by Dr. Greenstone. Thank you.

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration

U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

BOA (Congressional Correspondence) Customer Survey

From: (b)(6) @va.gov>
Sent: Monday, November 02, 2020 7:02 AM
To: (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Hi (b)(6)
Any chance you can complete this response today?

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (OCC CI) (b)(6) @va.gov>
Sent: Friday, October 30, 2020 9:37 AM
To: (b)(6) @va.gov>; (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Attached is the response approved by Dr. Greenstone with one edit made in the table of 21 days instead of 14.

Thank you,

(b)(6)
(b)(6) to the Executive Director, Clinical Integration and Field Operations
VHA Office of Community Care
(b)(6) Office
Mobile
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 3:14 PM
To: (b)(6) (OCC CI) (b)(6) @va.gov> (b)(6) @va.gov>

Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Thank you (b)(6)

Sincerely,

(b)(6)
(b)(6)
Congressional Correspondence (10D1A6)
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

BOA (Congressional Correspondence) Customer Survey

From: (b)(6) (OCC CI) (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 1:07 PM
To: (b)(6) @va.gov> (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

No (b)(6) is OOO today and the CI proposed response is with Dr. Greenstone for review now and I expect he will complete by COB today and then we will be able to send to you.

(b)(6)
(b)(6) to the Executive Director, Clinical Integration and Field Operations
VHA Office of Community Care
(b)(6) Office
Mobile
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Wednesday, October 28, 2020 2:37 PM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Afternoon (b)(6) and Greetings from Colorful Colorado!

Do you have the requested responses to the three questions. We'll actually go ahead and put the final response together and forward it to OCC leadership for review. In addition to Dr. Greenstone it will need to go through Policy and Dr. Upton's office as well before it is sent to the SECVA's office. Thank you.

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

From: (b)(6) @va.gov>
Sent: Tuesday, October 27, 2020 4:05 PM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good evening,
Our team has prepared and submitted our draft responses for Dr. Greenstone's review and concurrence. Once he reviews, our action team will send to you. I'm pushing for the request by COB tomorrow.

Thank you!
(b)(6)

From: (b)(6)
Sent: Friday, October 23, 2020 9:50 AM
To: (b)(6) @va.gov>
Cc (b)(6) @va.gov>; (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,
Yes, absolutely- We will have a response to you by next Wednesday.

Thanks,
(b)(6)

(b)(6)
(b)(6) Clinical Integration Field Support

Clinical Integration [10D1D1]
VHA Office of Community Care – Clinical Network and Management
U.S. Department of Veterans Affairs
(b)(6)
(b)(6) @va.gov

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 9:41 AM
To: (b)(6) @va.gov>
Cc: (b)(6) @va.gov>; (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response
Importance: High

Good Morning (b)(6) and Greetings from Colorful Colorado!

Are you able to assist on behalf of CI with these three questions?

1) What steps is the VHA taking to reduce wait times for community care under the VCCP?
2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

DC would like our response back by next Friday. If possible, we need your input by COB on Wednesday, October 28th in order to finish the response and have leadership review it. Thank you.

Sincerely,

(b)(6)
(b)(6) ***Congressional Correspondence (10D1A6)***
VHA Office of Community Care – Business Operations & Administration
U.S. Department of Veterans Affairs
3773 Cherry Creek North Drive
Denver, CO 80209
(b)(6)

BOA (Congressional Correspondence) Customer Survey

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 7:34 AM

To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff <(b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,

CI has submitted (b)(6) @va.gov) to serve as the SME on this response.

Thank you,

--

(b)(6)
(b)(6)
AUSH for Community Care (VHA 13)

From: (b)(6) @va.gov>
Sent: Friday, October 23, 2020 9:27 AM
To: (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good Morning,

Clinical Integration submits (b)(6) as the SME to work with (b)(6) on this response.

Thank You,

(b)(6)
Clinical Integration
VHA Office of Community Care
U.S. Department of Veterans Affairs
Ph: (b)(6)

From: (b)(6) @va.gov>
Sent: Thursday, October 22, 2020 12:02 PM
To: (b)(6) @va.gov>; (b)(6) (OCC CI) (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon (b)(6) looks like OVAC is deferring to CI on all the questions. Are you going to be the SME for this response. (b)(6) is waiting to get an SME **today**.

Thank you,

(b)(6)

AUSH for Community Care
Please do not change the subject line of this email

From: (b)(6) (ERPi) (b)(6) @va.gov>
Sent: Thursday, October 22, 2020 11:52 AM
To: (b)(6) @va.gov>; VHA 15ACC OVAC Action (b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Subject: RE: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good morning,

After discussing with Dr. Kirsh, OVAC is deferring to OCC. We are happy to review any draft responses though.

Thanks,
(b)(6)

1) What steps is the VHA taking to reduce wait times for community care under the VCCP? OCC
2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act? OVAC is deferring this to OCC as the question is around CC staffing.
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled? OVAC is deferring this to OCC as the question is around scheduling for community care under the VCCP.

(b)(6)

Contract support for Office of Veterans Access to Care (OVAC)
(b)(6) @va.gov | (b)(6) @erpi.net

From: (b)(6) @va.gov>
Sent: Monday, October 19, 2020 3:57 PM
To: VHA 15ACC OVAC Action (b)(6) @va.gov>

Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon OVAC,
The attached letter was assigned to 13 OCC can you please review and provide your inputs by **COB 10/22.**

Following questions:
1) What steps is the VHA taking to reduce wait times for community care under the VCCP?
2) What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?
3) Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?
Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

-----Original Message-----
From: (b)(6) @va.gov>
Sent: Monday, October 19, 2020 1:04 PM
To: VHA OCC Congressional Inquiry Triage Team (Encrypted)
(b)(6) @va.gov>
Cc: VHA 13 Community Care Support Staff (b)(6) @va.gov>; VHA 13CHIFO Clinical Integration Action (b)(6) @va.gov>
Subject: FW: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

Good afternoon,
Can you please work with CI to develop a response to the attached letter from Senator Loeffler by COB October 30th.

Thank you,

(b)(6)
AUSH for Community Care
Please do not change the subject line of this email

-----Original Message-----
From: (b)(6) @va.gov>
Sent: Friday, October 16, 2020 3:56 PM
To: (b)(6) @va.gov>
Subject: Case #: 03767978 - Due Date: 2020-10-30 17:00:00 - Action Requested - Prepare Response

New Task Assignment Alert!

A new case task was created on: 2020-10-16 15:56:01 and assigned to VHA-10D DUSH for Community Care.

Please see details below.
Case Subject: FW: Loeffler Letter to Dr. Stone re VCCP Primary MOC: (b)(6) Signature Level: USH

Task Created By: (b)(6) @va.gov
Office: VHA-10BEXC Executive Correspondence
Organization: VHA

Task Name: LCT-249762
Due Date is on: 2020-10-30 17:00:00
Action Requested: Prepare Response
Requested Activity: Please see attached and provide a signed and dated letter to the Member of Congress with Appropriate Individual's signature. Upload into VIEWS and create a task back to 10B1 to close. Thank you.

To view case Task details and to provide response, please use the link below:
https://va.my.salesforce.com/a4at0000000GxoKAAS

Thank you!

The Honorable Kelly Loeffler
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

Dear Senator Loeffler:

Thank you for your inquiry to the Department of Veterans Affairs (VA) regarding your concerns with VA Community Care. I appreciate this opportunity to respond on behalf of the Veterans Health Administration.

VA launched the Veterans Community Care Program (VCCP) on June 6, 2019, implementing portions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which both ended the Veterans Choice Program and established a new Veterans Community Care Program.

Under the VCCP Veterans can work with their VA health care provider or other VA staff to determine eligibility for community care based on eligibility criteria. Eligible Veterans can choose to have VA provide their care or may elect to receive care in the community.

Our responses to your three specific questions are listed on the attachment included with this response. VA is working with all of our partners to ensure the program is a viable and efficient option for all eligible Veterans. If you have any additional questions, please have a member of your staff contact Mx. XXXX XXXXXX at 202-XXX-XXXX, or XXXX.XXXXXX@va.gov.

Thank you for your continued support of our mission.

Sincerely,

Richard A. Stone, M.D.
Executive in Charge

Department of Veterans Affairs (VA)
Responses to Senator Loeffler's Questions Regarding VCCP Wait Times

(b)(5)

(b)(5)

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VIEWS 3767978	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	3767978	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
	Office of the AUSH Operations	15	11/03/20	(b)(6)		11/03/20

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT	SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL

SYMBOL	EXTENSION	TITLE	DATE

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VIEWS 3767978	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	3767978	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
	Office of the AUSH Operations	15	11/03/20	(b)(6)		11/03/20

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

Enclosure

Department of Veterans Affairs (VA)
Response to Senator Loeffler Regarding
Veterans Community Care Program (VCCP) Wait Times

Question 1: What steps is the VHA taking to reduce wait times for community care under the VCCP?

VA Response: The Veterans Health Administration (VHA) is taking several steps to reduce wait times for community care under VCCP by implementing processes that will streamline and expedite the community care scheduling process.

For example, VHA recently began implementing Referral Coordination Teams (RCT) at VA Medical Centers (VAMCs) across the country to assist Veterans in making new appointments with specialists. This effort should reduce the time to schedule and complete an appointment with a specialist in VA or in the community and provide Veterans with information they need to advocate for their own care. A key focus for RCTs is to implement a streamlined referral and consult management process with attempts at more "real-time" scheduling while the Veteran is available on the phone or in person. Empowering Veterans with key information to help them make an informed decision about their options for care also decreases the administrative burden, allowing VHA to reduce the average wait times to schedule appointments. Currently, nearly 80% of our VAMCs have at least three RCTs in place, with a goal to have all specialists included by January 2021.

The need to execute multiple contact attempts to Veterans to establish a scheduled appointment was identified as the rate limiting step in community care scheduling. VHA is implementing a process to collect Veteran scheduling preferences prior to leaving their internal VHA appointment when a consult is forwarded or entered directly to community care. This new streamlined process to collect information with the Veteran face to face will minimize delays and help to ensure the Veteran receives timely care.

Additionally, VHA is exploring alternative ways to contact Veterans (via text or email) to expediate communication regarding appointment scheduling with Veterans. As of October 1, 2020, VHA has implemented VA Online Scheduling (VAOS) for certain specialty community care appointments. VAOS gives Veterans the ability to request specific services online and quickly expedite the ability to obtain appointments electronically with community providers. Moreover, VAOS allows Veterans to: (1) request initial primary care appointments, routine exams for podiatry, optometry and audiology; (2) request hearing aid support and nutrition visits; (3) view community care provider appointment details through the VAOS application; and (4) receive notifications about community care appointments.

Question 2: What steps has the VHA taken to adequately prepare staff for the scheduling and coordinating of community care required under the VA MISSION Act?

VA Response: VHA has sent out announcements and memoranda, presented on national conference calls, provided end-to-end training and updated the Field Guidebook on specific policies and procedures. Additionally, field staff were invited to "Office Hours" sessions hosted by the national program office. During these sessions, subject-matter experts presented training slides and answered questions to ensure understanding by our field staff. Moreover, information technology solutions have been updated to include Veterans' eligibility to assist the field. VHA staff have collaborated to ensure these trainings and office hours reach the intended audience. VHA also provides a community care staffing calculator to assist local VAMC leadership with making informed resource decisions.

Question 3: Has the VHA considered implementing an internal time frame by which a referral for community care under the VCCP should be scheduled?

VA Response: VHA is committed to meeting Veterans' care needs with excellence and monitors referral timeliness metrics closely for both VA services and community care. VHA established a scheduling process for when a consult reaches a facility's community care office; the current scheduling standards are depicted in the chart outlined below. VHA is currently reviewing these standards to assure they continue to meet the health care needs of our Veterans.

Appointment Scheduling Standards

	Initiate Referral Processing	**Time to Schedule**	**Time to Appointment**
	Days from consult receipt in VA facility community care office to initiate scheduling.	Days from consult receipt in VA facility community care office to appointment scheduled.	Days from consult receipt in VA facility community care office to community appointment date.
Target Days from Community Care Consult Entry	Within 2 Days	Within 21 Days	Within 30 Days

From: Law, Cassandra M.
Sent: Fri, 13 Nov 2020 17:43:10 +0000
To: (b)(6)
Cc: VHA 10B
Subject: Re: {ACTION/SIGN} CORRESPONDENCE – DR. STONE SIGNATURE REQUESTED - VIEWS 3767978 - Response to Senator Loeffler Regarding Veterans Community Care Program (VCCP) Wait Times

Cleared for electronic signature.
Cassandra M. Law
From: (b)(6) @va.gov>
Sent: Friday, November 13, 2020 12:37:52 PM
To: Law, Cassandra M. (b)(6) @va.gov>
Cc: VHA 10B (b)(6) @va.gov>
Subject: FW: {ACTION/SIGN} CORRESPONDENCE – DR. STONE SIGNATURE REQUESTED - VIEWS 3767978 - Response to Senator Loeffler Regarding Veterans Community Care Program (VCCP) Wait Times

Hi Cassie,

For clearance, please see the attached response to Senator Loeffler regarding Veterans Community Care Program (VCCP) Wait Times. The enclosure addresses Senator Loeffler's questions.

OCLA, Operations and Community Care have concurred. If cleared, please reply with " cleared for electronic signature".

Thank you,

(b)(6)
Office of the VHA Chief of Staff (10B)
iPhone: (b)(6)

From: (b)(6) @va.gov>
Sent: Friday, November 13, 2020 12:19 PM
To: VHA 10B (b)(6) @va.gov>
Cc: VHA 10BEXC Exec Correspondence Review (b)(6) @va.gov>
Subject: {ACTION/SIGN} CORRESPONDENCE – DR. STONE SIGNATURE REQUESTED - VIEWS 3767978 - Response to Senator Loeffler Regarding Veterans Community Care Program (VCCP) Wait Times
Importance: High

10B,

Please see Community Care's request for VHA EIC signature/autopen authorization re: VIEWS 3767978 - Response to Senator Loeffler Regarding

Veterans Community Care Program (VCCP) Wait Times. The attachments include:

- Incoming Letter
- Final Response & Enclosure
- Concurrences from OCLA, AUSHO (Operations), & Community Care

If you have questions or concerns, please let us know. Thanks.

(b)(6)

U.S. Department of Veterans Affairs
VHA Office of Executive Correspondence (10B1)
(b)(6)
(b)(6) @va.gov

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

November 13, 2020

The Honorable Kelly Loeffler
United States Senate
Washington, DC 20510

Dear Senator Loeffler:

Thank you for your October 14, 2020, letter to the Department of Veterans Affairs (VA) regarding your concerns with VA Community Care. I appreciate the opportunity to respond on behalf of the Veterans Health Administration.

VA launched the Veterans Community Care Program (VCCP) on June 6, 2019, implementing portions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act), which both ended the Veterans Choice Program and established a new Veterans Community Care Program.

Under VCCP, Veterans can work with their VA health care provider or other VA staff to determine eligibility for community care based on eligibility criteria. Eligible Veterans can choose to have VA provide their care or may elect to receive care in the community. VA continues to work with all of our partners to ensure VCCP is a viable and efficient option for all eligible Veterans.

Responses to the questions enumerated in your letter are enclosed. Should you have further questions, please have a member of your staff contact (b)(6) Congressional Relations Officer at (b)(6) @va.gov or (b)(6)

Thank you for your continued support of our mission.

Sincerely,

Richard A. Stone, M.D.
Executive in Charge

Enclosure

The Honorable Kelly Loeffler
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

Dear Senator Loeffler:

(b)(5)

Executive in Charge

Department of Veterans Affairs (VA)

Responses to Senator Loeffler's Questions Regarding VCCP Wait Times

(b)(5)

(b)(5)

VA | U.S. Department of Veterans Affairs

VETERANS HEALTH ADMINISTRATION

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VHA Notice 2021-xx, Veterans Community Care Program	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	05543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
×	**DUSH**	**10A**				
×	**AUSH-CC**	**13**	07/21/21			
×	**AUSH-QPS**	**17**	07/21/21			
×	**Associate Deputy USH**	**10ORE**	07/21/21	Erica M. Scavella 113911 Digitally signed by Erica M. Scavella 113911 Date: 2021.08.10 12:24:10 -04'00'		
×	**AUSH-O**	**15**	07/21/21			
×	**AUSH-CS**	**11**	07/21/21			
×	**AUSH-PCS**	**15**	07/21/21			
×	**AUSH-DEAN**	**14**	07/21/21			
×	**AUSH-S**	**19**	07/21/21			
×	**COS**	**10B**				
×	**Labor Management Relations**	**LMR**				

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VHA Notice 2021-xx, Veterans Community Care Program	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	05543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
×	**DUSH**	**10A**				
×	**AUSH-CC**	**13**	07/21/21			
×	**AUSH-QPS**	**17**	07/21/21			
×	**ADUSH-RM**	**10ORE**	07/21/21			
×	**AUSH-O**	**15**	07/21/21			
×	**AUSH-CS**	**11**	07/21/21			
×	**AUSH-PCS**	**15**	07/21/21			
×	**AUSH-DEAN**	**14**	07/21/21	Bowman, Marjorie A. Digitally signed by Bowman, Marjorie A. Date: 2021.08.06 10:56:23 -04'00'		
×	**AUSH-S**	**19**	07/21/21			
×	**COS**	**10B**				
×	**Labor Management Relations**	**LMR**				

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VHA Notice 2021-xx, Veterans Community Care Program	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	05543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
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×	**DUSH**	**10A**				
×	**AUSH-CC**	**13**				
×	**AUSH-QPS**	**17**				
×	**ADUSH-RM**	**10ORE**				
×	**AUSH-O**	**15**				
×	**AUSH-CS**	**11**				
×	**AUSH-PCS**	**12**		Beth A. Taylor 376247 Digitally signed by Beth A. Taylor 376247 Date: 2021.08.06 11:41:33 -04'00'		
×	**AUSH-DEAN**	**14**				
×	**AUSH-S**	**19**				
×	**COS**	**10B**				
×	**Labor Management Relations**	**LMR**				

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

VA FORM JAN 2019 **4265**

SUPERSEDES VA FORM 4265, MAY 2018, WHICH MAY BE USED.

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
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VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VIEWS 5543799	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	5543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

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	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
	Office of the AUSH Operations	15	07/30/21	(b)(6)		07/30/21

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

From: Matthews, Kameron
Sent: Tue, 10 Aug 2021 18:49:13 +0000
To: (b)(6) (VHACO)
Cc: VHA 11 Clinical Services Clearance;VHA 11 Clinical Services Correspondence
Subject: RE: VIEWS CCM - Case #: 05543799 - Due Date: 2021-08-16 17:00:00 - Action Requested - Provide Internal Concurrence

Cleared

From: (b)(6) (VHACO) (b)(6) @va.gov>
Sent: Tuesday, August 10, 2021 12:02 PM
To: Matthews, Kameron (b)(6) @va.gov>
Cc: VHA 11 Clinical Services Clearance (b)(6) @va.gov>; VHA 11 Clinical Services Correspondence (b)(6) @va.gov>
Subject: VIEWS CCM - Case #: 05543799 - Due Date: 2021-08-16 17:00:00 - Action Requested - Provide Internal Concurrence

Good Afternoon Dr. Matthews;

The above attachments regarding *VHA Notice 2021-xx, Veterans Community Care Program*, have been reviewed and are ready for concurrence. Please provide concurrence once you have completed your review.

VETERANS COMMUNITY CARE PROGRAM

1. In accordance with section 101 of the John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018 (P.L. 115-182, as amended), VA promulgated regulations at 38 C.F.R. § 17.4000 through 17.4040 to implement changes to 38 U.S.C. § 1703. These regulations established the Veterans Community Care Program (VCCP) on June 6, 2019, which is used to furnish care and services to Veterans in the community. The VCCP effectively replaced the Veterans Choice Program and VA's traditional community care program to allow Veterans Health Administration (VHA) to furnish care in the community to Veterans that meet the criteria of the cited regulations.

NOTE: *Section 1703 (Veterans Community Care Program) of 38 U.S.C. does not affect VHA's other independent authorities to furnish or pay for community care for individuals who meet the criteria in those authorities for that care. VHA may continue to furnish care and services in the community for individuals, irrespective of whether the individual meets the regulatory criteria for the VCCP, for: Veterans, through 38 U.S.C. §§ 1724 (Hospital care, medical services, and nursing home care abroad), 1725 (Reimbursement for emergency treatment), 1725A (Access to Walk-In Care), and 1728 (Reimbursement of certain medical expenses); and non-Veterans, through 1781 (Medical care for survivors and dependents of certain veterans), 1786 (newborn care), 1787 (Health care of family members of veterans stationed at Camp Lejune, North Carolina), 38 U.S.C. chapter 18 programs (Benefits for Children of Vietnam Veterans and Certain Other Veterans), and any other independent community care authorities.*

2. Care and services may only be furnished through the VCCP in accordance with 38 C.F.R. §§ 17.4000 through 17.4040. More information on the criteria and requirements can be found at https://ecfr.federalregister.gov/current/title-38/chapter-I/part-17/subject-group-ECFRdb26058010ca01a?toc=1, as well as Chapter 2 of the Community Care Guidebook, which can be accessed at https://dvagov.sharepoint.com/:w:/r/sites/VHAOCC/CNM/CI/OCCFGB/_layouts/15/Doc.aspx?sourcedoc=%7B86A65447-CDC8-446C-BDC3-4042541CEA8A%7D&file=Chapter%202.docx&wdLOR=c745567C3-DBC3-4F10-B40E-4F4469766384&action=default&mobileredirect=true. ***NOTE:*** *This is an internal VA website that is not available to the public.* For purposes of this notice, basic Veteran eligibility for VCCP is summarized from 38 C.F.R. § 17.4010 as follows:

a. A Veteran must be enrolled under the system of patient enrollment in 38 C.F.R. § 17.36, or otherwise meet the criteria to receive care and services notwithstanding the Veteran's failure to enroll in 38 C.F.R. § 17.37(a)-(c); and

b. VHA has determined that such a Veteran requires care and services.

c. Additionally, at least one of the following must true:

Thank you,

(b)(6)

Clinical Services (VHA-11 CS)
Veterans Health Administration
810 Vermont Ave NW
Washington, DC 20420
(b)(6) work
iPhone
(b)(6) @va.gov

-----Original Message-----
From: (b)(6) @va.gov>
Sent: Thursday, August 5, 2021 4:31 PM
To: (b)(6) (VHACO) (b)(6) @va.gov>
Subject: VIEWS CCM - Case #: 05543799 - Due Date: 2021-08-16 17:00:00 - Action Requested - Provide Internal Concurrence

Action Required: Provide Internal Concurrence

New Task Assignment Alert!

A new case task was created on: 2021-08-05 16:30:23 and assigned to VHA-11 Clinical Services.

Please see details below.
Case Subject: VHA Notice 2021-xx, Veterans Community Care Program Primary MOC:
Signature Level: Other

Task Created By: (b)(6) @va.gov
Office: VHA-10BRAP Office of Regulations, Appeals and Policy
Organization: VHA

Task Name: LCT-304443
Due Date is on: 2021-08-16 17:00:00
Action Requested: Provide Internal Concurrence Requested Activity: PLEASE DO NOT ASSIGN TO PROGRAM OFFICES - THIS IS FOR AUSH/ADUSH LEVEL CONCURRENCE ONLY. VHA Notice 2021-xx, Veterans Community Care Program is ready for your office's (AUSH/ADUSH) concurrence. Please let 10BRAP know if you have any questions. Thanks! (b)(6) @va.gov. Copy (b)(6) @va.gov with any questions.

To view case Task details and to provide response, please use the link below:

https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fva.my.salesforce.com%2Fa4at00000002Mg0AAE&data=04%7C01%7C%7C6d3493e3c80c4d6a988908d9584fe191%7Ce95f1b23abaf45ee821db7ab251ab3bf%7C0%7C0%7C637637922383433870%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=LVByfn34tMofOAkTOayHOQfn2kbSZn2kF7YEuNNDyz0%3D&reserved=0

Thank you!

For help with the VIEWS CCM, please contact your VIEWS Office Coordinator (VOC). A list of VOC's is available on the VIEWS Resource Center (https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvaww.oit.va.gov%2Fproducts%2Fviews%2F&data=04%7C01%7C%7C6d3493e3c80c4d6a988908d9584fe191%7Ce95f1b23abaf45ee821db7ab251ab3bf%7C0%7C0%7C637637922383433870%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=5rCLbwPvP%2FtQKF%2F%2Fht9SMf8bTd4r9S4mxm0Kq9sga1I%3D&reserved=0

From: Upton, Mark T.
Sent: Thu, 2 Sep 2021 16:22:46 +0000
To: (b)(6)
Cc: (b)(6); Pape, Lisa M.
Subject: RE: VHA Notice CC

I know the team involved have worked very hard on this, ok to go forward

---

From: (b)(6)@va.gov>
Sent: Thursday, September 2, 2021 12:22 PM
To: Upton, Mark T. (b)(6)@va.gov>
Cc: (b)(6)@va.gov>; Pape, Lisa M. (b)(6)@va.gov>
Subject: RE: VHA Notice CC

Good Afternoon,
Have you had a chance to review this Notice?

Thank you,
(b)(6)

From: (b)(6)
Sent: Wednesday, August 25, 2021 4:47 PM
To: Upton, Mark T. (b)(6)@va.gov>
Cc: (b)(6)@va.gov>; Pape, Lisa M. (b)(6)@va.gov>
Subject: VHA Notice CC

Good Afternoon Sir,
Below is a summary of a VHA notice for your concurrence. Attached is the full version. Please forward and questions or concerns to me.

This is a VHA directive, not a VA directive. **ALL** VHA offices have cc'd. You will always be the last to cc on any VHA handbook/directive/policy/notice.

VETERANS COMMUNITY CARE PROGRAM

1. In accordance with section 101 of the John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018 (P.L. 115-182, as amended), VA promulgated regulations at 38 C.F.R. § 17.4000 through.17.4040 to implement changes to 38 U.S.C. § 1703. These regulations established the Veterans Community Care Program (VCCP) on June 6, 2019, which is used to furnish care and services to Veterans in the community. The VCCP effectively replaced the Veterans Choice Program and VA's traditional community care program to allow Veterans Health Administration (VHA) to furnish care in the community to Veterans that meet the criteria of the cited regulations.

2. Care and services may only be furnished through the VCCP in accordance with 38 C.F.R. §§ 17.4000 through 17.4040. More information on the criteria and requirements can be found at https://ecfr.federalregister.gov/current/title-38/chapter-I/part-17/subject-group-ECFRdb26058010ca01a?toc=1, as well as Chapter 2 of the Community Care Guidebook, which can be accessed at https://dvagov.sharepoint.com/:w:/r/sites/VHAOCC/CNM/CI/OCCFGB/_layouts/15/Doc.aspx?sourcedoc=%7B86A65447-CDC8-446C-BDC3-4042541CEA8A%7D&file=Chapter%202.docx&wdLOR=c745567C3-DBC3-4F10-B40E-4F4469766384&action=default&mobileredirect=true.

3. For purposes of this notice, basic Veteran eligibility for VCCP is summarized from 38 C.F.R. § 17.4010 as follows:

a. A Veteran must be enrolled under the system of patient enrollment in 38 C.F.R. § 17.36, or otherwise meet the criteria to receive care and services notwithstanding the Veteran's failure to enroll in 38 C.F.R. § 17.37(a)-(c); and

b. VHA has determined that such a Veteran requires care and services.

c. Additionally, at least one of the following must true:

(1) No VA medical facility offers the care or services required (i.e., those services that VHA does not provide, such as full obstetrics care);

(2) VA does not operate a full-service VA medical facility in the State in which the Veteran resides (see 38 C.F.R. § 17.4005 for the definition of "full-service VA medical facility"; these States are Alaska, Hawaii, and New Hampshire, as well as the U.S. territories of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands);

(3) The Veteran qualifies under a "grandfathering" provision from the Veterans Choice Program (see 38 C.F.R. § 17.4010(a)(3) for these specific criteria);

(4) The Veteran has contacted VHA to receive care or services but VHA is not able to directly furnish such care or services in a manner that complies with the designated access standards established by the Secretary (average driving time and wait time access standards established in 38 C.F.R. § 17.4040);

(5) The Veteran and the Veteran's referring clinician determine it is in the best medical interest of the Veteran to use VCCP, based on consideration of the factors outlined in 38 C.F.R. § 17.4010(5)(i)-(vii) (see 38 C.F.R. § 17.4040) for additional information;

(6) In accordance with 38 C.F.R. § 17.4015, VHA has determined that one of its medical service lines that would furnish the care or services the Veteran requires is not

providing such care or services in a manner that complies with VA's standards for quality (see 38 C.F.R. 17.4015 for more information).

4. All care and services furnished through the VCCP may only be purchased through valid mechanisms recognized under VCCP, to include contracts (including those used to meet the requirements of 38 U.S.C. § 1703(h)), sharing agreements, and Veterans Care Agreements (VCA) under 38 U.S.C. § 1703A (and 38 C.F.R. § 17.4100-17.4135) when care and services can be purchased using a VCA.

5. Veteran preference for a provider must be followed when a provider has an existing contractual vehicle or sharing agreement with VA, regardless of whether the contract is national, regional, or local. However, Veteran preference alone is not enough to authorize the use of a VCA to procure care; the elements described in paragraph 5 below must be present to authorize use of a VCA.

6. Pursuant to 38 C.F.R. § 17.4115, a VCA may be used to furnish care only if such care or services are not feasibly available to a covered Veteran through a VA medical facility, contract or sharing agreement.

7. For implementation guidance, the Community Care Field Guidebook is available at: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx Questions regarding this notice should be addressed to the Community Care Office of Policy at (b)(6) @va.gov or (b)(6)

(b)(6)
Office of Deputy Under Secretary for Health (10A)
Veterans Health Administration
810 Vermont Avenue NW
Washington, DC 20420
Office (b)(6)
iPhone
E-mail: (b)(6) @va.gov
How was my service today?
We value your feedback-
please click on the link to take
the 10A Quick Card Survey

From: Law, Cassandra M.
Sent: Wed, 29 Sep 2021 22:52:57 +0000
To: (b)(6)
Cc: VHA 10B
Subject: RE: ACTION/ CONCURRENCE: VHA Notice 2021-xx, Veterans Community Care Program for 10B review and concurrence

Cleared.

Cassie

From: (b)(6) @va.gov>
Sent: Monday, September 27, 2021 9:50 AM
To: Law, Cassandra M. (b)(6) @va.gov>
Cc: VHA 10B (b)(6) @va.gov>
Subject: FW: ACTION/ CONCURRENCE: VHA Notice 2021-xx, Veterans Community Care Program for 10B review and concurrence

Hi Cassie,

For clearance, please see the attached VHA Notice on Veterans Community Care Program (VCCP), which provide guidance on when care and services may be furnished through VCCP in accordance with 38 C.F.R. §§ 17.4000 through 17.4040.

10A, ORE, Clinical Services, PCS, Community Care, DEAN, Ops., Support Services, and LMR have concurred. If cleared, please reply with cleared with edits.

Thank you,

(b)(6)
Office of the VHA Chief of Staff (10B)
iPhone: (b)(6)

From: (b)(6) @va.gov>
Sent: Monday, September 27, 2021 7:58 AM
To: VHA 10B (b)(6) @va.gov>
Cc: VHA Pub Managers (b)(6) @va.gov>
Subject: ACTION/ CONCURRENCE: VHA Notice 2021-xx, Veterans Community Care Program for 10B review and concurrence

Good afternoon 10B,

VHA Notice 2021-xx, Veterans Community Care Program is ready for VHA Chief of Staff concurrence.

Attached are the following documents:

- Draft policy
- VIEWS Concurrence
- LMR Concurrence
- CS Sheet

Please let us know if you have any questions.

Thanks,

(b)(6)

(b)(6)

(b)(6) VHA National Policy Operations
VHA | Office of Regulations, Appeals, and Policy (10BRAP)
(b)(6)
Document Management System - VHA Policy Management (sharepoint.com)

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT Notice 2021-XX VHA Urgent Care	NAME OF ADDRESSEE *(For Correspondence Only)*

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	5593463	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

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	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
X	AUSH Support	19	07/29/21	Edward Litvin 107044 Digitally signed by Edward Litvin 107044 Date: 2021.08.13 09:54:26 -04'00'		

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT Notice 2021-XX Veterans Community Care Program	NAME OF ADDRESSEE *(For Correspondence Only)*

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	05543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

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	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
X	AUSH for Support	19	08/05/21	Deborah E. Kramer 662649 Digitally signed by Deborah E. Kramer 662649 Date: 2021.08.16 17:35:15 -04'00'		08/16/21

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

VA FORM OCT 2020 **4265**

SUPERSEDES VA FORM 4265, FEB 2019, WHICH MAY BE USED.

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

NAME OF CONTACT		SIGNATURE OF INITIATING ASSISTANT SECRETARY, ADMINISTRATION HEAD OR KEY STAFF OFFICE OFFICIAL	
SYMBOL	EXTENSION	TITLE	DATE

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA NOTICE 2021-19

October 6, 2021

VETERANS COMMUNITY CARE PROGRAM

1. In accordance with section 101 of the John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018 (P.L. 115-182, as amended), VA promulgated regulations at 38 C.F.R. § 17.4000 through.17.4040 to implement changes to 38 U.S.C. § 1703. These regulations established the Veterans Community Care Program (VCCP) on June 6, 2019, which is used to furnish care and services to Veterans in the community. VCCP effectively replaced the Veterans Choice Program and VA's traditional community care program to allow Veterans Health Administration (VHA) to furnish care in the community to Veterans that meet the criteria of the cited regulations.

NOTE: *Section 1703 (Veterans Community Care Program) of 38 U.S.C. does not affect VHA's other independent authorities to furnish or pay for community care for individuals who meet the criteria in those authorities for that care. VHA may continue to furnish care and services in the community for individuals, irrespective of whether the individual meets the regulatory criteria for VCCP, for: Veterans, through 38 U.S.C. §§ 1724 (Hospital care, medical services, and nursing home care abroad), 1725 (Reimbursement for emergency treatment), 1725A (Access to Walk-In Care), and 1728 (Reimbursement of certain medical expenses); and non-Veterans, through 1781 (Medical care for survivors and dependents of certain veterans), 1786 (newborn care), 1787 (Health care of family members of veterans stationed at Camp Lejune, North Carolina), 38 U.S.C. chapter 18 programs (Benefits for Children of Vietnam Veterans and Certain Other Veterans), and any other independent community care authorities.*

2. Care and services may only be furnished through VCCP in accordance with 38 C.F.R. §§ 17.4000 through 17.4040. More information on the criteria and requirements can be found at https://ecfr.federalregister.gov/current/title-38/chapter-I/part-17/subject-group-ECFRdb26058010ca01a?toc=1, as well as Chapter 2 of the Community Care Guidebook, which can be accessed at https://dvagov.sharepoint.com/:w:/r/sites/VHAOCC/CNM/CI/OCCFGB/_layouts/15/Doc.aspx?sourcedoc=%7B86A65447-CDC8-446C-BDC3-4042541CEA8A%7D&file=Chapter%202.docx&wdLOR=c745567C3-DBC3-4F10-B40E-4F4469766384&action=default&mobileredirect=true. ***NOTE:*** *This is an internal VA website that is not available to the public.* For purposes of this notice, basic Veteran eligibility for VCCP is summarized from 38 C.F.R. § 17.4010 as follows:

a. A Veteran must be enrolled under the system of patient enrollment in 38 C.F.R. § 17.36, or otherwise meet the criteria to receive care and services notwithstanding the Veteran's failure to enroll in 38 C.F.R. § 17.37(a)-(c); and

b. VHA has determined that such a Veteran requires care and services.

c. Additionally, at least one of the following must true:

(1) No VA medical facility offers the care or services required (i.e., those services that VHA does not provide, such as full obstetrics care);

(2) VA does not operate a full-service VA medical facility in the State in which the Veteran resides (see 38 C.F.R. § 17.4005 for the definition of "full-service VA medical facility"; these States are Alaska, Hawaii, and New Hampshire, as well as the U.S. territories of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands);

(3) The Veteran qualifies under a "grandfathering" provision from the Veterans Choice Program (see 38 C.F.R. § 17.4010(a)(3) for these specific criteria);

(4) The Veteran has contacted VHA to receive care or services but VHA is not able to directly furnish such care or services in a manner that complies with the designated access standards established by the Secretary (average driving time and wait time access standards established in 38 C.F.R. § 17.4040);

(5) The Veteran and the Veteran's referring clinician determine it is in the best medical interest of the Veteran to use VCCP, based on consideration of the factors outlined in 38 C.F.R. § 17.4010(5)(i)-(vii) (see 38 C.F.R. § 17.4040 for additional information);

(6) In accordance with 38 C.F.R. § 17.4015, VHA has determined that one of its medical service lines that would furnish the care or services the Veteran requires is not providing such care or services in a manner that complies with VA's standards for quality (see 38 C.F.R. 17.4015 for more information). ***NOTE:*** *VA medical service lines that are designated as underperforming to give effect to this particular eligibility will be announced in Federal Register Notices as applicable. VHA cannot utilize this eligibility criterion unless and until such Federal Register Notices announce underperforming VA medical service lines.*

3. All care and services furnished through VCCP may only be purchased through valid mechanisms recognized under VCCP, to include contracts (including those used to meet the requirements of 38 U.S.C. § 1703(h)), sharing agreements, and Veterans Care Agreements (VCA) under 38 U.S.C. § 1703A (and 38 C.F.R. § 17.4100-17.4135) when care and services can be purchased using a VCA.

4. Veteran preference for a provider must be followed when a provider has an existing contractual vehicle or sharing agreement with VA, regardless of whether the contract is national, regional or local. However, Veteran preference alone is not enough to authorize the use of a VCA to procure care; the elements described in paragraph 5 below must be present to authorize use of a VCA.

5. Pursuant to 38 C.F.R. § 17.4115, a VCA may be used to furnish care only if such care or services are not feasibly available to a covered Veteran through a VA medical facility, contract or sharing agreement. ***NOTE:*** *Hospital care, medical services or*

extended care services are not feasibly available through a VA medical facility, contract or sharing agreement when VA determines that the medical condition of the covered individual, the travel involved, the nature of the care or services or a combination of these factors make the use of a VA medical facility, contract or sharing agreement impracticable or inadvisable.

NOTE: *National contracts are the preferred mechanism for purchasing community care. The Patient-Centered Community Care (PC3) national contract may be used until September 30, 2021 to purchase care while the Community Care Network contracts are being awarded and implemented. Additionally, with an approved waiver from the Office of Community Care, local contracts signed by a warranted contracting officer may be used. In accordance with paragraph 4 above, any waivers for a local contract submitted on the basis of Veteran preference must be approved; VA cannot require the Veteran to see a different provider that is under the national contract.*

6. For implementation guidance, the Community Care Field Guidebook is available at: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx
NOTE: *This is an internal VA web site that is not available to the public.*

7. Questions regarding this notice should be addressed to the Community Care Office of Policy at (b)(6) @va.gov or (b)(6)

8. VHA Notice 2020-22, Veterans Community Care Program, expired on June 30, 2021.

9. This VHA notice will expire and be archived as of October 31, 2022.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Julianne Flynn
Acting Assistant Under Secretary for Health
for Community Care

DISTRIBUTION: Emailed to the VHA Publications Distribution List on October 7, 2021.

VA U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT	NAME OF ADDRESSEE *(For Correspondence Only)*
VHA Notice 2021-xx, Veterans Community Care Program	

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS	CONTROL NO.	NAME OF REVIEWER
	05543799	

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCURRENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
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	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
×	**DUSH**	**10A**				
×	**AUSH-CC**	**13**	07/21/21	JULIANNE FLYNN 306310 Digitally signed by JULIANNE FLYNN 306310 Date: 2021.10.06 09:27:26 -04'00'		
×	**AUSH-QPS**	**17**	07/21/21			
×	**ADUSH-RM**	**10ORE**	07/21/21			
×	**AUSH-O**	**15**	07/21/21			
×	**AUSH-CS**	**11**	07/21/21			
×	**AUSH-PCS**	**15**	07/21/21			
×	**AUSH-DEAN**	**14**	07/21/21			
×	**AUSH-S**	**19**	07/21/21			
×	**COS**	**10B**				
×	**Labor Management Relations**	**LMR**				

NAME OF AUTHORIZED SIGNER	SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER	DATE

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(Continued)

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VA FORM JAN 2019 **4265**

SUPERSEDES VA FORM 4265, MAY 2018, WHICH MAY BE USED.

CONCURRENCE AND SUMMARY SHEET
(Continued)

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From: (b)(6) on behalf of Office of the AUSHO Communications
To: VHA 15 Operations MCD; VHA VISN Directors; VHA VISN Admin Reps
Cc: VHA 10BCOM Communications Directors; VHA VISN PAOs; VHA 15 Operations SS
Subject: Data Release 162
Date: Thursday, March 25, 2021 10:43:00 AM
Attachments: DR162.032021.Public Data - Pending Appointments.pdf
Data Release 162 Fact Sheet FINAL 032325.docx

Good Afternoon,

Summary

In keeping with the commitment to improve transparency in Department of Veterans Affairs' (VA) processes and in accordance with Section 206 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), VA today is releasing the latest update of facility-level patient access data, which highlights notable access improvements. In this release, VA is providing two reports:

1. Completed Appointments (As of February 2021)*
2. Pending Appointments (Snapshot of data on March 15, 2021)*

Notable Improvements:

1. In February 2021, VA completed more than 5,072,000 appointments.
2. VA completed 95.12% of appointments in February 2021 within 30 days of the clinically indicated or Veteran's preferred date.
3. From June 1, 2014, to March 15, 2021, the clinical electronic wait list (EWL) went from 56,271 appointments to 42— a 99.93% reduction.

As a High Reliability Organization (HRO), VA is committed to exploring all processes that contribute to improvement in timely healthcare delivery to our Veterans. This includes improving processes related to tracking and managing facility-level Veteran access data.

VA recently enhanced its public website, www.accesstocare.va.gov providing a clearer picture of access to healthcare at the Veterans Health Administration, with tools Veterans and their caregivers can use to plan for their health care needs. With VA's continued improvements, implementation of the MISSION Act and increased telehealth availability, Veterans have more options today, including in-person and virtual care in VA or care in the community. VA continues to deliver safe, high-quality and timely care to Veterans.

VA is no longer updating the Patient Access Data Report such that this is the last distribution of the Patient Access Progress Update Release. For current wait times and other relevant access data, please visit accesstocare.va.gov.

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(1V01) (402) Togus, ME HCS	46,426	39,200	84.44%	7,226	15.56%	43	0	37,099	0	2,101	0	1,979	0	1,296	0	744	0	3,207	0	10.50	46.30	4.19
(1V01) (402) Togus, ME	29,338	24,526	83.60%	4,812	16.40%	0	0	23,240	0	1,286	0	1,310	0	806	0	496	0	2,200	0	7.23	43.33	2.47
(1V01) (402GA) Caribou, ME	893	876	98.10%	17	1.90%	0	0	825	0	51	0	16	0	1	0	0	0	0	0	5.82	3.00	1.89
(1V01) (402GB) Calais, ME	334	299	89.52%	35	10.48%	0	0	277	0	22	0	20	0	9	0	5	0	1	0	9.91		0.00
(1V01) (402GC) Rumford, ME	479	468	97.70%	11	2.30%	0	0	455	0	13	0	4	0	3	0	1	0	3	0	9.03		0.24
(1V01) (402GD) Saco, ME	1,866	1,772	94.96%	94	5.04%	0	0	1,688	0	84	0	42	0	22	0	3	0	27	0	8.90		3.79
(1V01) (402GE) Lewiston, ME	3,415	2,875	84.19%	540	15.81%	0	0	2,740	0	135	0	169	0	107	0	73	0	191	0	16.51	43.96	7.82
(1V01) (402GF) Lincoln, ME	143	73	51.05%	70	48.95%	0	0	70	0	3	0	21	0	29	0	17	0	3	0	41.27		0.00
(1V01) (402HB) Bangor, ME	7,542	6,078	80.59%	1,464	19.41%	0	0	5,688	0	390	0	308	0	271	0	130	0	755	0	12.37	68.37	5.64
(1V01) (402HC) Portland, ME	2,412	2,229	92.41%	183	7.59%	0	0	2,112	0	117	0	89	0	48	0	19	0	27	0	9.86	11.33	3.46
(1V01) (402HL) Bingham, ME - Mobile	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(1V01) (402QA) Fort Kent, ME	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0.00		
(1V01) (405) White River Junction, VT HCS	28,485	25,745	90.38%	2,740	9.62%	36	0	24,398	0	1,347	0	1,073	0	454	0	336	0	877	0	11.22	16.00	0.92
(1V01) (405) White River Junction, VT	20,532	18,566	90.42%	1,966	9.58%	0	0	17,545	0	1,021	0	740	0	340	0	227	0	659	0	11.66	15.39	0.89
(1V01) (405GA) Bennington, VT	485	476	98.14%	9	1.86%	0	0	467	0	9	0	4	0	0	0	1	0	4	0	9.45	0.08	0.42
(1V01) (405GC) Brattleboro, VT	279	269	96.42%	10	3.58%	0	0	261	0	8	0	8	0	1	0	0	0	1	0	3.46	6.14	0.80
(1V01) (405HA) Burlington Lakeside, VT	4,177	3,668	87.81%	509	12.19%	0	0	3,495	0	173	0	201	0	67	0	78	0	163	0	13.30	20.60	0.77
(1V01) (405HC) Littleton, NH	2,023	1,829	90.41%	194	9.59%	0	0	1,734	0	95	0	88	0	36	0	27	0	43	0	10.71	15.25	4.21
(1V01) (405HE) Keene, NH	235	209	88.94%	26	11.06%	0	0	201	0	8	0	20	0	5	0	0	0	1	0	9.32	7.00	0.00
(1V01) (405HF) Rutland, VT	482	461	95.64%	21	4.36%	0	0	444	0	17	0	8	0	5	0	3	0	5	0	7.05	18.55	0.08
(1V01) (405QB) Newport, VT	272	267	98.16%	5	1.84%	0	0	251	0	16	0	4	0	0	0	0	0	1	0	4.88	14.39	0.00
(1V01) (518) Bedford, MA HCS	16,937	14,476	85.47%	2,461	14.53%	112	0	12,861	0	1,615	0	769	0	429	0	232	0	1,031	0	24.66	29.01	8.19
(1V01) (518) Bedford, MA (Edith Nourse Rogers)	15,315	13,034	85.11%	2,281	14.89%	0	0	11,512	0	1,522	0	695	0	385	0	206	0	995	0	30.99	29.67	6.75
(1V01) (518GA) Lynn, MA	722	647	89.61%	75	10.39%	0	0	597	0	50	0	23	0	6	0	17	0	29	0	15.65	3.88	16.36
(1V01) (518GB) Haverhill, MA	563	486	86.32%	77	13.68%	0	0	468	0	18	0	36	0	32	0	3	0	6	0	22.53	0.65	
(1V01) (518GE) Gloucester, MA	337	309	91.69%	28	8.31%	0	0	284	0	25	0	15	0	6	0	6	0	1	0	6.90	13.42	12.89
(1V01) (523) Boston, MA HCS	76,455	71,089	92.98%	5,366	7.02%	11	1	67,488	0	3,601	1	2,429	0	879	0	547	0	1,511	0	3.71	11.45	3.03
(1V01) (523) Jamaica Plain, MA	31,773	28,963	91.16%	2,810	8.84%	0	1	27,433	0	1,530	1	1,247	0	454	0	284	0	825	0	2.52	13.34	3.84
(1V01) (523A4) West Roxbury, MA	13,980	12,756	91.24%	1,224	8.76%	0	0	12,094	0	662	0	458	0	155	0	129	0	482	0	4.39	14.05	0.17
(1V01) (523A5) Brockton, MA	22,693	21,808	96.10%	885	3.90%	0	0	20,735	0	1,073	0	498	0	176	0	85	0	126	0	3.04	6.71	2.70
(1V01) (523BY) Lowell, MA	5,951	5,591	93.95%	360	6.05%	0	0	5,326	0	265	0	179	0	80	0	38	0	63	0	6.16	8.44	0.84
(1V01) (523BZ) Causeway, MA	1,301	1,252	96.23%	49	3.77%	0	0	1,222	0	30	0	20	0	10	0	7	0	12	0	8.86	2.25	2.96
(1V01) (523GA) Framingham, MA	381	358	93.96%	23	6.04%	0	0	334	0	24	0	18	0	2	0	1	0	2	0	8.29	18.33	0.36
(1V01) (523GC) Quincy, MA	194	190	97.94%	4	2.06%	0	0	187	0	3	0	3	0	0	0	1	0	0	0	3.16		
(1V01) (523GD) Plymouth, MA	182	171	93.96%	11	6.04%	0	0	157	0	14	0	6	0	2	0	2	0	1	0	9.71		
(1V01) (608) Manchester, NH HCS	31,846	27,652	86.83%	4,194	13.17%	292	0	25,666	0	1,986	0	2,157	0	951	0	448	0	638	0	10.19	18.47	3.29
(1V01) (608) Manchester, NH	28,831	25,059	86.92%	3,772	13.08%	0	0	23,241	0	1,818	0	1,980	0	882	0	407	0	503	0	9.18	17.49	2.75
(1V01) (608GA) Portsmouth, NH	537	496	92.36%	41	7.64%	0	0	430	0	66	0	30	0	4	0	4	0	3	0	11.95	14.06	7.22
(1V01) (608GC) Somersworth, NH	785	556	70.83%	229	29.17%	0	0	506	0	50	0	71	0	29	0	26	0	103	0	24.51	108.76	5.30
(1V01) (608GD) Conway, NH	753	687	91.24%	66	8.76%	0	0	659	0	28	0	28	0	12	0	7	0	19	0	13.84		0.00
(1V01) (608HA) Tilton, NH	940	854	90.85%	86	9.15%	0	0	830	0	24	0	48	0	24	0	4	0	10	0	9.82		1.00
(1V01) (631) Central Western Massachusetts HCS	28,028	24,949	89.01%	3,079	10.99%	61	1	23,299	1	1,650	0	1,358	0	730	0	360	0	631	0	6.81	22.78	5.61
(1V01) (631) Central Western Massachusetts, MA (Edward P. Boland)	14,483	12,758	88.09%	1,725	11.91%	0	1	11,789	1	969	0	765	0	373	0	219	0	368	0	4.67	25.38	2.53

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(1V01) (631BY) Springfield, MA	4,294	3,880	90.36%	414	9.64%	0	0	3,674	0	206	0	177	0	126	0	39	0	72	0	7.93	17.27	9.62
(1V01) (631GC) Pittsfield, MA	1,213	1,192	98.27%	21	1.73%	0	0	1,157	0	35	0	9	0	6	0	4	0	2	0	3.07	0.00	1.30
(1V01) (631GD) Greenfield, MA	746	703	94.24%	43	5.76%	0	0	677	0	26	0	20	0	8	0	7	0	8	0	24.90	3.80	2.06
(1V01) (631GE) Worcester, MA	1,236	1,139	92.15%	97	7.85%	0	0	1,092	0	47	0	38	0	26	0	13	0	20	0	8.49	3.92	1.17
(1V01) (631GF) Fitchburg, MA	1,170	1,109	94.79%	61	5.21%	0	0	1,065	0	44	0	27	0	13	0	2	0	19	0	14.94	0.00	2.63
(1V01) (631QA) Plantation Street, MA	2,543	2,160	84.94%	383	15.06%	0	0	2,023	0	137	0	153	0	105	0	35	0	90	0		19.52	
(1V01) (631QB) Lake Avenue, MA	2,343	2,008	85.70%	335	14.30%	0	0	1,822	0	186	0	169	0	73	0	41	0	52	0		19.53	14.67
(1V01) (650) Providence, RI HCS	63,159	59,674	94.48%	3,485	5.52%	112	0	56,543	0	3,131	0	1,366	0	671	0	422	0	1,026	0	9.79	8.85	1.95
(1V01) (650) Providence, RI	40,733	38,471	94.45%	2,262	5.55%	0	0	36,427	0	2,044	0	775	0	418	0	303	0	766	0	10.01	9.84	2.06
(1V01) (650GA) New Bedford, MA	3,718	3,675	98.84%	43	1.16%	0	0	3,593	0	82	0	30	0	6	0	6	0	1	0	2.56	1.49	1.70
(1V01) (650GB) Hyannis, MA	5,570	5,416	97.24%	154	2.76%	0	0	5,194	0	222	0	82	0	16	0	18	0	38	0	5.10	5.41	1.65
(1V01) (650GD) Middletown, RI	2,719	2,420	89.00%	299	11.00%	0	0	2,330	0	90	0	64	0	37	0	43	0	155	0	24.71	2.12	2.09
(1V01) (650QA) Eagle Square, RI	9,825	9,106	92.68%	719	7.32%	0	0	8,456	0	650	0	408	0	194	0	51	0	66	0		7.72	
(1V01) (650QB) Eagle Street, RI	594	586	98.65%	8	1.35%	0	0	543	0	43	0	7	0	0	0	1	0	0	0		4.50	
(1V01) (689) Connecticut HCS	68,438	62,671	91.57%	5,767	8.43%	18	0	58,990	0	3,681	0	2,586	0	1,040	0	564	0	1,577	0	5.93	9.98	2.92
(1V01) (689) West Haven, CT	37,628	33,462	88.93%	4,166	11.07%	0	0	31,170	0	2,292	0	1,719	0	730	0	468	0	1,249	0	10.44	12.04	2.52
(1V01) (689A4) Newington, CT	24,009	22,482	93.64%	1,527	6.36%	0	0	21,192	0	1,290	0	824	0	296	0	91	0	316	0	3.84	8.81	4.00
(1V01) (689GA) Waterbury, CT	589	582	98.81%	7	1.19%	0	0	572	0	10	0	3	0	0	0	1	0	3	0	1.97		2.71
(1V01) (689GB) Stamford, CT	415	414	99.76%	1	0.24%	0	0	408	0	6	0	0	0	0	0	0	0	1	0	0.87		0.31
(1V01) (689GC) Willimantic, CT	794	785	98.87%	9	1.13%	0	0	774	0	11	0	4	0	2	0	1	0	2	0	2.42	0.14	14.42
(1V01) (689GD) Winsted, CT	176	173	98.30%	3	1.70%	0	0	170	0	3	0	3	0	0	0	0	0	0	0	1.76		0.55
(1V01) (689GE) Danbury, CT	349	337	96.56%	12	3.44%	0	0	322	0	15	0	4	0	3	0	0	0	5	0	11.24		1.20
(1V01) (689GF) Orange, CT	2,004	2,004	100.00%	0	0.00%	0	0	1,993	0	11	0	0	0	0	0	0	0	0	0		0.30	
(1V01) (689HC) New London, CT (John J. McGuirk)	1,825	1,796	98.41%	29	1.59%	0	0	1,753	0	43	0	21	0	5	0	2	0	1	0	3.64	0.43	5.51
(1V01) (689QA) Errera, CT	649	636	98.00%	13	2.00%	0	0	636	0	0	0	8	0	4	0	1	0	0	0	1.75	1.75	0.43
(1V02) (528A8) Albany, NY HCS	46,075	43,174	93.70%	2,901	6.30%	0	0	41,499	0	1,675	0	1,196	0	465	0	209	0	1,031	0	5.57	8.24	7.25
(1V02) (528A8) Albany, NY (Samuel S. Stratton)	31,916	29,341	91.93%	2,575	8.07%	0	0	27,953	0	1,388	0	1,051	0	418	0	184	0	922	0	9.67	8.29	7.84
(1V02) (528G2) Westport, NY	454	446	98.24%	8	1.76%	0	0	443	0	3	0	5	0	2	0	0	0	1	0	3.08	3.50	0.00
(1V02) (528G3) Bainbridge, NY	589	583	98.98%	6	1.02%	0	0	572	0	11	0	4	0	0	0	0	0	2	0	3.25	1.56	0.00
(1V02) (528G6) Fonda, NY	1,232	1,221	99.11%	11	0.89%	0	0	1,211	0	10	0	4	0	6	0	0	0	1	0	4.69	0.03	0.10
(1V02) (528G7) Catskill, NY	454	436	96.04%	18	3.96%	0	0	400	0	36	0	8	0	1	0	5	0	4	0	7.61	40.58	6.16
(1V02) (528GT) Glens Falls, NY	3,086	2,989	96.86%	97	3.14%	0	0	2,900	0	89	0	46	0	10	0	4	0	37	0	4.75	3.06	0.52
(1V02) (528GV) Plattsburgh, NY	1,875	1,843	98.29%	32	1.71%	0	0	1,819	0	24	0	7	0	8	0	4	0	13	0	3.08	17.50	8.78
(1V02) (528GW) Schenectady, NY	1,657	1,622	97.89%	35	2.11%	0	0	1,568	0	54	0	21	0	7	0	3	0	4	0	3.13	0.00	0.00
(1V02) (528GX) Troy, NY	973	967	99.38%	6	0.62%	0	0	950	0	17	0	4	0	1	0	1	0	0	0	1.69	0.00	0.00
(1V02) (528GY) Clifton Park, NY	1,659	1,607	96.87%	52	3.13%	0	0	1,588	0	19	0	22	0	8	0	6	0	16	0	5.14	56.00	0.00
(1V02) (528GZ) Kingston, NY	1,794	1,757	97.94%	37	2.06%	0	0	1,739	0	18	0	7	0	2	0	1	0	27	0	4.44	13.13	2.10
(1V02) (528QK) Saranac Lake, NY	386	362	93.78%	24	6.22%	0	0	356	0	6	0	17	0	2	0	1	0	4	0	7.13	0.64	0.20
(1V02) (528A6) Finger Lakes, NY HCS	35,707	31,879	89.28%	3,828	10.72%	0	0	29,391	0	2,488	0	1,369	0	786	0	547	0	1,126	0	9.75	21.58	2.57
(1V02) (528A5) Canandaigua, NY	6,861	6,271	91.40%	590	8.60%	0	0	5,092	0	1,179	0	285	0	111	0	49	0	145	0	10.35	17.94	4.08
(1V02) (528A6) Bath, NY	12,069	11,148	92.37%	921	7.63%	0	0	10,757	0	391	0	276	0	157	0	108	0	380	0	4.35	25.45	2.15
(1V02) (528G4) Elmira, NY	1,463	1,437	98.22%	26	1.78%	0	0	1,375	0	62	0	21	0	2	0	1	0	2	0	3.51	8.35	0.21
(1V02) (528G8) Wellsville, NY	723	526	72.75%	197	27.25%	0	0	490	0	36	0	68	0	84	0	12	0	33	0	36.92	26.47	0.61

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(1V02) (528QC) Rochester Calkins, NY	14,292	12,283	85.94%	2,009	14.06%	0	0	11,514	0	769	0	646	0	422	0	376	0	565	0	9.84	21.60	2.30
(1V02) (528QE) Coudersport, PA	58	55	94.83%	3	5.17%	0	0	50	0	5	0	3	0	0	0	0	0	0	0	7.63		
(1V02) (528QF) Wellsboro, PA	241	159	65.98%	82	34.02%	0	0	113	0	46	0	70	0	10	0	1	0	1	0	17.90	3.67	0.00
(1V02) (528) Western New York HCS	57,452	54,348	94.60%	3,104	5.40%	124	0	52,249	0	2,099	0	1,282	0	593	0	323	0	906	0	10.07	7.97	4.51
(1V02) (528) Buffalo, NY	45,300	42,665	94.18%	2,635	5.82%	0	0	40,846	0	1,819	0	1,093	0	488	0	273	0	781	0	17.68	8.02	5.20
(1V02) (528A4) Batavia, NY	4,189	3,935	93.94%	254	6.06%	0	0	3,811	0	124	0	106	0	83	0	33	0	32	0	5.07	7.69	3.24
(1V02) (528GB) Jamestown, NY	2,330	2,297	98.58%	33	1.42%	0	0	2,257	0	40	0	22	0	2	0	2	0	7	0	2.27	0.00	0.79
(1V02) (528GC) Dunkirk, NY	1,468	1,459	99.39%	9	0.61%	0	0	1,452	0	7	0	2	0	1	0	1	0	5	0	1.71	0.00	0.41
(1V02) (528GD) Niagara Falls, NY	1,246	1,157	92.86%	89	7.14%	0	0	1,115	0	42	0	31	0	12	0	9	0	37	0	10.89	5.14	1.47
(1V02) (528GK) Lockport, NY	1,018	975	95.78%	43	4.22%	0	0	944	0	31	0	13	0	3	0	4	0	23	0	9.06	0.00	0.91
(1V02) (528GQ) West Seneca, NY	1,158	1,133	97.84%	25	2.16%	0	0	1,114	0	19	0	3	0	4	0	1	0	17	0	5.73	0.00	0.00
(1V02) (528GR) Olean, NY	630	617	97.94%	13	2.06%	0	0	601	0	16	0	11	0	0	0	0	0	2	0	2.32	0.50	0.26
(1V02) (528QA) Buffalo Main Street, NY	70	69	98.57%	1	1.43%	0	0	68	0	1	0	1	0	0	0	0	0	0	0	3.00		
(1V02) (528QB) Packard, NY	43	41	95.35%	2	4.65%	0	0	41	0	0	0	0	0	0	0	0	0	2	0	19.24		
(1V02) (528A7) Syracuse, NY HCS	77,101	72,528	94.07%	4,573	5.93%	0	0	68,996	0	3,532	0	2,174	0	967	0	650	0	782	0	3.77	8.63	4.83
(1V02) (528A7) Syracuse, NY	39,646	36,912	93.10%	2,734	6.90%	0	0	34,702	0	2,210	0	1,323	0	608	0	363	0	440	0	4.50	7.96	3.18
(1V02) (528G5) Auburn, NY	1,790	1,729	96.59%	61	3.41%	0	0	1,630	0	99	0	38	0	14	0	1	0	8	0	4.73	6.11	4.13
(1V02) (528G9) Tompkins County, NY	2,107	2,054	97.48%	53	2.52%	0	0	1,993	0	61	0	28	0	8	0	3	0	14	0	4.26	0.15	3.71
(1V02) (528GL) Massena, NY	2,182	2,140	98.08%	42	1.92%	0	0	2,082	0	58	0	24	0	6	0	3	0	9	0	4.23	2.85	1.29
(1V02) (528GM) Rome, NY (Donald J. Mitchell)	8,627	8,058	93.40%	569	6.60%	0	0	7,751	0	307	0	161	0	143	0	212	0	53	0	4.11	11.28	4.31
(1V02) (528GN) Binghamton, NY	6,065	5,761	94.99%	304	5.01%	0	0	5,552	0	209	0	157	0	51	0	24	0	72	0	3.60	8.39	2.84
(1V02) (528GO) Watertown, NY	5,679	5,568	98.05%	111	1.95%	0	0	5,454	0	114	0	70	0	17	0	4	0	20	0	3.04	1.88	3.15
(1V02) (528GP) Oswego, NY	2,091	2,082	99.57%	9	0.43%	0	0	2,059	0	23	0	6	0	1	0	1	0	1	0	1.01	0.44	1.12
(1V02) (528QG) Erie West, NY	3,888	3,588	92.28%	300	7.72%	0	0	3,330	0	258	0	235	0	50	0	8	0	7	0		0.54	6.84
(1V02) (528QH) South Salina, NY	82	82	100.00%	0	0.00%	0	0	82	0	0	0	0	0	0	0	0	0	0	0			
(1V02) (528QI) Erie East, NY	1,923	1,674	87.05%	249	12.95%	0	0	1,523	0	151	0	124	0	64	0	25	0	36	0		13.69	
(1V02) (528QN) Watertown 2, NY	3,021	2,880	95.33%	141	4.67%	0	0	2,838	0	42	0	8	0	5	0	6	0	122	0		10.55	2.86
(1V02) (526) Bronx, NY HCS	28,911	27,210	94.12%	1,701	5.88%	6	0	25,962	0	1,248	0	846	0	306	0	142	0	407	0	6.40	8.31	1.00
(1V02) (526) Bronx, NY (James J. Peters)	27,369	25,744	94.06%	1,625	5.94%	0	0	24,539	0	1,205	0	804	0	295	0	137	0	389	0	7.17	8.31	1.13
(1V02) (526GA) White Plains, NY	880	824	93.64%	56	6.36%	0	0	795	0	29	0	29	0	4	0	5	0	18	0	1.53	1.83	0.01
(1V02) (526GB) Yonkers, NY	433	432	99.77%	1	0.23%	0	0	431	0	1	0	1	0	0	0	0	0	0	0	1.17		0.00
(1V02) (526GD) Sunnyside, NY (Thomas P. Noonan Jr.)	229	210	91.70%	19	8.30%	0	0	197	0	13	0	12	0	7	0	0	0	0	0	7.69		
(1V02) (561) New Jersey HCS	59,504	52,027	87.43%	7,477	12.57%	6	0	49,447	0	2,580	0	2,818	0	1,223	0	864	0	2,572	0	5.86	27.61	3.28
(1V02) (561) East Orange, NJ	24,198	20,836	86.11%	3,362	13.89%	0	0	19,440	0	1,396	0	1,592	0	626	0	387	0	757	0	12.21	17.30	4.72
(1V02) (561A4) Lyons, NJ	12,309	9,925	80.63%	2,384	19.37%	0	0	9,371	0	554	0	544	0	297	0	270	0	1,273	0	3.73	41.90	2.06
(1V02) (561BZ) Brick, NJ (James J. Howard)	12,675	11,305	89.19%	1,370	10.81%	0	0	10,964	0	341	0	461	0	260	0	174	0	475	0	3.69	33.83	4.23
(1V02) (561GA) Hamilton, NJ	449	445	99.11%	4	0.89%	0	0	440	0	5	0	2	0	0	0	1	0	1	0	2.74	0.19	0.00
(1V02) (561GD) Hackensack, NJ	2,834	2,811	99.19%	23	0.81%	0	0	2,784	0	27	0	10	0	5	0	2	0	6	0	2.18	0.77	0.16
(1V02) (561GE) Jersey City, NJ	921	912	99.02%	9	0.98%	0	0	908	0	4	0	5	0	0	0	0	0	4	0	0.78		12.00
(1V02) (561GF) Piscataway, NJ	1,180	1,091	92.46%	89	7.54%	0	0	997	0	94	0	74	0	4	0	3	0	8	0	7.42	0.00	4.92
(1V02) (561GH) Morristown, NJ	948	857	90.40%	91	9.60%	0	0	784	0	73	0	46	0	10	0	8	0	27	0	17.37		1.35
(1V02) (561GI) Tinton Falls, NJ	2,632	2,565	97.45%	67	2.55%	0	0	2,513	0	52	0	30	0	12	0	9	0	16	0	2.55	10.25	1.45
(1V02) (561GJ) Paterson, NJ	1,013	937	92.50%	76	7.50%	0	0	904	0	33	0	52	0	9	0	10	0	5	0	8.56		4.94

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(1V02) (561GK) Sussex, NJ	345	343	99.42%	2	0.58%	0	0	342	0	1	0	2	0	0	0	0	0	0	0	1.07		
(1V02) (620) Hudson Valley, NY HCS	21,469	20,022	93.26%	1,447	6.74%	4	0	18,986	0	1,036	0	823	0	236	0	126	0	262	0	7.31	7.62	2.39
(1V02) (620) Montrose, NY (Franklin Delano Roosevelt)	3,915	3,658	93.44%	257	6.56%	0	0	3,529	0	129	0	97	0	58	0	32	0	70	0	15.30	8.30	2.76
(1V02) (620A4) Castle Point, NY	10,542	9,645	91.49%	897	8.51%	0	0	9,037	0	608	0	564	0	149	0	74	0	110	0	7.69	7.07	1.46
(1V02) (620GA) New City, NY	1,440	1,410	97.92%	30	2.08%	0	0	1,371	0	39	0	15	0	5	0	4	0	6	0	5.48	3.62	2.72
(1V02) (620GB) Carmel, NY	905	826	91.27%	79	8.73%	0	0	784	0	42	0	17	0	5	0	3	0	54	0	10.34	18.45	0.00
(1V02) (620GD) Goshen, NY	1,301	1,258	96.69%	43	3.31%	0	0	1,190	0	68	0	31	0	4	0	2	0	6	0	7.04	3.66	0.33
(1V02) (620GE) Port Jervis, NY	1,393	1,338	96.05%	55	3.95%	0	0	1,282	0	56	0	42	0	1	0	1	0	11	0	4.35	9.07	4.00
(1V02) (620GF) Monticello, NY	687	646	94.03%	41	5.97%	0	0	602	0	44	0	24	0	6	0	8	0	3	0	3.88	8.05	5.34
(1V02) (620GG) Poughkeepsie, NY	1,065	1,041	97.75%	24	2.25%	0	0	1,006	0	35	0	17	0	4	0	2	0	1	0	5.34	2.73	0.00
(1V02) (620GH) Eastern Dutchess, NY	221	200	90.50%	21	9.50%	0	0	185	0	15	0	16	0	4	0	0	0	1	0	7.77	7.68	
(1V02) (630) New York Harbor HCS	44,883	42,286	94.21%	2,597	5.79%	15	0	40,322	0	1,964	0	1,497	0	713	0	282	0	105	0	5.18	7.86	1.27
(1V02) (630) Manhattan, NY	18,922	18,236	96.37%	686	3.63%	0	0	17,289	0	947	0	567	0	82	0	14	0	23	0	5.60	4.15	2.05
(1V02) (630A4) Brooklyn, NY	22,567	21,056	93.30%	1,511	6.70%	0	0	20,347	0	709	0	622	0	555	0	258	0	76	0	4.78	10.98	0.53
(1V02) (630A5) St. Albans, NY	2,185	1,898	86.86%	287	13.14%	0	0	1,710	0	188	0	234	0	44	0	5	0	4	0	8.89	11.75	0.13
(1V02) (630GA) Harlem, NY	173	173	100.00%	0	0.00%	0	0	173	0	0	0	0	0	0	0	0	0	0	0	0.14		0.00
(1V02) (630GB) Staten Island, NY	1,036	923	89.09%	113	10.91%	0	0	803	0	120	0	74	0	32	0	5	0	2	0	4.83	7.14	0.00
(1V02) (632) Northport, NY HCS	32,328	30,459	94.22%	1,869	5.78%	11	0	29,152	0	1,307	0	1,048	0	346	0	176	0	299	0	9.78	7.00	3.88
(1V02) (632) Northport, NY	26,098	24,485	93.82%	1,613	6.18%	0	0	23,420	0	1,065	0	870	0	304	0	149	0	290	0	19.11	7.04	2.66
(1V02) (632GA) East Meadow, NY	1,503	1,456	96.87%	47	3.13%	0	0	1,415	0	41	0	38	0	7	0	0	0	2	0	4.20	7.29	0.53
(1V02) (632HA) Valley Stream, NY	760	681	89.61%	79	10.39%	0	0	572	0	109	0	43	0	23	0	9	0	4	0	15.07		4.19
(1V02) (632HB) Riverhead, NY	1,463	1,451	99.18%	12	0.82%	0	0	1,432	0	19	0	8	0	2	0	2	0	0	0	2.15	1.34	1.79
(1V02) (632HC) Bay Shore, NY	1,219	1,181	96.88%	38	3.12%	0	0	1,148	0	33	0	27	0	5	0	5	0	1	0	5.20		9.53
(1V02) (632HD) Patchogue, NY	1,285	1,205	93.77%	80	6.23%	0	0	1,165	0	40	0	62	0	5	0	11	0	2	0	6.27	13.56	21.96
(1V04) (460) Wilmington, DE HCS	38,505	33,809	87.80%	4,696	12.20%	24	0	32,174	0	1,635	0	1,459	0	759	0	396	0	2,082	0	5.60	38.90	4.66
(1V04) (460) Wilmington, DE	25,384	21,480	84.62%	3,904	15.38%	0	0	20,314	0	1,166	0	1,103	0	597	0	331	0	1,873	0	6.71	41.65	4.59
(1V04) (460GA) Sussex County, DE	3,723	3,400	91.32%	323	8.68%	0	0	3,290	0	110	0	155	0	81	0	27	0	60	0	6.86	34.38	2.69
(1V04) (460GC) Kent County, DE	2,361	2,226	94.28%	135	5.72%	0	0	2,128	0	98	0	46	0	27	0	10	0	52	0	4.98	39.08	16.08
(1V04) (460GD) Cape May County, NJ	1,283	1,160	90.41%	123	9.59%	0	0	1,096	0	64	0	40	0	20	0	15	0	48	0	6.11	38.30	4.50
(1V04) (460HE) Atlantic County, NJ	3,299	3,216	97.48%	83	2.52%	0	0	3,120	0	96	0	33	0	20	0	9	0	21	0	2.79	8.67	2.89
(1V04) (460HG) Cumberland County, NJ	2,455	2,327	94.79%	128	5.21%	0	0	2,226	0	101	0	82	0	14	0	4	0	28	0	2.87	18.57	1.82
(1V04) (503) Altoona, PA HCS	47,230	46,519	98.49%	711	1.51%	0	0	45,077	0	1,442	0	463	0	152	0	61	0	35	0	1.29	4.25	2.94
(1V04) (503) Altoona, PA (James E. Van Zandt)	25,053	24,514	97.85%	539	2.15%	0	0	23,584	0	930	0	352	0	113	0	51	0	23	0	1.12	4.31	3.89
(1V04) (503GA) Johnstown, PA	7,226	7,162	99.11%	64	0.89%	0	0	7,042	0	120	0	41	0	17	0	4	0	2	0	1.33	3.92	1.13
(1V04) (503GB) DuBois, PA	5,678	5,645	99.42%	33	0.58%	0	0	5,442	0	203	0	28	0	4	0	1	0	0	0	1.92	4.15	2.83
(1V04) (503GC) State College, PA	5,703	5,654	99.14%	49	0.86%	0	0	5,517	0	137	0	29	0	12	0	3	0	5	0	1.49	4.29	0.93
(1V04) (503GD) Huntingdon County, PA	1,657	1,643	99.16%	14	0.84%	0	0	1,616	0	27	0	7	0	3	0	1	0	3	0	1.05	4.93	0.08
(1V04) (503GE) Indiana County, PA	1,913	1,901	99.37%	12	0.63%	0	0	1,876	0	25	0	6	0	3	0	1	0	2	0	0.38	3.42	1.70
(1V04) (529) Butler, PA HCS	25,839	25,455	98.51%	384	1.49%	2	0	24,982	0	473	0	216	0	52	0	62	0	54	0	0.62	4.10	2.36
(1V04) (529) Duffy Road, PA (Abie Abraham)	14,745	14,372	97.47%	373	2.53%	0	0	13,957	0	415	0	214	0	51	0	60	0	48	0	1.07	4.16	2.16
(1V04) (529A4) New Castle Road, PA (Butler)	1,669	1,669	100.00%	0	0.00%	0	0	1,668	0	1	0	0	0	0	0	0	0	0	0	0.05	10.50	
(1V04) (529GA) Hermitage, PA (Michael A. Marzano)	2,555	2,546	99.65%	9	0.35%	0	0	2,524	0	22	0	2	0	1	0	2	0	4	0	0.46	0.72	8.98
(1V04) (529GB) Lawrence County, PA	1,537	1,536	99.93%	1	0.07%	0	0	1,529	0	7	0	0	0	0	0	0	0	1	0	0.16	0.00	1.51

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(1V04) (529GC) Armstrong County, PA	1,621	1,621	100.00%	0	0.00%	0	0	1,615	0	6	0	0	0	0	0	0	0	0	0	0.17	2.19	1.71
(1V04) (529GD) Clarion County, PA	1,233	1,233	100.00%	0	0.00%	0	0	1,218	0	15	0	0	0	0	0	0	0	0	0	1.20	3.44	2.67
(1V04) (529GF) Cranberry Township, PA	2,479	2,478	99.96%	1	0.04%	0	0	2,471	0	7	0	0	0	0	0	0	0	1	0	0.37	1.24	1.19
(1V04) (542) Coatesville, PA HCS	14,582	13,425	92.07%	1,157	7.93%	52	0	12,957	0	468	0	328	0	130	0	166	0	533	0	3.30	31.77	4.42
(1V04) (542) Coatesville, PA	10,434	9,348	89.59%	1,086	10.41%	0	0	8,979	0	369	0	280	0	126	0	165	0	515	0	2.59	31.92	4.97
(1V04) (542BU) Coatesville, PA - VADOM	20	20	100.00%	0	0.00%	0	0	20	0	0	0	0	0	0	0	0	0	0	0			2.13
(1V04) (542GA) Delaware County, PA	2,149	2,119	98.60%	30	1.40%	0	0	2,080	0	39	0	20	0	2	0	1	0	7	0	2.97	0.61	3.10
(1V04) (542GE) Spring City, PA	1,979	1,938	97.93%	41	2.07%	0	0	1,878	0	60	0	28	0	2	0	0	0	11	0	4.77		2.11
(1V04) (562) Erie, PA HCS	30,860	28,475	92.27%	2,385	7.73%	59	0	27,441	0	1,034	0	791	0	400	0	461	0	733	0	4.25	27.72	1.21
(1V04) (562) Erie, PA	20,805	18,825	90.48%	1,980	9.52%	0	0	18,125	0	700	0	628	0	285	0	407	0	660	0	4.27	29.18	1.22
(1V04) (562GA) Crawford County, PA	2,809	2,667	94.94%	142	5.06%	0	0	2,517	0	150	0	60	0	28	0	27	0	27	0	6.03	11.87	1.55
(1V04) (562GB) Ashtabula County, OH	1,876	1,833	97.71%	43	2.29%	0	0	1,788	0	45	0	22	0	5	0	4	0	12	0	2.63	1.91	1.05
(1V04) (562GC) McKean County, PA	500	485	97.00%	15	3.00%	0	0	467	0	18	0	6	0	3	0	0	0	6	0	3.88	25.87	0.00
(1V04) (562GD) Venango County, PA	1,978	1,938	97.98%	40	2.02%	0	0	1,865	0	73	0	19	0	10	0	4	0	7	0	3.87	9.60	1.55
(1V04) (562GE) Warren County, PA	2,892	2,727	94.29%	165	5.71%	0	0	2,679	0	48	0	56	0	69	0	19	0	21	0	4.03	17.38	0.69
(1V04) (595) Lebanon, PA HCS	75,980	69,728	91.77%	6,252	8.23%	9	0	66,485	0	3,243	0	2,553	0	1,196	0	643	0	1,860	0	6.26	15.84	4.47
(1V04) (595) Lebanon, PA	51,668	46,993	90.95%	4,675	9.05%	0	0	44,767	0	2,226	0	1,917	0	955	0	495	0	1,308	0	4.66	14.03	4.56
(1V04) (595GA) Cumberland County, PA	10,652	10,171	95.48%	481	4.52%	0	0	9,700	0	471	0	227	0	94	0	28	0	132	0	6.19	15.07	5.39
(1V04) (595GC) Lancaster County, PA	2,543	2,327	91.51%	216	8.49%	0	0	2,188	0	139	0	119	0	36	0	27	0	34	0	7.11	21.86	3.56
(1V04) (595GD) Berks County, PA	3,375	3,327	98.58%	48	1.42%	0	0	3,276	0	51	0	26	0	3	0	4	0	15	0	3.35	5.91	1.11
(1V04) (595GE) York, PA	6,425	5,678	88.37%	747	11.63%	0	0	5,388	0	290	0	221	0	98	0	81	0	347	0	12.95	52.71	4.63
(1V04) (595GF) Schuylkill County, PA	1,277	1,194	93.50%	83	6.50%	0	0	1,128	0	66	0	43	0	10	0	7	0	23	0	11.88		1.38
(1V04) (595PA) Lebanon, PA - PRRTP	4	4	100.00%	0	0.00%	0	0	4	0	0	0	0	0	0	0	0	0	0	0			
(1V04) (595QA) Annville, PA (Fort Indiantown Gap)	36	34	94.44%	2	5.56%	0	0	34	0	0	0	0	0	0	0	1	0	1	0	10.22		
(1V04) (642) Philadelphia, PA HCS	73,854	67,084	90.83%	6,770	9.17%	26	3	63,352	3	3,732	0	2,932	0	1,534	0	878	0	1,426	0	5.23	12.64	2.45
(1V04) (642) Philadelphia, PA (Corporal Michael J. Crescenz)	52,900	46,910	88.68%	5,990	11.32%	0	0	43,858	0	3,052	0	2,587	0	1,394	0	754	0	1,255	0	6.12	12.79	2.81
(1V04) (642GA) Burlington County, NJ	6,301	6,127	97.24%	174	2.76%	0	0	5,961	0	166	0	76	0	26	0	15	0	57	0	4.57	9.39	1.34
(1V04) (642GC) Horsham, PA (Victor J. Saracini)	8,003	7,637	95.43%	366	4.57%	0	1	7,317	1	320	0	145	0	78	0	50	0	93	0	5.79	10.27	2.72
(1V04) (642GD) Gloucester County, NJ	3,663	3,490	95.28%	173	4.72%	0	2	3,374	2	116	0	81	0	27	0	49	0	16	0	2.88	17.43	10.94
(1V04) (642GF) Camden, NJ	1,399	1,344	96.07%	55	3.93%	0	0	1,291	0	53	0	32	0	9	0	10	0	4	0	6.24	23.00	0.09
(1V04) (642GH) West Philadelphia, PA	663	658	99.25%	5	0.75%	0	0	633	0	25	0	4	0	0	0	0	0	1	0	2.76		1.00
(1V04) (642QA) Chestnut Street, PA	925	918	99.24%	7	0.76%	0	0	918	0	0	0	7	0	0	0	0	0	0	0			
(1V04) (646) Pittsburgh, PA HCS	78,154	72,885	93.26%	5,269	6.74%	21	0	68,839	0	4,046	0	2,675	0	920	0	439	0	1,235	0	5.48	12.35	4.52
(1V04) (646) Pittsburgh, PA	36,791	33,190	90.21%	3,601	9.79%	0	0	30,915	0	2,275	0	1,669	0	659	0	330	0	943	0	11.05	13.63	4.13
(1V04) (646A4) Heinz, PA (H. John Heinz III)	9,633	8,666	89.96%	967	10.04%	0	0	8,072	0	594	0	520	0	164	0	80	0	203	0	12.40	14.37	5.98
(1V04) (646GA) Belmont County, OH	4,868	4,809	98.79%	59	1.21%	0	0	4,601	0	208	0	51	0	3	0	2	0	3	0	2.53	2.31	4.48
(1V04) (646GB) Westmoreland County, PA	9,709	9,541	98.27%	168	1.73%	0	0	9,171	0	370	0	109	0	26	0	4	0	29	0	4.45	4.10	3.49
(1V04) (646GC) Beaver County, PA	5,628	5,508	97.87%	120	2.13%	0	0	5,284	0	224	0	80	0	13	0	8	0	19	0	3.77	3.19	3.99
(1V04) (646GD) Washington County, PA	6,705	6,471	96.51%	234	3.49%	0	0	6,237	0	234	0	159	0	43	0	9	0	23	0	3.76	9.27	5.18
(1V04) (646GE) Fayette County, PA	4,820	4,700	97.51%	120	2.49%	0	0	4,559	0	141	0	87	0	12	0	6	0	15	0	3.41	2.24	5.59
(1V04) (693) Wilkes-Barre, PA HCS	56,119	52,353	93.29%	3,766	6.71%	14	0	50,611	0	1,742	0	1,534	0	782	0	350	0	1,100	0	2.40	12.71	6.58
(1V04) (693) Wilkes-Barre, PA	37,838	34,817	92.02%	3,021	7.98%	0	0	33,539	0	1,278	0	1,181	0	605	0	282	0	953	0	2.11	13.87	3.89
(1V04) (693B4) Allentown, PA	9,876	9,249	93.65%	627	6.35%	0	0	8,967	0	282	0	288	0	160	0	57	0	122	0	3.75	7.61	13.58

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(1V04) (693GA) Sayre, PA	1,755	1,709	97.38%	46	2.62%	0	0	1,670	0	39	0	21	0	9	0	1	0	15	0	2.00	7.77	3.56
(1V04) (693GB) Williamsport, PA	3,427	3,397	99.12%	30	0.88%	0	0	3,348	0	49	0	10	0	7	0	7	0	6	0	1.13	0.86	2.82
(1V04) (693GC) Tobyhanna, PA	329	325	98.78%	4	1.22%	0	0	320	0	5	0	2	0	0	0	1	0	1	0	2.28	21.00	0.00
(1V04) (693GF) Columbia County, PA	1,463	1,444	98.70%	19	1.30%	0	0	1,413	0	31	0	15	0	0	0	2	0	2	0	2.35		0.06
(1V04) (693GG) Northampton County, PA	635	630	99.21%	5	0.79%	0	0	611	0	19	0	4	0	0	0	0	0	1	0	2.30		1.08
(1V04) (693QA) Wayne County, PA	796	782	98.24%	14	1.76%	0	0	743	0	39	0	13	0	1	0	0	0	0	0	2.77		
(1V05) (540) Clarksburg, WV HCS	33,177	31,831	95.94%	1,346	4.06%	8	0	30,614	0	1,217	0	740	0	290	0	114	0	202	0	3.97	6.17	4.85
(1V05) (540) Clarksburg, WV (Louis A. Johnson)	28,050	26,870	95.79%	1,180	4.21%	0	0	25,867	0	1,003	0	635	0	264	0	102	0	179	0	3.58	6.14	5.33
(1V05) (540BU) Clarksburg, WV - VADOM	7	7	100.00%	0	0.00%	0	0	7	0	0	0	0	0	0	0	0	0	0	0			
(1V05) (540GA) Tucker County, WV	436	427	97.94%	9	2.06%	0	0	384	0	43	0	7	0	1	0	1	0	0	0	5.38		6.69
(1V05) (540GB) Wood County, WV	2,246	2,127	94.70%	119	5.30%	0	0	2,020	0	107	0	71	0	19	0	8	0	21	0	6.81	8.66	5.77
(1V05) (540GC) Braxton County, WV	1,003	1,001	99.80%	2	0.20%	0	0	991	0	10	0	2	0	0	0	0	0	0	0	1.04	0.00	2.48
(1V05) (540GD) Monongalia County, WV	1,331	1,299	97.60%	32	2.40%	0	0	1,254	0	45	0	21	0	6	0	3	0	2	0	5.55	6.42	1.07
(1V05) (540HK) Clarksburg, WV - Mobile	104	100	96.15%	4	3.85%	0	0	91	0	9	0	4	0	0	0	0	0	0	0	9.38		
(1V05) (512) Baltimore, MD HCS	51,900	46,154	88.93%	5,746	11.07%	12	1	43,390	1	2,764	0	2,332	0	1,186	0	627	0	1,601	0	3.32	12.81	19.15
(1V05) (512) Baltimore, MD	32,984	28,246	85.64%	4,738	14.36%	0	0	26,381	0	1,865	0	1,831	0	986	0	522	0	1,399	0	6.84	15.15	26.89
(1V05) (512A5) Perry Point, MD	5,803	5,488	94.57%	315	5.43%	0	0	5,250	0	238	0	122	0	68	0	28	0	97	0	1.69	12.34	4.25
(1V05) (512GA) Cambridge, MD	3,118	3,011	96.57%	107	3.43%	0	0	2,919	0	92	0	37	0	41	0	5	0	24	0	2.91	5.59	2.53
(1V05) (512GC) Glen Burnie, MD	2,421	2,323	95.95%	98	4.05%	0	0	2,183	0	140	0	36	0	15	0	28	0	19	0	1.82	6.69	4.54
(1V05) (512GD) Loch Raven, MD	3,530	3,276	92.80%	254	7.20%	0	0	3,057	0	219	0	178	0	57	0	13	0	6	0	3.93	7.14	6.43
(1V05) (512GE) Pocomoke City, MD	643	630	97.98%	13	2.02%	0	0	590	0	40	0	11	0	1	0	0	0	1	0	0.85	0.89	4.62
(1V05) (512GF) Eastern Baltimore County, MD	1,074	1,041	96.93%	33	3.07%	0	1	967	1	74	0	31	0	1	0	0	0	1	0	0.88	7.78	3.51
(1V05) (512GG) Fort Meade, MD	1,582	1,493	94.37%	89	5.63%	0	0	1,434	0	59	0	26	0	15	0	25	0	23	0	0.24	1.58	38.94
(1V05) (512PA) 512PA	121	92	76.03%	29	23.97%	0	0	60	0	32	0	27	0	2	0	0	0	0	0			
(1V05) (512QA) Baltimore West Fayette Street, MD	624	554	88.78%	70	11.22%	0	0	549	0	5	0	33	0	0	0	6	0	31	0			23.42
(1V05) (613) Martinsburg, WV HCS	45,943	42,571	92.66%	3,372	7.34%	32	0	40,736	0	1,835	0	1,549	0	508	0	360	0	955	0	3.36	12.30	10.55
(1V05) (613) Martinsburg, WV	30,453	27,664	90.84%	2,789	9.16%	0	0	26,315	0	1,349	0	1,261	0	415	0	266	0	847	0	3.76	12.18	12.00
(1V05) (613BU) Martinsburg, WV - VADOM	58	57	98.28%	1	1.72%	0	0	57	0	0	0	1	0	0	0	0	0	0	0			0.00
(1V05) (613GA) Cumberland, MD	2,159	1,948	90.23%	211	9.77%	0	0	1,853	0	95	0	69	0	13	0	65	0	64	0	3.16	48.70	1.63
(1V05) (613GB) Hagerstown, MD	3,109	2,993	96.27%	116	3.73%	0	0	2,903	0	90	0	62	0	36	0	4	0	14	0	3.65	35.82	16.70
(1V05) (613GC) Stephens City, VA	3,216	3,122	97.08%	94	2.92%	0	0	3,052	0	70	0	72	0	14	0	2	0	6	0	3.17	6.40	6.06
(1V05) (613GD) Franklin, WV	161	160	99.38%	1	0.62%	0	0	159	0	1	0	0	0	1	0	0	0	0	0	1.82		0.00
(1V05) (613GE) Petersburg, WV	1,262	1,255	99.45%	7	0.55%	0	0	1,236	0	19	0	4	0	0	0	1	0	2	0	1.35	0.00	7.72
(1V05) (613GF) Harrisonburg, VA	1,977	1,945	98.38%	32	1.62%	0	0	1,907	0	38	0	22	0	3	0	6	0	1	0	1.29	0.00	3.46
(1V05) (613GG) Fort Detrick, MD	3,548	3,427	96.59%	121	3.41%	0	0	3,254	0	173	0	58	0	26	0	16	0	21	0	5.85	4.32	12.46
(1V05) (688) Washington, DC HCS	54,728	50,241	91.80%	4,487	8.20%	28	1	47,494	1	2,747	0	2,044	0	1,092	0	620	0	731	0	2.26	12.58	9.44
(1V05) (688) Washington, DC	45,397	41,196	90.75%	4,201	9.25%	0	1	38,709	1	2,487	0	1,890	0	1,017	0	597	0	697	0	1.77	13.01	18.51
(1V05) (688GA) Fort Belvoir, VA	3,008	2,976	98.94%	32	1.06%	0	0	2,928	0	48	0	23	0	4	0	1	0	4	0	3.01	1.82	0.15
(1V05) (688GB) Southeast Washington, DC	224	219	97.77%	5	2.23%	0	0	212	0	7	0	2	0	2	0	1	0	0	0	4.07	0.76	3.59
(1V05) (688GD) Charlotte Hall, MD	2,016	1,984	98.41%	32	1.59%	0	0	1,945	0	39	0	13	0	16	0	2	0	1	0	2.87	1.95	0.42
(1V05) (688GE) Southern Prince Georges County, MD	2,301	2,177	94.61%	124	5.39%	0	0	2,108	0	69	0	59	0	31	0	15	0	19	0	1.81	13.56	2.15
(1V05) (688GF) Montgomery County, MD	1,253	1,163	92.82%	90	7.18%	0	0	1,072	0	91	0	54	0	22	0	4	0	10	0	1.67	9.35	2.86

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(1V05) (688GG) Lexington Park, MD	519	517	99.61%	2	0.39%	0	0	512	0	5	0	2	0	0	0	0	0	0	0	0.13	11.20	0.00
(1V05) (688QA) Franklin Street, DC	10	9	90.00%	1	10.00%	0	0	8	0	1	0	1	0	0	0	0	0	0	0			0.00
(1V05) (517) Beckley, WV HCS	24,278	23,077	95.05%	1,201	4.95%	0	0	22,421	0	656	0	469	0	250	0	158	0	324	0	2.57	9.59	2.42
(1V05) (517) Beckley, WV	21,293	20,140	94.59%	1,153	5.41%	0	0	19,649	0	491	0	440	0	239	0	155	0	319	0	1.89	9.59	2.24
(1V05) (517GB) Greenbrier County, WV	1,802	1,798	99.78%	4	0.22%	0	0	1,669	0	129	0	2	0	0	0	2	0	0	0	4.20	0.00	2.70
(1V05) (517HK) Beckley, WV - Mobile	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(1V05) (517QA) Princeton, WV	1,182	1,138	96.28%	44	3.72%	0	0	1,102	0	36	0	27	0	11	0	1	0	5	0	4.13	0.00	4.50
(1V05) (581) Huntington, WV HCS	48,676	46,033	94.57%	2,643	5.43%	0	0	43,873	0	2,160	0	1,266	0	480	0	299	0	598	0	3.00	12.14	2.67
(1V05) (581) Huntington, WV (Hershel "Woody" Williams)	36,984	34,568	93.47%	2,416	6.53%	0	0	32,817	0	1,751	0	1,151	0	430	0	279	0	556	0	3.29	12.49	3.32
(1V05) (581GA) Prestonsburg, KY	2,743	2,652	96.68%	91	3.32%	0	0	2,609	0	43	0	45	0	22	0	10	0	14	0	2.13	22.04	1.62
(1V05) (581GB) Charleston, WV	7,441	7,324	98.43%	117	1.57%	0	0	6,974	0	350	0	60	0	25	0	9	0	23	0	3.27	6.56	1.35
(1V05) (581GG) Gallipolis, OH	962	950	98.75%	12	1.25%	0	0	940	0	10	0	8	0	0	0	1	0	3	0	0.85	0.04	0.44
(1V05) (581GH) Lenore, WV	543	536	98.71%	7	1.29%	0	0	530	0	6	0	2	0	3	0	0	0	2	0	1.83	0.00	0.17
(1V05) (581QA) Huntington Ninth Street, WV	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0.00		
(1V06) (558) Durham, NC HCS	113,100	99,764	88.21%	13,336	11.79%	69	0	94,619	0	5,145	0	5,005	0	3,017	0	1,929	0	3,385	0	7.32	15.41	11.75
(1V06) (558) Durham, NC	61,892	52,640	85.05%	9,252	14.95%	0	0	49,641	0	2,999	0	3,311	0	2,056	0	1,394	0	2,491	0	12.93	15.13	6.07
(1V06) (558GA) Greenville, NC	25,971	23,610	90.91%	2,361	9.09%	0	0	22,587	0	1,023	0	868	0	491	0	323	0	679	0	5.60	16.86	5.24
(1V06) (558GB) Raleigh, NC	5,685	5,377	94.58%	308	5.42%	0	0	5,089	0	288	0	178	0	55	0	28	0	47	0	7.08	21.82	4.81
(1V06) (558GC) Morehead City, NC	3,821	3,665	95.92%	156	4.08%	0	0	3,519	0	146	0	102	0	38	0	7	0	9	0	2.89	2.88	6.95
(1V06) (558GD) Durham County, NC	1,812	1,748	96.47%	64	3.53%	0	0	1,694	0	54	0	46	0	13	0	3	0	2	0			3.08
(1V06) (558GE) Hillandale Road, NC	4,899	4,615	94.20%	284	5.80%	0	0	4,398	0	217	0	152	0	65	0	29	0	38	0	10.36	0.00	
(1V06) (558GF) Wake County, NC	2,643	2,158	81.65%	485	18.35%	0	0	2,004	0	154	0	178	0	158	0	94	0	55	0			49.66
(1V06) (558GG) Raleigh-Atlantic Avenue, NC	3,810	3,589	94.20%	221	5.80%	0	0	3,473	0	116	0	92	0	80	0	27	0	22	0	4.64	12.98	0.59
(1V06) (558GH) Clayton-East Raleigh, NC	2,434	2,231	91.66%	203	8.34%	0	0	2,094	0	137	0	76	0	61	0	24	0	42	0	2.28	10.69	5.44
(1V06) (558QA) Brier Creek, NC	133	131	98.50%	2	1.50%	0	0	120	0	11	0	2	0	0	0	0	0	0	0		2.49	
(1V06) (565) Fayetteville, NC HCS	117,342	106,153	90.46%	11,189	9.54%	111	1	100,249	0	5,904	0	4,876	0	2,196	0	1,402	0	2,715	1	7.46	21.10	2.99
(1V06) (565) Fayetteville, NC	16,660	15,169	91.05%	1,491	8.95%	0	0	14,723	0	446	0	471	0	176	0	75	0	769	0	0.09	32.92	1.10
(1V06) (565GA) Jacksonville, NC	5,284	5,194	98.30%	90	1.70%	0	0	5,082	0	112	0	58	0	12	0	4	0	16	0	1.76	20.63	0.38
(1V06) (565GC) Wilmington, NC	19,923	18,731	94.02%	1,192	5.98%	0	0	17,551	0	1,180	0	533	0	286	0	142	0	231	0	4.73	12.43	2.35
(1V06) (565GD) Hamlet, NC	1,485	1,428	96.16%	57	3.84%	0	0	1,369	0	59	0	35	0	3	0	0	0	19	0	6.60		3.30
(1V06) (565GE) Robeson County, NC	2,348	2,305	98.17%	43	1.83%	0	0	2,223	0	82	0	32	0	6	0	1	0	4	0	2.87		0.18
(1V06) (565GF) Goldsboro, NC	3,252	3,121	95.97%	131	4.03%	0	0	2,972	0	149	0	62	0	60	0	3	0	6	0	3.37		11.26
(1V06) (565GG) Lee County, NC	3,451	3,378	97.88%	73	2.12%	0	0	3,200	0	178	0	51	0	11	0	5	0	6	0	4.20	4.60	4.07
(1V06) (565GH) Brunswick County, NC	2,111	2,032	96.26%	79	3.74%	0	0	1,995	0	37	0	40	0	13	0	18	0	8	0	4.23	7.79	1.30
(1V06) (565GJ) Jacksonville 2, NC	126	126	100.00%	0	0.00%	0	0	121	0	5	0	0	0	0	0	0	0	0	0	0.94		
(1V06) (565GL) Cumberland County, NC	59,443	51,710	86.99%	7,733	13.01%	0	1	48,241	0	3,469	0	3,423	0	1,549	0	1,129	0	1,632	1	10.67	19.45	0.56
(1V06) (565GM) Jacksonville 3, NC	1,286	1,180	91.76%	106	8.24%	0	0	1,146	0	34	0	35	0	58	0	13	0	0	0			8.71
(1V06) (565GN) Jacksonville 4, NC	35	23	65.71%	12	34.29%	0	0	10	0	13	0	11	0	1	0	0	0	0	0			25.00
(1V06) (565QA) Robeson Street, NC	1,122	1,101	98.13%	21	1.87%	0	0	1,098	0	3	0	13	0	3	0	3	0	2	0		43.03	
(1V06) (565QD) Raeford Road, NC	816	655	80.27%	161	19.73%	0	0	518	0	137	0	112	0	18	0	9	0	22	0		18.71	
(1V06) (590) Hampton, VA HCS	73,416	64,664	88.08%	8,752	11.92%	61	0	60,803	0	3,861	0	3,559	0	1,709	0	1,226	0	2,258	0	6.24	29.43	7.12
(1V06) (590) Hampton, VA	56,693	49,154	86.70%	7,539	13.30%	0	0	45,979	0	3,175	0	2,993	0	1,503	0	1,106	0	1,937	0	5.01	31.09	9.37
(1V06) (590BU) Hampton, VA - VADOM	5	5	100.00%	0	0.00%	0	0	5	0	0	0	0	0	0	0	0	0	0	0			

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(1V06) (590GB) Virginia Beach, VA	6,074	5,550	91.37%	524	8.63%	0	0	5,297	0	253	0	158	0	82	0	64	0	220	0	17.81	18.47	2.34
(1V06) (590GC) Albemarle, NC	1,402	1,321	94.22%	81	5.78%	0	0	1,272	0	49	0	57	0	14	0	7	0	3	0	4.19	0.00	4.29
(1V06) (590GD) Chesapeake, VA	7,787	7,356	94.47%	431	5.53%	0	0	7,054	0	302	0	258	0	70	0	23	0	80	0	4.86	9.51	4.98
(1V06) (590GE) Portsmouth, VA	1,455	1,278	87.84%	177	12.16%	0	0	1,196	0	82	0	93	0	40	0	26	0	18	0	16.57		7.65
(1V06) (637) Asheville, NC HCS	56,644	50,371	88.93%	6,273	11.07%	6	0	47,596	0	2,775	0	2,552	0	1,405	0	844	0	1,472	0	8.84	16.68	5.64
(1V06) (637) Asheville, NC (Charles George)	42,239	36,673	86.82%	5,566	13.18%	0	0	34,563	0	2,110	0	2,176	0	1,277	0	747	0	1,366	0	11.29	17.41	6.31
(1V06) (637GA) Franklin, NC	3,427	3,251	94.86%	176	5.14%	0	0	3,124	0	127	0	61	0	41	0	44	0	30	0	7.05	14.50	5.67
(1V06) (637GB) Rutherford County, NC	1,675	1,563	93.31%	112	6.69%	0	0	1,482	0	81	0	52	0	19	0	19	0	22	0	10.17	19.28	1.44
(1V06) (637GC) Hickory, NC	9,303	8,884	95.50%	419	4.50%	0	0	8,427	0	457	0	263	0	68	0	34	0	54	0	4.78	8.98	5.12
(1V06) (652) Richmond, VA HCS	117,307	106,900	91.13%	10,407	8.87%	58	0	101,782	0	5,118	0	3,792	0	2,011	0	1,649	0	2,955	0	6.82	17.55	7.12
(1V06) (652) Richmond, VA (Hunter Holmes McGuire)	98,582	89,057	90.34%	9,525	9.66%	0	0	84,533	0	4,524	0	3,387	0	1,794	0	1,570	0	2,774	0	7.58	17.42	9.08
(1V06) (652GA) Fredericksburg, VA	5,930	5,639	95.09%	291	4.91%	0	0	5,453	0	186	0	139	0	118	0	12	0	22	0	7.27	6.28	1.32
(1V06) (652GB) Fredericksburg 2, VA	4,095	4,017	98.10%	78	1.90%	0	0	3,870	0	147	0	44	0	17	0	6	0	11	0	1.73	6.93	3.36
(1V06) (652GC) Henrico County, VA	1,495	1,367	91.44%	128	8.56%	0	0	1,287	0	80	0	66	0	28	0	13	0	21	0	9.89	10.37	1.22
(1V06) (652GE) Charlottesville, VA	5,114	4,763	93.14%	351	6.86%	0	0	4,622	0	141	0	131	0	50	0	46	0	124	0	4.69	40.77	1.44
(1V06) (652GF) Emporia, VA	2,091	2,057	98.37%	34	1.63%	0	0	2,017	0	40	0	25	0	4	0	2	0	3	0	0.81	15.41	0.80
(1V06) (658) Salem, VA HCS	73,434	65,446	89.12%	7,988	10.88%	11	2	61,803	0	3,643	0	3,203	0	1,638	0	931	0	2,216	2	6.31	18.12	4.45
(1V06) (658) Salem, VA	59,146	51,694	87.40%	7,452	12.60%	0	2	48,418	0	3,276	0	2,981	0	1,479	0	865	0	2,127	2	7.34	18.19	3.49
(1V06) (658BU) Salem, VA - VADOM	5	5	100.00%	0	0.00%	0	0	4	0	1	0	0	0	0	0	0	0	0	0			
(1V06) (658GA) Tazewell, VA	747	735	98.39%	12	1.61%	0	0	725	0	10	0	6	0	2	0	2	0	2	0	2.18	14.67	2.30
(1V06) (658GB) Danville, VA	4,073	3,675	90.23%	398	9.77%	0	0	3,523	0	152	0	148	0	115	0	54	0	81	0	10.95	2.35	7.57
(1V06) (658GC) Lynchburg, VA	3,931	3,840	97.69%	91	2.31%	0	0	3,697	0	143	0	43	0	36	0	8	0	4	0	3.69	0.00	5.82
(1V06) (658GD) Staunton, VA	2,404	2,403	99.96%	1	0.04%	0	0	2,390	0	13	0	0	0	0	0	0	0	1	0	2.59	0.47	0.06
(1V06) (658GE) Wytheville, VA	3,128	3,094	98.91%	34	1.09%	0	0	3,046	0	48	0	25	0	6	0	2	0	1	0	1.46	0.00	3.36
(1V06) (659) Salisbury, NC HCS	180,398	154,747	85.78%	25,651	14.22%	81	2	145,402	1	9,345	0	8,124	1	4,653	0	2,905	0	9,969	0	6.55	37.83	10.98
(1V06) (659) Salisbury, NC (W.G. (Bill) Hefner Salisbury)	51,820	45,256	87.33%	6,564	12.67%	0	2	42,890	1	2,366	0	1,904	1	1,019	0	690	0	2,951	0	5.94	35.33	6.19
(1V06) (659BY) Kernersville, NC	63,820	52,880	82.86%	10,940	17.14%	0	0	49,881	0	2,999	0	3,357	0	2,285	0	1,386	0	3,912	0	8.00	40.43	18.77
(1V06) (659BZ) South Charlotte, NC	55,515	48,000	86.46%	7,515	13.54%	0	0	44,521	0	3,479	0	2,539	0	1,224	0	756	0	2,996	0	5.78	39.17	8.95
(1V06) (659GA) North Charlotte, NC	9,243	8,611	93.16%	632	6.84%	0	0	8,110	0	501	0	324	0	125	0	73	0	110	0	4.09	17.37	4.34
(2V07) (508) Atlanta, GA HCS	155,701	141,734	91.03%	13,967	8.97%	18	0	133,784	0	7,950	0	7,910	0	2,692	0	1,301	0	2,064	0	4.59	12.26	2.97
(2V07) (508) Atlanta, GA	60,106	52,636	87.57%	7,470	12.43%	0	0	49,127	0	3,509	0	4,108	0	1,412	0	810	0	1,140	0	5.00	11.23	1.01
(2V07) (508GA) Fort McPherson, GA	13,882	12,947	93.26%	935	6.74%	0	0	12,289	0	658	0	510	0	217	0	51	0	157	0	5.06	42.53	8.65
(2V07) (508GE) Oakwood, GA	7,091	6,796	95.84%	295	4.16%	0	0	6,489	0	307	0	153	0	48	0	44	0	50	0	5.10	11.50	0.17
(2V07) (508GF) West Cobb County, GA	3,926	3,792	96.59%	134	3.41%	0	0	3,693	0	99	0	80	0	28	0	4	0	22	0	4.61	2.65	0.21
(2V07) (508GG) Stockbridge, GA	4,284	4,093	95.54%	191	4.46%	0	0	3,985	0	108	0	121	0	18	0	11	0	41	0	4.60	11.73	0.28
(2V07) (508GH) Lawrenceville, GA	6,787	6,543	96.40%	244	3.60%	0	0	6,194	0	349	0	177	0	40	0	16	0	11	0	4.67	10.07	0.61
(2V07) (508GI) Newnan, GA	4,775	4,695	98.32%	80	1.68%	0	0	4,496	0	199	0	63	0	6	0	3	0	8	0	3.37	3.81	0.00
(2V07) (508GJ) Blairsville, GA	3,849	3,732	96.96%	117	3.04%	0	0	3,562	0	170	0	86	0	8	0	8	0	15	0	4.64	6.93	0.82
(2V07) (508GK) Carrollton, GA (Trinka Davis Village)	6,591	5,970	90.58%	621	9.42%	0	0	5,662	0	308	0	386	0	121	0	20	0	94	0	4.09	20.60	1.99
(2V07) (508GL) Rome, GA	1,824	1,788	98.03%	36	1.97%	0	0	1,752	0	36	0	23	0	3	0	0	0	10	0	4.64	0.94	0.39
(2V07) (508GM) Pickens County, GA	1,592	1,553	97.55%	39	2.45%	0	0	1,507	0	46	0	34	0	2	0	1	0	2	0	1.71	2.85	1.52
(2V07) (508GN) Covington, GA	1,949	1,914	98.20%	35	1.80%	0	0	1,847	0	67	0	27	0	5	0	1	0	2	0	3.77	0.78	0.72
(2V07) (508GO) Northeast Cobb County, GA	2,585	2,444	94.55%	141	5.45%	0	0	2,349	0	95	0	91	0	21	0	16	0	13	0	6.55	3.57	0.00

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(2V07) (508GP) South Cobb County, GA	1,953	1,916	98.11%	37	1.89%	0	0	1,820	0	96	0	35	0	1	0	1	0	0	0			3.21
(2V07) (508QC) Henderson Mill, GA	1,639	1,518	92.62%	121	7.38%	0	0	1,434	0	84	0	93	0	22	0	4	0	2	0			0.10
(2V07) (508QE) Gwinnett County, GA	4,191	4,063	96.95%	128	3.05%	0	0	3,870	0	193	0	95	0	19	0	8	0	6	0	2.87	1.19	4.86
(2V07) (508QF) Atlanta North Arcadia Avenue, GA	24,422	21,482	87.96%	2,940	12.04%	0	0	20,088	0	1,394	0	1,566	0	616	0	281	0	477	0	4.61	19.21	0.73
(2V07) (508QH) South Fulton County, GA	1,546	1,422	91.98%	124	8.02%	0	0	1,324	0	98	0	97	0	13	0	12	0	2	0			6.62
(2V07) (508QI) North DeKalb County, GA	423	390	92.20%	33	7.80%	0	0	379	0	11	0	31	0	0	0	2	0	0	0		5.86	
(2V07) (508QJ) North Fulton County, GA	2,286	2,040	89.24%	246	10.76%	0	0	1,917	0	123	0	134	0	92	0	8	0	12	0	1.27	10.68	
(2V07) (509) Augusta, GA HCS	64,082	58,736	91.66%	5,346	8.34%	20	1	55,726	1	3,010	0	2,524	0	1,126	0	642	0	1,054	0	5.96	11.86	7.37
(2V07) (509) Augusta Downtown, GA (Charlie Norwood)	27,639	24,414	88.33%	3,225	11.67%	0	0	23,106	0	1,308	0	1,224	0	672	0	482	0	847	0		12.57	1.56
(2V07) (509A0) Augusta Uptown, GA	29,142	27,255	93.52%	1,887	6.48%	0	1	25,753	1	1,502	0	1,159	0	421	0	139	0	168	0	6.34	8.30	7.88
(2V07) (509GA) Athens, GA	3,466	3,337	96.28%	129	3.72%	0	0	3,247	0	90	0	66	0	25	0	16	0	22	0	5.99	5.93	3.95
(2V07) (509GB) Aiken, SC	2,890	2,813	97.34%	77	2.66%	0	0	2,721	0	92	0	57	0	6	0	3	0	11	0	4.35	29.87	1.97
(2V07) (509QA) Statesboro, GA (Ray Hendrix)	945	917	97.04%	28	2.96%	0	0	899	0	18	0	18	0	2	0	2	0	6	0	3.50		0.00
(2V07) (521) Birmingham, AL HCS	106,873	101,872	95.32%	5,001	4.68%	13	0	98,052	0	3,820	0	2,535	0	1,165	0	459	0	842	0	2.55	7.58	1.99
(2V07) (521) Birmingham, AL	44,341	41,002	92.47%	3,339	7.53%	0	0	39,166	0	1,836	0	1,641	0	791	0	301	0	606	0	2.57	7.57	1.80
(2V07) (521GA) Huntsville, AL	19,284	18,294	94.87%	990	5.13%	0	0	17,174	0	1,120	0	493	0	256	0	114	0	127	0	4.55	17.06	3.48
(2V07) (521GC) Florence, AL	4,256	4,236	99.53%	20	0.47%	0	0	4,218	0	18	0	17	0	1	0	0	0	2	0	1.20	0.50	0.55
(2V07) (521GD) Rainbow City, AL	3,573	3,570	99.92%	3	0.08%	0	0	3,523	0	47	0	1	0	0	0	1	0	1	0	2.84	0.00	1.15
(2V07) (521GE) Oxford, AL	3,821	3,794	99.29%	27	0.71%	0	0	3,724	0	70	0	15	0	5	0	3	0	4	0	1.54	9.95	2.98
(2V07) (521GF) Jasper, AL	2,129	2,090	98.17%	39	1.83%	0	0	2,082	0	8	0	7	0	22	0	4	0	6	0	0.96	5.33	0.42
(2V07) (521GG) Bessemer, AL	3,062	3,000	97.98%	62	2.02%	0	0	2,946	0	54	0	43	0	8	0	1	0	10	0	1.95	3.44	3.37
(2V07) (521GH) Childersburg, AL	2,827	2,820	99.75%	7	0.25%	0	0	2,799	0	21	0	6	0	0	0	0	0	1	0	1.32	4.78	0.43
(2V07) (521GI) Guntersville, AL	3,836	3,741	97.52%	95	2.48%	0	0	3,697	0	44	0	15	0	22	0	21	0	37	0	2.05	21.41	0.67
(2V07) (521GJ) Birmingham 7th Avenue South, AL	12,707	12,360	97.27%	347	2.73%	0	0	11,923	0	437	0	255	0	54	0	13	0	25	0	1.49	9.77	0.56
(2V07) (521QA) Callahan, AL	7,037	6,965	98.98%	72	1.02%	0	0	6,800	0	165	0	42	0	6	0	1	0	23	0		3.34	
(2V07) (534) Charleston, SC HCS	96,552	94,301	97.67%	2,251	2.33%	32	0	91,817	0	2,484	0	1,485	0	409	0	174	0	183	0	1.75	4.59	0.62
(2V07) (534) Charleston, SC (Ralph H. Johnson)	42,024	40,504	96.38%	1,520	3.62%	0	0	39,028	0	1,476	0	1,045	0	237	0	99	0	139	0	0.42	4.82	0.36
(2V07) (534BY) Savannah, GA	16,735	16,484	98.50%	251	1.50%	0	0	16,119	0	365	0	125	0	78	0	31	0	17	0	1.78	3.94	1.63
(2V07) (534GB) Myrtle Beach, SC	4,629	4,554	98.38%	75	1.62%	0	0	4,429	0	125	0	65	0	6	0	2	0	2	0	2.44	1.19	1.80
(2V07) (534GC) Beaufort, SC	4,427	4,417	99.77%	10	0.23%	0	0	4,385	0	32	0	8	0	0	0	0	0	2	0	0.76	3.26	0.52
(2V07) (534GD) Goose Creek, SC	7,659	7,550	98.58%	109	1.42%	0	0	7,328	0	222	0	82	0	13	0	7	0	7	0	0.87	4.76	0.19
(2V07) (534GE) Hinesville, GA	6,593	6,423	97.42%	170	2.58%	0	0	6,332	0	91	0	84	0	64	0	15	0	7	0	4.60	1.66	0.53
(2V07) (534GF) Trident 1, SC	7,381	7,376	99.93%	5	0.07%	0	0	7,339	0	37	0	4	0	0	0	0	0	1	0	0.73	9.50	
(2V07) (534QA) Market Commons, SC	5,684	5,574	98.06%	110	1.94%	0	0	5,443	0	131	0	71	0	11	0	20	0	8	0	0.00	4.63	0.65
(2V07) (534QB) Trident 2, SC	1,321	1,320	99.92%	1	0.08%	0	0	1,315	0	5	0	1	0	0	0	0	0	0	0		0.00	0.20
(2V07) (534QC) Charleston City Hall Lane, SC	99	99	100.00%	0	0.00%	0	0	99	0	0	0	0	0	0	0	0	0	0	0			0.16
(2V07) (544) Columbia, SC HCS	108,932	101,680	93.34%	7,252	6.66%	13	0	96,859	0	4,821	0	3,387	0	1,685	0	722	0	1,458	0	3.93	10.74	6.84
(2V07) (544) Columbia, SC (Wm. Jennings Bryan Dorn)	68,255	62,596	91.71%	5,659	8.29%	0	0	59,564	0	3,032	0	2,407	0	1,453	0	595	0	1,204	0	4.71	11.31	11.40
(2V07) (544BZ) Greenville, SC	13,446	12,589	93.63%	857	6.37%	0	0	11,664	0	925	0	487	0	131	0	78	0	161	0	5.15	9.53	6.93
(2V07) (544GB) Florence, SC	5,087	5,012	98.53%	75	1.47%	0	0	4,910	0	102	0	39	0	12	0	5	0	19	0	2.91	4.11	2.58
(2V07) (544GC) Rock Hill, SC	8,353	8,165	97.75%	188	2.25%	0	0	7,895	0	270	0	148	0	15	0	5	0	20	0	2.90	10.56	4.36
(2V07) (544GD) Anderson, SC	3,977	3,864	97.16%	113	2.84%	0	0	3,690	0	174	0	89	0	15	0	4	0	5	0	2.48	4.57	2.69

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(2V07) (544GE) Orangeburg, SC	2,862	2,849	99.55%	13	0.45%	0	0	2,750	0	99	0	11	0	1	0	0	0	1	0	3.12	0.76	1.09
(2V07) (544GF) Sumter, SC	2,055	1,985	96.59%	70	3.41%	0	0	1,939	0	46	0	49	0	14	0	5	0	2	0	8.63	0.31	2.36
(2V07) (544GG) Spartanburg, SC	4,146	4,003	96.55%	143	3.45%	0	0	3,891	0	112	0	88	0	22	0	13	0	20	0	2.68	2.97	12.87
(2V07) (544HK) Columbia, SC - Mobile	751	617	82.16%	134	17.84%	0	0	556	0	61	0	69	0	22	0	17	0	26	0		13.20	
(2V07) (557) Dublin, GA HCS	60,089	55,479	92.33%	4,610	7.67%	43	0	53,216	0	2,263	0	1,735	0	925	0	494	0	1,456	0	4.80	32.57	2.40
(2V07) (557) Dublin, GA (Carl Vinson)	28,105	24,668	87.77%	3,437	12.23%	0	0	23,417	0	1,251	0	1,183	0	645	0	352	0	1,257	0	6.27	39.88	1.93
(2V07) (557GA) Macon, GA	11,905	11,270	94.67%	635	5.33%	0	0	10,834	0	436	0	263	0	186	0	79	0	107	0	4.23	17.64	3.85
(2V07) (557GB) Albany, GA	5,774	5,636	97.61%	138	2.39%	0	0	5,453	0	183	0	100	0	13	0	4	0	21	0	3.87	7.72	4.06
(2V07) (557GC) Milledgeville, GA	1,359	1,343	98.82%	16	1.18%	0	0	1,330	0	13	0	11	0	2	0	0	0	3	0	1.59		3.07
(2V07) (557GE) Brunswick, GA	3,217	2,933	91.17%	284	8.83%	0	0	2,783	0	150	0	112	0	64	0	54	0	54	0	8.99	24.13	1.73
(2V07) (557GF) Tifton, GA	3,258	3,199	98.19%	59	1.81%	0	0	3,096	0	103	0	39	0	11	0	1	0	8	0	5.38	3.12	0.50
(2V07) (557HA) Perry, GA	6,471	6,430	99.37%	41	0.63%	0	0	6,303	0	127	0	27	0	4	0	4	0	6	0	1.96	1.23	2.46
(2V07) (619) Central Alabama HCS	55,831	51,520	92.28%	4,311	7.72%	9	0	49,593	0	1,927	0	1,306	0	567	0	417	0	2,021	0	3.55	39.70	18.07
(2V07) (619) Montgomery, AL (Central Alabama)	8,002	7,244	90.53%	758	9.47%	0	0	6,942	0	302	0	354	0	112	0	66	0	226	0		20.80	1.39
(2V07) (619A4) Tuskegee, AL (Central Alabama)	11,491	10,175	88.55%	1,316	11.45%	0	0	9,737	0	438	0	332	0	118	0	128	0	738	0	2.73	55.63	4.78
(2V07) (619GA) Columbus, GA	5,216	4,837	92.73%	379	7.27%	0	0	4,728	0	109	0	106	0	54	0	23	0	196	0	2.16	41.63	50.35
(2V07) (619GD) Wiregrass, AL	4,594	4,163	90.62%	431	9.38%	0	0	3,712	0	451	0	112	0	38	0	67	0	214	0	11.84	37.73	9.22
(2V07) (619GE) Monroe County, AL	698	695	99.57%	3	0.43%	0	0	686	0	9	0	1	0	1	0	0	0	1	0	1.14		0.46
(2V07) (619GF) Central Alabama Montgomery, AL	13,842	12,918	93.32%	924	6.68%	0	0	12,479	0	439	0	235	0	127	0	66	0	496	0	3.53	53.78	0.07
(2V07) (619QA) Dothan 2, AL	3,428	3,095	90.29%	333	9.71%	0	0	3,039	0	56	0	92	0	74	0	62	0	105	0	2.09		33.21
(2V07) (619QB) Fort Benning, GA	8,560	8,393	98.05%	167	1.95%	0	0	8,270	0	123	0	74	0	43	0	5	0	45	0	1.49	17.41	2.60
(2V07) (679) Tuscaloosa, AL HCS	21,284	19,846	93.24%	1,438	6.76%	19	0	19,069	0	777	0	603	0	286	0	210	0	339	0	6.07	11.58	7.45
(2V07) (679) Tuscaloosa, AL	20,855	19,436	93.20%	1,419	6.80%	0	0	18,669	0	767	0	593	0	280	0	209	0	337	0	6.12	11.58	7.60
(2V07) (679GA) Selma, AL	264	261	98.86%	3	1.14%	0	0	259	0	2	0	0	0	1	0	1	0	1	0	2.90		0.16
(2V07) (679HK) Tuscaloosa, AL - Mobile	165	149	90.30%	16	9.70%	0	0	141	0	8	0	10	0	5	0	0	0	1	0	7.63		
(2V08) (516) Bay Pines, FL HCS	189,597	177,063	93.39%	12,534	6.61%	14	1	168,777	1	8,286	0	6,289	0	2,799	0	1,447	0	1,999	0	3.95	11.41	7.20
(2V08) (516) Bay Pines, FL (C.W. Bill Young)	83,321	77,091	92.52%	6,230	7.48%	0	0	73,113	0	3,978	0	2,775	0	1,453	0	814	0	1,188	0	4.29	11.72	6.27
(2V08) (516BZ) Lee County, FL	51,465	48,180	93.62%	3,285	6.38%	0	1	45,561	1	2,619	0	1,889	0	648	0	360	0	388	0	3.10	10.46	9.14
(2V08) (516GA) Sarasota, FL	11,954	11,423	95.56%	531	4.44%	0	0	11,092	0	331	0	328	0	140	0	36	0	27	0	3.22	4.41	5.28
(2V08) (516GB) St. Petersburg, FL	2,492	2,436	97.75%	56	2.25%	0	0	2,398	0	38	0	33	0	5	0	2	0	16	0	3.97	0.17	9.53
(2V08) (516GC) Palm Harbor, FL	6,762	6,580	97.31%	182	2.69%	0	0	6,407	0	173	0	139	0	18	0	6	0	19	0	2.99	5.60	7.28
(2V08) (516GD) Bradenton, FL	13,971	12,582	90.06%	1,389	9.94%	0	0	12,062	0	520	0	682	0	401	0	134	0	172	0	7.05	13.32	5.87
(2V08) (516GE) Port Charlotte, FL	8,851	8,264	93.37%	587	6.63%	0	0	7,886	0	378	0	278	0	87	0	74	0	148	0	5.91	19.63	6.14
(2V08) (516GF) Naples, FL	6,807	6,623	97.30%	184	2.70%	0	0	6,488	0	135	0	97	0	40	0	17	0	30	0	2.70	8.39	4.70
(2V08) (516GH) Sebring, FL	3,974	3,884	97.74%	90	2.26%	0	0	3,770	0	114	0	68	0	7	0	4	0	11	0	1.53	10.46	3.11
(2V08) (546) Miami, FL HCS	106,727	92,575	86.74%	14,152	13.26%	3	0	86,416	0	6,159	0	6,125	0	3,097	0	2,027	0	2,903	0	5.49	17.18	8.80
(2V08) (546) Miami, FL (Bruce W. Carter)	59,824	49,685	83.05%	10,139	16.95%	0	0	46,309	0	3,376	0	3,873	0	2,316	0	1,700	0	2,250	0	5.10	18.77	9.07
(2V08) (546BZ) Sunrise, FL (William "Bill" Kling)	33,037	29,808	90.23%	3,229	9.77%	0	0	27,845	0	1,963	0	1,700	0	651	0	266	0	612	0	6.13	14.74	10.63
(2V08) (546GA) Miami Flagler, FL	44	44	100.00%	0	0.00%	0	0	43	0	1	0	0	0	0	0	0	0	0	0	0.59		
(2V08) (546GB) Key West, FL	2,154	2,061	95.68%	93	4.32%	0	0	2,015	0	46	0	55	0	32	0	4	0	2	0	1.48	7.18	2.04
(2V08) (546GC) Homestead, FL	3,936	3,672	93.29%	264	6.71%	0	0	3,353	0	319	0	203	0	34	0	15	0	12	0	6.90	6.99	8.15
(2V08) (546GD) Pembroke Pines, FL	2,564	2,383	92.94%	181	7.06%	0	0	2,127	0	256	0	152	0	18	0	6	0	5	0	6.77	7.13	11.89
(2V08) (546GE) Key Largo, FL	606	564	93.07%	42	6.93%	0	0	532	0	32	0	41	0	1	0	0	0	0	0	5.66	4.85	1.88

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(2V08) (546GF) Hollywood, FL	2,728	2,580	94.57%	148	5.43%	0	0	2,451	0	129	0	79	0	34	0	25	0	10	0	5.44	17.37	2.95
(2V08) (546GH) Deerfield Beach, FL	1,834	1,778	96.95%	56	3.05%	0	0	1,741	0	37	0	22	0	11	0	11	0	12	0	2.33	21.47	2.80
(2V08) (548) West Palm Beach, FL HCS	104,403	99,740	95.53%	4,663	4.47%	7	0	94,802	0	4,938	0	2,965	0	836	0	312	0	550	0	3.74	6.72	5.62
(2V08) (548) West Palm Beach, FL	77,073	72,750	94.39%	4,323	5.61%	0	0	68,358	0	4,392	0	2,783	0	808	0	293	0	439	0	3.68	6.76	5.86
(2V08) (548BU) West Palm Beach, FL - VADOM	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0			
(2V08) (548GA) Fort Pierce, FL	5,009	4,969	99.20%	40	0.80%	0	0	4,842	0	127	0	32	0	0	0	0	0	8	0	2.60	3.77	2.24
(2V08) (548GB) Delray Beach, FL	5,841	5,808	99.44%	33	0.56%	0	0	5,722	0	86	0	26	0	2	0	0	0	5	0	2.77	3.27	1.48
(2V08) (548GC) Stuart, FL	6,027	6,012	99.75%	15	0.25%	0	0	5,944	0	68	0	4	0	1	0	0	0	10	0	1.30	3.52	3.31
(2V08) (548GD) Boca Raton, FL	3,125	3,097	99.10%	28	0.90%	0	0	3,027	0	70	0	18	0	2	0	1	0	7	0	2.15	3.11	1.56
(2V08) (548GE) Vero Beach, FL	3,854	3,729	96.76%	125	3.24%	0	0	3,693	0	36	0	28	0	10	0	12	0	75	0	13.12	43.13	26.97
(2V08) (548GF) Okeechobee, FL	1,718	1,715	99.83%	3	0.17%	0	0	1,696	0	19	0	1	0	0	0	0	0	2	0	0.70	8.16	0.89
(2V08) (548QA) Port Saint Lucie, FL	1,753	1,657	94.52%	96	5.48%	0	0	1,517	0	140	0	73	0	13	0	6	0	4	0		7.83	0.17
(2V08) (573) Gainesville, FL HCS	227,778	213,554	93.76%	14,224	6.24%	306	0	204,561	0	8,993	0	6,790	0	3,086	0	1,501	0	2,847	0	3.40	11.09	6.55
(2V08) (573) Gainesville, FL (Malcom Randall)	53,736	49,157	91.48%	4,579	8.52%	0	0	46,637	0	2,520	0	1,958	0	1,017	0	505	0	1,099	0	3.08	12.40	2.63
(2V08) (573A4) Lake City, FL	15,034	13,749	91.45%	1,285	8.55%	0	0	12,928	0	821	0	435	0	265	0	125	0	460	0	1.86	25.85	2.79
(2V08) (573BY) Jacksonville 1, FL	36,754	33,234	90.42%	3,520	9.58%	0	0	31,822	0	1,412	0	1,695	0	820	0	425	0	580	0	5.03	12.81	15.59
(2V08) (573GA) Valdosta, GA	4,748	4,695	98.88%	53	1.12%	0	0	4,606	0	89	0	41	0	2	0	2	0	8	0	2.60	11.64	1.71
(2V08) (573GD) Ocala, FL	9,379	9,209	98.19%	170	1.81%	0	0	9,007	0	202	0	106	0	28	0	7	0	29	0	2.30	4.24	5.62
(2V08) (573GE) Saint Augustine, FL	8,704	8,546	98.18%	158	1.82%	0	0	8,083	0	463	0	109	0	31	0	4	0	14	0	4.66	5.85	3.97
(2V08) (573GF) Tallahassee, FL (Sergeant Ernest I. "Boots" Thomas)	22,061	20,918	94.82%	1,143	5.18%	0	0	20,055	0	863	0	642	0	204	0	126	0	171	0	5.49	5.79	4.11
(2V08) (573GI) The Villages, FL	27,399	26,227	95.72%	1,172	4.28%	0	0	25,381	0	846	0	640	0	208	0	97	0	227	0	2.65	7.17	8.35
(2V08) (573GJ) St. Marys, GA	3,157	3,077	97.47%	80	2.53%	0	0	2,978	0	99	0	37	0	22	0	4	0	17	0	2.79	0.00	11.20
(2V08) (573GK) Marianna, FL	1,888	1,853	98.15%	35	1.85%	0	0	1,773	0	80	0	26	0	7	0	0	0	2	0	3.01	0.00	3.41
(2V08) (573GL) Palatka, FL	2,443	2,428	99.39%	15	0.61%	0	0	2,406	0	22	0	7	0	1	0	1	0	6	0	1.65	7.72	3.92
(2V08) (573GM) Waycross, GA	2,794	2,775	99.32%	19	0.68%	0	0	2,746	0	29	0	4	0	4	0	5	0	6	0	3.00	0.00	1.08
(2V08) (573GN) Perry, FL	620	620	100.00%	0	0.00%	0	0	615	0	5	0	0	0	0	0	0	0	0	0	1.36	4.20	1.86
(2V08) (573GO) Middleburg, FL	3,703	3,553	95.95%	150	4.05%	0	0	3,398	0	155	0	78	0	38	0	15	0	19	0	6.19	0.29	8.02
(2V08) (573QA) Gainesville 1-16th Street, FL	65	62	95.38%	3	4.62%	0	0	61	0	1	0	3	0	0	0	0	0	0	0			2.37
(2V08) (573QB) Gainesville 2-98th Street, FL	889	838	94.26%	51	5.74%	0	0	787	0	51	0	36	0	5	0	2	0	8	0		7.29	
(2V08) (573QC) Gainesville 3-64th Street (C), FL	269	249	92.57%	20	7.43%	0	0	141	0	108	0	18	0	1	0	1	0	0	0		12.49	
(2V08) (573QD) Gainesville 4-64th Street (O), FL	5,289	5,066	95.78%	223	4.22%	0	0	4,843	0	223	0	117	0	49	0	26	0	31	0		4.99	
(2V08) (573QE) Gainesville 5-64th Street (D), FL	4,174	3,867	92.64%	307	7.36%	0	0	3,611	0	256	0	218	0	48	0	22	0	19	0		7.11	
(2V08) (573QF) Gainesville 6-23rd Avenue, FL	16	14	87.50%	2	12.50%	0	0	9	0	5	0	2	0	0	0	0	0	0	0			
(2V08) (573QG) Jacksonville Southpoint, FL	9,973	9,341	93.66%	632	6.34%	0	0	8,918	0	423	0	299	0	175	0	82	0	76	0	2.13	11.36	14.10
(2V08) (573QH) Ocala West, FL	2,596	2,589	99.73%	7	0.27%	0	0	2,559	0	30	0	3	0	1	0	1	0	2	0		1.73	
(2V08) (573QJ) Jacksonville 2, FL	7,690	7,137	92.81%	553	7.19%	0	0	6,908	0	229	0	280	0	153	0	51	0	69	0	3.21	7.13	10.31
(2V08) (573QK) Lake City Commerce Drive, FL	4,397	4,350	98.93%	47	1.07%	0	0	4,289	0	61	0	36	0	7	0	0	0	4	0	2.37	3.75	2.74
(2V08) (672) San Juan, PR HCS	140,369	128,020	91.20%	12,349	8.80%	1	0	120,490	0	7,530	0	5,352	0	3,240	0	1,622	0	2,135	0	3.49	10.71	5.20
(2V08) (672) San Juan, PR	95,730	84,265	88.02%	11,465	11.98%	0	0	78,170	0	6,095	0	4,907	0	2,990	0	1,532	0	2,036	0	4.02	12.67	3.76
(2V08) (672B0) Ponce, PR (Eurípides Rubio)	16,714	16,653	99.64%	61	0.36%	0	0	16,358	0	295	0	46	0	8	0	1	0	6	0	1.88	1.63	0.70
(2V08) (672BZ) Mayaguez, PR	14,843	14,188	95.59%	655	4.41%	0	0	13,484	0	704	0	325	0	217	0	76	0	37	0	5.59	5.40	12.97

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(2V08) (672GA) Saint Croix, VI	537	536	99.81%	1	0.19%	0	0	535	0	1	0	1	0	0	0	0	0	0	0	2.02		
(2V08) (672GB) Saint Thomas, VI	914	827	90.48%	87	9.52%	0	0	805	0	22	0	17	0	16	0	10	0	44	0	4.36		
(2V08) (672GC) Arecibo, PR	4,896	4,849	99.04%	47	0.96%	0	0	4,696	0	153	0	34	0	8	0	1	0	4	0	3.61	4.51	3.08
(2V08) (672GD) Ceiba, PR	3,586	3,571	99.58%	15	0.42%	0	0	3,390	0	181	0	5	0	1	0	2	0	7	0	3.71	0.31	0.31
(2V08) (672GE) Guayama, PR	2,338	2,323	99.36%	15	0.64%	0	0	2,249	0	74	0	15	0	0	0	0	0	0	0	2.12	0.53	5.31
(2V08) (672QA) Comerio, PR	437	437	100.00%	0	0.00%	0	0	437	0	0	0	0	0	0	0	0	0	0	0	0.37		
(2V08) (672QB) Utuado, PR	257	255	99.22%	2	0.78%	0	0	250	0	5	0	1	0	0	0	0	0	1	0	1.69	0.00	
(2V08) (672QC) Vieques, PR	117	116	99.15%	1	0.85%	0	0	116	0	0	0	1	0	0	0	0	0	0	0	1.79		
(2V08) (673) Tampa, FL HCS	193,543	181,678	93.87%	11,865	6.13%	16	0	173,272	0	8,406	0	5,868	0	2,569	0	1,364	0	2,064	0	2.91	11.75	3.12
(2V08) (673) Tampa, FL (James A. Haley)	67,381	61,636	91.47%	5,745	8.53%	0	0	58,270	0	3,366	0	3,223	0	1,493	0	447	0	582	0	3.23	8.24	3.18
(2V08) (673BV) Tampa, FL - VADOM	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0			
(2V08) (673BZ) New Port Richey, FL	17,695	17,564	99.26%	131	0.74%	0	0	17,178	0	386	0	90	0	15	0	5	0	21	0	2.85	1.12	2.63
(2V08) (673GB) Lakeland, FL	11,391	11,169	98.05%	222	1.95%	0	0	10,964	0	205	0	137	0	41	0	16	0	28	0	2.74	4.00	
(2V08) (673GC) Brooksville, FL	7,603	7,498	98.62%	105	1.38%	0	0	7,289	0	209	0	78	0	13	0	4	0	10	0	2.70	5.27	1.20
(2V08) (673GF) Zephyrhills, FL	3,168	3,063	96.69%	105	3.31%	0	0	3,000	0	63	0	23	0	10	0	6	0	66	0	7.38	30.27	0.56
(2V08) (673GG) South Hillsborough, FL	11,512	11,033	95.84%	479	4.16%	0	0	10,593	0	440	0	377	0	62	0	20	0	20	0	2.76	9.92	1.93
(2V08) (673GH) Lecanto, FL	7,718	7,684	99.56%	34	0.44%	0	0	7,595	0	89	0	29	0	2	0	1	0	2	0	1.07	2.32	1.02
(2V08) (673QA) Forty Sixth Street North, FL	925	733	79.24%	192	20.76%	0	0	486	0	247	0	189	0	1	0	0	0	2	0		15.99	14.23
(2V08) (673QB) Forty Sixth Street South, FL	28,892	25,864	89.52%	3,028	10.48%	0	0	23,893	0	1,971	0	789	0	524	0	719	0	996	0		18.75	3.94
(2V08) (673QC) West Lakeland, FL	3,616	3,465	95.82%	151	4.18%	0	0	3,164	0	301	0	131	0	14	0	5	0	1	0		3.83	4.75
(2V08) (673QD) Deer Park, FL	1,109	1,094	98.65%	15	1.35%	0	0	1,055	0	39	0	6	0	8	0	0	0	1	0		2.39	
(2V08) (673QE) Highway Nineteen, FL	3,034	2,902	95.65%	132	4.35%	0	0	2,849	0	53	0	56	0	17	0	18	0	41	0		6.63	
(2V08) (673QF) Winners Circle, FL	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(2V08) (673QG) Little Road, FL	116	116	100.00%	0	0.00%	0	0	114	0	2	0	0	0	0	0	0	0	0	0			0.66
(2V08) (673QH) Bruce B. Downs Boulevard, FL	2,138	2,005	93.78%	133	6.22%	0	0	1,824	0	181	0	65	0	25	0	9	0	34	0		14.20	
(2V08) (673QI) Medical View Lane, FL	310	306	98.71%	4	1.29%	0	0	300	0	6	0	3	0	1	0	0	0	0	0		4.38	1.48
(2V08) (673QJ) Hidden River, FL	26,931	25,542	94.84%	1,389	5.16%	0	0	24,694	0	848	0	672	0	343	0	114	0	260	0	2.92	24.19	0.50
(2V08) (675) Orlando, FL HCS	228,943	216,408	94.52%	12,535	5.48%	99	1	204,693	1	11,715	0	7,533	0	2,472	0	951	0	1,579	0	2.48	9.35	5.84
(2V08) (675) Orlando, FL	100,136	92,676	92.55%	7,460	7.45%	0	1	85,888	1	6,788	0	4,862	0	1,512	0	463	0	623	0	3.16	8.47	12.82
(2V08) (675GA) Viera, FL	44,516	42,330	95.09%	2,186	4.91%	0	0	40,287	0	2,043	0	1,266	0	460	0	297	0	163	0	2.09	9.15	3.44
(2V08) (675GB) Daytona Beach, FL (William V. Chappell, Jr.)	28,250	26,611	94.20%	1,639	5.80%	0	0	25,789	0	822	0	525	0	298	0	125	0	691	0	2.77	19.42	1.19
(2V08) (675GC) Kissimmee, FL	4,986	4,927	98.82%	59	1.18%	0	0	4,770	0	157	0	38	0	5	0	3	0	13	0	2.48		5.42
(2V08) (675GD) Deltona, FL	4,417	4,358	98.66%	59	1.34%	0	0	4,240	0	118	0	47	0	3	0	1	0	8	0	2.51	9.83	2.14
(2V08) (675GE) Tavares, FL	4,937	4,897	99.19%	40	0.81%	0	0	4,741	0	156	0	24	0	6	0	6	0	4	0	2.50	3.06	3.50
(2V08) (675GF) Clermont, FL	4,014	3,972	98.95%	42	1.05%	0	0	3,866	0	106	0	29	0	2	0	1	0	10	0	2.69	3.92	2.56
(2V08) (675GG) Lake Baldwin, FL	32,450	31,531	97.17%	919	2.83%	0	0	30,136	0	1,395	0	643	0	172	0	41	0	63	0	1.90	5.03	5.28
(2V08) (675QB) Port Orange, FL	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0			
(2V08) (675QC) Westside Pavilion, FL	3,335	3,206	96.13%	129	3.87%	0	0	3,168	0	38	0	98	0	14	0	14	0	3	0			1.51
(2V08) (675QG) Palm Bay, FL	1,899	1,897	99.89%	2	0.11%	0	0	1,805	0	92	0	1	0	0	0	0	0	1	0	2.94		
(2V09) (596) Lexington, KY HCS	37,569	35,467	94.40%	2,102	5.60%	38	0	32,912	0	2,555	0	1,410	0	452	0	148	0	92	0	4.92	7.41	0.48
(2V09) (596) Lexington-Leestown, KY (Franklin R. Sousley Campus)	14,742	14,119	95.77%	623	4.23%	0	0	13,276	0	843	0	408	0	133	0	37	0	45	0	5.35	7.56	0.52
(2V09) (596A4) Lexington-Cooper, KY (Troy Bowling Campus)	18,268	16,895	92.48%	1,373	7.52%	0	0	15,341	0	1,554	0	926	0	310	0	96	0	41	0		7.46	0.70

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(2V09) (596GA) Somerset, KY	2,822	2,733	96.85%	89	3.15%	0	0	2,621	0	112	0	61	0	8	0	15	0	5	0	5.97	6.11	0.43
(2V09) (596GB) Morehead, KY	206	203	98.54%	3	1.46%	0	0	196	0	7	0	1	0	1	0	0	0	1	0	4.64	2.30	0.00
(2V09) (596GC) Hazard, KY	557	551	98.92%	6	1.08%	0	0	547	0	4	0	6	0	0	0	0	0	0	0	1.51	7.97	0.00
(2V09) (596GD) Berea, KY	974	966	99.18%	8	0.82%	0	0	931	0	35	0	8	0	0	0	0	0	0	0	2.57	6.19	0.51
(2V09) (603) Louisville, KY HCS	84,043	81,924	97.48%	2,119	2.52%	9	0	79,365	0	2,559	0	1,187	0	402	0	193	0	337	0	2.33	5.50	2.50
(2V09) (603) Louisville, KY (Robley Rex)	46,570	44,971	96.57%	1,599	3.43%	0	0	43,092	0	1,879	0	877	0	337	0	152	0	233	0	0.42	5.58	0.50
(2V09) (603GA) Fort Knox, KY	6,031	5,970	98.99%	61	1.01%	0	0	5,866	0	104	0	37	0	5	0	4	0	15	0	2.33	2.03	2.67
(2V09) (603GB) New Albany, IN	4,162	4,118	98.94%	44	1.06%	0	0	4,047	0	71	0	28	0	4	0	6	0	6	0	1.50	1.72	2.78
(2V09) (603GC) Shively, KY	6,181	6,069	98.19%	112	1.81%	0	0	5,987	0	82	0	64	0	25	0	8	0	15	0	2.39	0.41	4.20
(2V09) (603GD) Stonybrook, KY	5,952	5,811	97.63%	141	2.37%	0	0	5,669	0	142	0	93	0	14	0	7	0	27	0	4.77	2.25	2.14
(2V09) (603GE) Newburg, KY	7,454	7,348	98.58%	106	1.42%	0	0	7,168	0	180	0	55	0	9	0	11	0	31	0	3.27	10.47	3.11
(2V09) (603GF) Grayson County, KY	4,606	4,584	99.52%	22	0.48%	0	0	4,539	0	45	0	9	0	4	0	3	0	6	0	1.20	2.47	1.57
(2V09) (603GG) Scott County, IN	2,729	2,701	98.97%	28	1.03%	0	0	2,655	0	46	0	21	0	3	0	0	0	4	0	2.34	0.95	2.08
(2V09) (603GH) Carrollton, KY	353	347	98.30%	6	1.70%	0	0	337	0	10	0	3	0	1	0	2	0	0	0	3.37	12.80	5.07
(2V09) (603PB) Louisville (SARRTP)	5	5	100.00%	0	0.00%	0	0	5	0	0	0	0	0	0	0	0	0	0	0			0.00
(2V09) (614) Memphis, TN HCS	75,748	71,419	94.28%	4,329	5.72%	8	0	68,795	0	2,624	0	1,908	0	1,012	0	529	0	880	0	2.80	11.74	3.55
(2V09) (614) Memphis, TN	48,307	45,154	93.47%	3,153	6.53%	0	0	43,331	0	1,823	0	1,421	0	665	0	318	0	749	0	1.71	11.42	1.71
(2V09) (614GA) Tupelo, MS	5,075	4,920	96.95%	155	3.05%	0	0	4,849	0	71	0	73	0	17	0	30	0	35	0	2.64	5.04	12.37
(2V09) (614GB) Jonesboro, AR	2,897	2,852	98.45%	45	1.55%	0	0	2,805	0	47	0	12	0	6	0	1	0	26	0	3.56	2.86	2.41
(2V09) (614GC) Holly Springs, MS	1,526	1,427	93.51%	99	6.49%	0	0	1,370	0	57	0	33	0	14	0	12	0	40	0	10.21	0.42	12.25
(2V09) (614GD) Savannah, TN	1,316	1,293	98.25%	23	1.75%	0	0	1,274	0	19	0	9	0	3	0	5	0	6	0	2.83	0.00	3.38
(2V09) (614GE) Covington, TN	3,999	3,988	99.72%	11	0.28%	0	0	3,881	0	107	0	8	0	1	0	2	0	0	0	0.50	0.00	0.77
(2V09) (614GF) Nonconnah Boulevard, TN	8,321	7,599	91.32%	722	8.68%	0	0	7,202	0	397	0	255	0	287	0	159	0	21	0	1.84	20.13	2.81
(2V09) (614GG) Jackson, TN	3,268	3,181	97.34%	87	2.66%	0	0	3,116	0	65	0	66	0	18	0	1	0	2	0	3.08	3.55	0.51
(2V09) (614GI) Dyersburg, TN	722	692	95.84%	30	4.16%	0	0	661	0	31	0	30	0	0	0	0	0	0	0	4.29	0.00	2.07
(2V09) (614GN) Helena, AR	317	313	98.74%	4	1.26%	0	0	306	0	7	0	1	0	1	0	1	0	1	0	2.13		1.14
(2V09) (621) Mountain Home, TN HCS	100,202	95,263	95.07%	4,939	4.93%	11	0	90,124	0	5,139	0	2,664	0	922	0	432	0	921	0	4.66	9.87	3.64
(2V09) (621) Mountain Home, TN (James H. Quillen)	60,939	57,373	94.15%	3,566	5.85%	0	0	54,363	0	3,010	0	2,024	0	731	0	322	0	489	0	4.36	8.84	2.80
(2V09) (621BU) Mountain Home, TN - VADOM	65	65	100.00%	0	0.00%	0	0	65	0	0	0	0	0	0	0	0	0	0	0	0.51	0.00	
(2V09) (621BY) Knoxville, TN (William C. Tallent)	17,976	17,465	97.16%	511	2.84%	0	0	16,488	0	977	0	346	0	111	0	22	0	32	0	4.90	4.47	5.51
(2V09) (621GA) Rogersville, TN	1,676	1,668	99.52%	8	0.48%	0	0	1,558	0	110	0	7	0	0	0	0	0	1	0	4.49	0.00	0.41
(2V09) (621GC) Norton, VA	2,286	2,276	99.56%	10	0.44%	0	0	2,217	0	59	0	6	0	1	0	0	0	3	0	2.83	0.00	5.55
(2V09) (621GG) Morristown, TN	2,820	2,789	98.90%	31	1.10%	0	0	2,717	0	72	0	21	0	6	0	3	0	1	0	2.27	0.00	0.03
(2V09) (621GI) Sevierville, TN (Dannie A. Carr)	4,762	4,506	94.62%	256	5.38%	0	0	3,881	0	625	0	189	0	29	0	23	0	15	0	10.17	19.50	1.17
(2V09) (621GJ) Bristol, VA	3,018	2,960	98.08%	58	1.92%	0	0	2,885	0	75	0	35	0	15	0	1	0	7	0	3.41	0.00	2.19
(2V09) (621GK) Campbell County, TN	1,755	1,733	98.75%	22	1.25%	0	0	1,639	0	94	0	10	0	7	0	2	0	3	0	3.80	0.00	6.71
(2V09) (621GO) Mountain City, TN	1,062	1,053	99.15%	9	0.85%	0	0	987	0	66	0	7	0	1	0	0	0	1	0	4.46	0.00	2.07
(2V09) (621QA) Jonesville, VA	397	397	100.00%	0	0.00%	0	0	397	0	0	0	0	0	0	0	0	0	0	0	1.11		
(2V09) (621QB) Marion, VA	338	332	98.22%	6	1.78%	0	0	318	0	14	0	3	0	1	0	1	0	1	0	5.66		
(2V09) (621QC) Vansant, VA	205	205	100.00%	0	0.00%	0	0	205	0	0	0	0	0	0	0	0	0	0	0	3.32		
(2V09) (621QD) Knox County, TN	700	690	98.57%	10	1.43%	0	0	674	0	16	0	7	0	2	0	0	0	1	0		2.11	2.84
(2V09) (621QE) Downtown West, TN	2,203	1,751	79.48%	452	20.52%	0	0	1,730	0	21	0	9	0	18	0	58	0	367	0		30.03	
(2V09) (626) Middle Tennessee HCS	182,610	168,432	92.24%	14,178	7.76%	51	0	161,347	0	7,085	0	5,699	0	2,920	0	1,864	0	3,695	0	4.95	14.01	3.26

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(2V09) (626) Nashville, TN	58,528	52,511	89.72%	6,017	10.28%	0	0	49,908	0	2,603	0	2,528	0	1,472	0	999	0	1,018	0	8.02	11.64	2.76
(2V09) (626A4) Murfreesboro, TN (Alvin C. York)	47,742	43,236	90.56%	4,506	9.44%	0	0	41,239	0	1,997	0	1,622	0	737	0	476	0	1,671	0	3.84	20.26	2.92
(2V09) (626GA) Dover, TN	1,215	1,181	97.20%	34	2.80%	0	0	1,159	0	22	0	12	0	7	0	4	0	11	0	5.74		13.48
(2V09) (626GC) Bowling Green, KY	4,952	4,466	90.19%	486	9.81%	0	0	4,346	0	120	0	152	0	85	0	83	0	166	0	13.66	2.97	7.76
(2V09) (626GE) Clarksville, TN	13,935	12,863	92.31%	1,072	7.69%	0	0	12,423	0	440	0	339	0	163	0	122	0	448	0	4.53	6.33	2.48
(2V09) (626GF) Chattanooga, TN	16,686	16,058	96.24%	628	3.76%	0	0	15,590	0	468	0	324	0	165	0	62	0	77	0	2.67	5.33	3.60
(2V09) (626GG) Tullahoma, TN	1,203	1,198	99.58%	5	0.42%	0	0	1,198	0	0	0	2	0	1	0	1	0	1	0	0.35	0.45	1.78
(2V09) (626GH) Cookeville, TN	5,425	5,218	96.18%	207	3.82%	0	0	5,088	0	130	0	111	0	39	0	12	0	45	0	5.01	4.92	4.37
(2V09) (626GJ) Hopkinsville, KY	4,622	4,375	94.66%	247	5.34%	0	0	4,187	0	188	0	109	0	39	0	26	0	73	0	9.52	2.92	9.29
(2V09) (626GK) McMinnville, TN	2,307	2,284	99.00%	23	1.00%	0	0	1,807	0	477	0	16	0	1	0	1	0	5	0	9.81	4.25	1.68
(2V09) (626GL) Roane County, TN	2,209	2,184	98.87%	25	1.13%	0	0	2,139	0	45	0	3	0	9	0	0	0	13	0	2.52	2.52	2.21
(2V09) (626GM) Maury County, TN	3,057	2,984	97.61%	73	2.39%	0	0	2,918	0	66	0	30	0	9	0	9	0	25	0	2.17	66.60	6.94
(2V09) (626GN) Athens, TN	2,193	2,020	92.11%	173	7.89%	0	0	1,966	0	54	0	107	0	34	0	12	0	20	0	6.68	9.18	6.43
(2V09) (626GO) International Plaza, TN	4,450	4,307	96.79%	143	3.21%	0	0	4,264	0	43	0	50	0	36	0	18	0	39	0	4.28	2.78	2.60
(2V09) (626GP) Gallatin, TN	1,883	1,855	98.51%	28	1.49%	0	0	1,828	0	27	0	16	0	6	0	1	0	5	0	1.80	1.86	0.00
(2V09) (626QA) Albion Street, TN	1,758	1,729	98.35%	29	1.65%	0	0	1,683	0	46	0	22	0	5	0	0	0	2	0	1.83		0.00
(2V09) (626QB) Charlotte Avenue, TN	6,464	6,284	97.22%	180	2.78%	0	0	6,116	0	168	0	128	0	21	0	10	0	21	0	3.04	10.42	0.17
(2V09) (626QC) Pointe Centre, TN	2,348	2,190	93.27%	158	6.73%	0	0	2,096	0	94	0	44	0	68	0	20	0	26	0		8.21	3.71
(2V09) (626QD) Glenis Drive, TN	383	363	94.78%	20	5.22%	0	0	357	0	6	0	16	0	1	0	2	0	1	0			7.04
(2V09) (626QE) Glenis Drive 2, TN	10	10	100.00%	0	0.00%	0	0	10	0	0	0	0	0	0	0	0	0	0	0			
(2V09) (626QF) Dalton Drive, TN	1,240	1,116	90.00%	124	10.00%	0	0	1,025	0	91	0	68	0	22	0	6	0	28	0		13.73	
(3V10) (538) Chillicothe, OH HCS	31,043	28,596	92.12%	2,447	7.88%	1	0	27,597	0	999	0	1,209	0	568	0	258	0	412	0	3.00	13.80	2.59
(3V10) (538) Chillicothe, OH	18,071	16,259	89.97%	1,812	10.03%	0	0	15,496	0	763	0	937	0	391	0	180	0	304	0	3.46	14.25	2.02
(3V10) (538GA) Athens, OH	2,863	2,767	96.65%	96	3.35%	0	0	2,710	0	57	0	40	0	24	0	7	0	25	0	1.89	12.45	1.35
(3V10) (538GB) Portsmouth, OH	2,232	2,209	98.97%	23	1.03%	0	0	2,182	0	27	0	8	0	6	0	4	0	5	0	2.58	0.79	1.19
(3V10) (538GC) Marietta, OH	1,722	1,521	88.33%	201	11.67%	0	0	1,486	0	35	0	82	0	75	0	25	0	19	0	1.57	24.70	4.07
(3V10) (538GD) Lancaster, OH	3,685	3,512	95.31%	173	4.69%	0	0	3,445	0	67	0	60	0	49	0	28	0	36	0	3.55	10.61	6.39
(3V10) (538GE) Cambridge, OH	1,800	1,661	92.28%	139	7.72%	0	0	1,616	0	45	0	81	0	23	0	14	0	21	0	5.47	12.92	0.57
(3V10) (538GF) Wilmington, OH	670	667	99.55%	3	0.45%	0	0	662	0	5	0	1	0	0	0	0	0	2	0	1.70	0.00	1.58
(3V10) (539) Cincinnati, OH HCS	64,537	59,069	91.53%	5,468	8.47%	19	0	56,133	0	2,936	0	2,769	0	1,226	0	481	0	992	0	3.43	13.39	2.05
(3V10) (539) Cincinnati, OH	37,662	33,900	90.01%	3,762	9.99%	0	0	31,880	0	2,020	0	1,920	0	846	0	349	0	647	0	2.18	15.38	0.93
(3V10) (539A4) Fort Thomas, KY	1,037	940	90.65%	97	9.35%	0	0	880	0	60	0	59	0	24	0	8	0	6	0		14.08	6.34
(3V10) (539BV) Fort Thomas, KY - PRRTP	10	9	90.00%	1	10.00%	0	0	9	0	0	0	1	0	0	0	0	0	0	0			
(3V10) (539GA) Bellevue, KY	1,261	1,168	92.62%	93	7.38%	0	0	1,107	0	61	0	31	0	13	0	12	0	37	0	17.24		1.61
(3V10) (539GB) Clermont County, OH	3,987	3,744	93.91%	243	6.09%	0	0	3,615	0	129	0	115	0	59	0	13	0	56	0	4.20	13.89	1.45
(3V10) (539GC) Dearborn, IN	3,507	3,406	97.12%	101	2.88%	0	0	3,284	0	122	0	61	0	20	0	7	0	13	0	2.77	7.54	2.01
(3V10) (539GD) Florence, KY	4,962	4,749	95.71%	213	4.29%	0	0	4,556	0	193	0	109	0	42	0	14	0	48	0	3.89	12.12	4.00
(3V10) (539GE) Hamilton, OH	3,798	3,557	93.65%	241	6.35%	0	0	3,488	0	69	0	92	0	72	0	26	0	51	0	2.28	16.28	0.37
(3V10) (539GF) Georgetown, OH	1,000	912	91.20%	88	8.80%	0	0	867	0	45	0	46	0	23	0	5	0	14	0	11.04	12.03	1.04
(3V10) (539QB) Highland Avenue, OH	6,804	6,188	90.95%	616	9.05%	0	0	5,972	0	216	0	325	0	125	0	46	0	120	0		9.75	
(3V10) (539QC) Vine Street, OH	46	46	100.00%	0	0.00%	0	0	45	0	1	0	0	0	0	0	0	0	0	0	1.51		
(3V10) (539QD) Norwood, OH	463	450	97.19%	13	2.81%	0	0	430	0	20	0	10	0	2	0	1	0	0	0		4.88	2.08
(3V10) (541) Cleveland, OH HCS	182,098	169,776	93.23%	12,322	6.77%	29	0	160,936	0	8,840	0	6,601	0	2,354	0	1,240	0	2,127	0	5.88	10.85	3.03

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(3V10) (541) Cleveland, OH (Louis Stokes Cleveland)	57,092	52,096	91.25%	4,996	8.75%	0	0	48,489	0	3,607	0	2,844	0	915	0	518	0	719	0	8.48	10.29	0.93
(3V10) (541BY) Canton, OH	12,706	11,697	92.06%	1,009	7.94%	0	0	11,024	0	673	0	637	0	162	0	88	0	122	0	7.09	13.09	3.34
(3V10) (541BZ) Youngstown, OH	13,035	12,290	94.28%	745	5.72%	0	0	11,875	0	415	0	384	0	221	0	64	0	76	0	4.83	12.22	2.76
(3V10) (541GB) Lorain, OH	9,929	9,648	97.17%	281	2.83%	0	0	9,365	0	283	0	102	0	84	0	34	0	61	0	4.47	5.56	2.49
(3V10) (541GC) Sandusky, OH	6,935	6,380	92.00%	555	8.00%	0	0	5,948	0	432	0	174	0	85	0	64	0	232	0	9.00	29.40	7.89
(3V10) (541GD) Mansfield, OH (David F. Winder)	9,707	9,387	96.70%	320	3.30%	0	0	9,185	0	202	0	137	0	43	0	45	0	95	0	3.48	9.16	2.28
(3V10) (541GF) Lake County, OH	8,704	8,304	95.40%	400	4.60%	0	0	8,034	0	270	0	230	0	57	0	30	0	83	0	6.93	6.72	2.32
(3V10) (541GG) Akron, OH	22,582	21,020	93.08%	1,562	6.92%	0	0	19,912	0	1,108	0	677	0	327	0	192	0	366	0	5.33	11.04	2.35
(3V10) (541GH) East Liverpool, OH	3,933	3,863	98.22%	70	1.78%	0	0	3,753	0	110	0	35	0	7	0	7	0	21	0	4.00	3.40	1.10
(3V10) (541GI) Warren, OH	4,002	3,894	97.30%	108	2.70%	0	0	3,828	0	66	0	48	0	20	0	18	0	22	0	3.73	2.89	1.54
(3V10) (541GJ) New Philadelphia, OH	4,201	3,976	94.64%	225	5.36%	0	0	3,831	0	145	0	130	0	47	0	13	0	35	0	6.54	8.65	4.42
(3V10) (541GK) Ravenna, OH	3,954	3,813	96.43%	141	3.57%	0	0	3,652	0	161	0	101	0	11	0	7	0	22	0	4.03	6.01	3.46
(3V10) (541GL) Parma, OH	23,784	21,949	92.28%	1,835	7.72%	0	0	20,671	0	1,278	0	1,037	0	369	0	158	0	271	0	5.43	13.44	7.06
(3V10) (541GM) Cleveland Superior Avenue, OH	65	58	89.23%	7	10.77%	0	0	47	0	11	0	7	0	0	0	0	0	0	0			
(3V10) (541QB) Cleveland Euclid Avenue, OH	985	980	99.49%	5	0.51%	0	0	976	0	4	0	3	0	0	0	1	0	1	0	44.11	24.38	0.00
(3V10) (541QE) Cleveland East Boulevard 3, OH - Mobile	247	221	89.47%	26	10.53%	0	0	187	0	34	0	24	0	1	0	0	0	1	0		9.28	
(3V10) (541QF) Cuyahoga County 4, OH - Mobile	237	200	84.39%	37	15.61%	0	0	159	0	41	0	31	0	5	0	1	0	0	0		12.14	
(3V10) (552) Dayton, OH HCS	64,394	61,509	95.52%	2,885	4.48%	4	0	58,988	0	2,521	0	1,589	0	622	0	219	0	455	0	2.93	7.87	3.93
(3V10) (552) Dayton, OH	48,751	46,483	95.35%	2,268	4.65%	0	0	44,314	0	2,169	0	1,275	0	523	0	178	0	292	0	2.08	7.90	4.26
(3V10) (552GA) Middletown, OH	4,917	4,701	95.61%	216	4.39%	0	0	4,594	0	107	0	69	0	47	0	20	0	80	0	3.95	14.76	2.08
(3V10) (552GB) Lima, OH	4,981	4,904	98.45%	77	1.55%	0	0	4,868	0	36	0	34	0	20	0	9	0	14	0	0.70	4.14	0.94
(3V10) (552GC) Richmond, IN	3,365	3,147	93.52%	218	6.48%	0	0	3,030	0	117	0	125	0	25	0	10	0	58	0	10.30	5.53	1.79
(3V10) (552GD) Springfield, OH	2,029	1,928	95.02%	101	4.98%	0	0	1,837	0	91	0	85	0	6	0	2	0	8	0	4.77	6.20	6.13
(3V10) (552GF) Wright-Patterson, OH	351	346	98.58%	5	1.42%	0	0	345	0	1	0	1	0	1	0	0	0	3	0	4.31	0.00	1.19
(3V10) (757) Columbus, OH HCS	56,582	51,416	90.87%	5,166	9.13%	29	0	48,412	0	3,004	0	2,502	0	1,072	0	657	0	935	0	5.73	11.90	5.79
(3V10) (757) Columbus, OH (Chalmers P. Wylie)	45,661	41,165	90.15%	4,496	9.85%	0	0	38,627	0	2,538	0	2,165	0	939	0	574	0	818	0	4.39	12.50	8.00
(3V10) (757GA) Zanesville, OH	1,111	993	89.38%	118	10.62%	0	0	916	0	77	0	67	0	21	0	18	0	12	0	9.22	13.05	14.47
(3V10) (757GB) Grove City, OH	2,775	2,734	98.52%	41	1.48%	0	0	2,690	0	44	0	15	0	9	0	3	0	14	0	4.28	4.95	2.43
(3V10) (757GC) Marion, OH	2,965	2,745	92.58%	220	7.42%	0	0	2,618	0	127	0	123	0	37	0	29	0	31	0	7.75	6.88	3.75
(3V10) (757GD) Newark, OH (Daniel L. Kinnard)	3,014	2,767	91.80%	247	8.20%	0	0	2,609	0	158	0	108	0	53	0	27	0	59	0	14.76	6.87	6.33
(3V10) (757QC) Columbus Airport Drive, OH	1,056	1,012	95.83%	44	4.17%	0	0	952	0	60	0	24	0	13	0	6	0	1	0			3.70
(3V10) (506) Ann Arbor, MI HCS	65,418	59,413	90.82%	6,005	9.18%	16	0	56,065	0	3,348	0	2,748	0	1,349	0	575	0	1,333	0	5.05	22.38	3.03
(3V10) (506) Ann Arbor, MI	44,153	39,744	90.01%	4,409	9.99%	0	0	37,199	0	2,545	0	1,972	0	891	0	404	0	1,142	0	6.06	24.02	3.90
(3V10) (506GA) Toledo, OH	14,948	13,658	91.37%	1,290	8.63%	0	0	13,085	0	573	0	598	0	390	0	140	0	162	0	3.50	18.13	2.07
(3V10) (506GB) Flint, MI	1,874	1,828	97.55%	46	2.45%	0	0	1,760	0	68	0	38	0	4	0	0	0	4	0	3.85	3.56	1.42
(3V10) (506GC) Jackson, MI	1,455	1,439	98.90%	16	1.10%	0	0	1,396	0	43	0	12	0	1	0	2	0	1	0	2.60	5.85	0.89
(3V10) (506QA) Ann Arbor Packard Road, MI (Packard Road)	597	572	95.81%	25	4.19%	0	0	566	0	6	0	13	0	9	0	1	0	2	0		0.20	0.28
(3V10) (506QB) Green Road, MI	2,391	2,172	90.84%	219	9.16%	0	0	2,059	0	113	0	115	0	54	0	28	0	22	0		28.20	
(3V10) (515) Battle Creek, MI HCS	55,103	48,390	87.82%	6,713	12.18%	64	0	45,784	0	2,606	0	1,849	0	1,028	0	1,154	0	2,682	0	5.42	29.32	4.82
(3V10) (515) Battle Creek, MI	17,411	14,878	85.45%	2,533	14.55%	0	0	14,101	0	777	0	576	0	329	0	619	0	1,009	0	6.55	33.73	4.97
(3V10) (515BY) Wyoming, MI	28,481	24,551	86.20%	3,930	13.80%	0	0	23,003	0	1,548	0	1,123	0	640	0	521	0	1,646	0	5.88	29.23	5.07

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(3V10) (515GA) Muskegon, MI	4,905	4,810	98.06%	95	1.94%	0	0	4,692	0	118	0	54	0	19	0	5	0	17	0	3.54	1.81	3.47
(3V10) (515GB) Lansing, MI	3,320	3,232	97.35%	88	2.65%	0	0	3,119	0	113	0	52	0	21	0	8	0	7	0	3.75	2.21	4.06
(3V10) (515GC) Benton Harbor, MI	986	919	93.20%	67	6.80%	0	0	869	0	50	0	44	0	19	0	1	0	3	0	7.81	4.00	4.12
(3V10) (553) Detroit, MI HCS	61,515	56,819	92.37%	4,696	7.63%	14	1	54,104	1	2,715	0	2,444	0	954	0	536	0	762	0	4.50	10.87	3.06
(3V10) (553) Detroit, MI (John D. Dingell)	53,033	48,377	91.22%	4,656	8.78%	0	1	45,749	1	2,628	0	2,422	0	947	0	534	0	753	0	6.43	10.91	3.48
(3V10) (553GA) Yale, MI	4,993	4,987	99.88%	6	0.12%	0	0	4,981	0	6	0	4	0	0	0	0	0	2	0	0.82		0.09
(3V10) (553GB) Pontiac, MI	3,375	3,352	99.32%	23	0.68%	0	0	3,274	0	78	0	14	0	2	0	0	0	7	0	1.61	4.94	2.08
(3V10) (553QA) Piquette Street, MI	114	103	90.35%	11	9.65%	0	0	100	0	3	0	4	0	5	0	2	0	0	0	10.92		
(3V10) (583) Indianapolis, IN HCS	78,725	73,181	92.96%	5,544	7.04%	37	0	66,801	0	6,380	0	3,038	0	1,348	0	443	0	715	0	2.58	8.46	10.66
(3V10) (583) Indianapolis, IN (Richard L. Roudebush)	62,323	57,661	92.52%	4,662	7.48%	0	0	52,021	0	5,640	0	2,485	0	1,152	0	362	0	663	0	3.89	8.17	12.79
	155	88	56.77%	67	43.23%	0	0	67	0	21	0	56	0	11	0	0	0	0	0	3.89	8.17	12.79
(3V10) (583BU) Indianapolis, IN - VADOM	638	611	95.77%	27	4.23%	0	0	575	0	36	0	23	0	0	0	2	0	2	0		4.91	
(3V10) (583GA) Terre Haute, IN	1,160	1,136	97.93%	24	2.07%	0	0	1,115	0	21	0	14	0	8	0	0	0	2	0	0.11	6.76	0.13
(3V10) (583GB) Bloomington, IN	4,741	4,669	98.48%	72	1.52%	0	0	4,617	0	52	0	32	0	16	0	13	0	11	0	1.39	8.38	0.00
(3V10) (583GC) Martinsville, IN	499	487	97.60%	12	2.40%	0	0	463	0	24	0	4	0	8	0	0	0	0	0	2.73	9.84	1.87
(3V10) (583GD) Indianapolis West, IN	3,045	2,731	89.69%	314	10.31%	0	0	2,542	0	189	0	177	0	88	0	25	0	24	0	2.39	14.72	9.81
(3V10) (583GE) West Lafayette, IN	1,169	1,118	95.64%	51	4.36%	0	0	1,071	0	47	0	41	0	6	0	2	0	2	0	2.90	2.76	5.38
(3V10) (583GF) Wakeman, IN	1,598	1,513	94.68%	85	5.32%	0	0	1,409	0	104	0	47	0	11	0	24	0	3	0	2.09	10.00	3.65
(3V10) (583GG) Shelbyville, IN	950	822	86.53%	128	13.47%	0	0	724	0	98	0	77	0	29	0	14	0	8	0	4.87	14.09	21.12
(3V10) (583QA) Monroe County, IN	429	418	97.44%	11	2.56%	0	0	403	0	15	0	8	0	3	0	0	0	0	0			2.66
(3V10) (583QB) Indianapolis Meridian Street, IN	22	22	100.00%	0	0.00%	0	0	22	0	0	0	0	0	0	0	0	0	0	0	0.41		
(3V10) (583QC) Vigo County, IN	440	435	98.86%	5	1.14%	0	0	420	0	15	0	3	0	2	0	0	0	0	0			4.06
(3V10) (583QD) Indianapolis YMCA, IN	1,120	1,034	92.32%	86	7.68%	0	0	916	0	118	0	71	0	14	0	1	0	0	0		3.55	
(3V10) (583QE) Cold Spring Road, IN	436	436	100.00%	0	0.00%	0	0	436	0	0	0	0	0	0	0	0	0	0	0			
(3V10) (610) Northern Indiana HCS	57,017	51,394	90.14%	5,623	9.86%	3	0	48,712	0	2,682	0	1,789	0	902	0	909	0	2,023	0	4.25	29.38	5.04
(3V10) (610) Marion, IN	12,872	11,252	87.41%	1,620	12.59%	0	0	10,826	0	426	0	243	0	281	0	381	0	715	0	5.96	54.08	4.19
(3V10) (610A4) Fort Wayne, IN	23,741	21,423	90.24%	2,318	9.76%	0	0	20,044	0	1,379	0	879	0	399	0	299	0	741	0	5.11	19.11	0.39
(3V10) (610BU) Marion, IN - VADOM	26	26	100.00%	0	0.00%	0	0	26	0	0	0	0	0	0	0	0	0	0	0			
(3V10) (610BY) St. Joseph County, IN	9,788	8,471	86.54%	1,317	13.46%	0	0	7,954	0	517	0	455	0	154	0	195	0	513	0	3.67	34.92	2.64
(3V10) (610GB) Muncie, IN	2,820	2,780	98.58%	40	1.42%	0	0	2,698	0	82	0	32	0	4	0	3	0	1	0	1.84	2.05	3.87
(3V10) (610GC) Goshen, IN	1,629	1,621	99.51%	8	0.49%	0	0	1,604	0	17	0	5	0	1	0	0	0	2	0	1.96	2.30	0.27
(3V10) (610GD) Peru, IN	3,277	3,237	98.78%	40	1.22%	0	0	3,189	0	48	0	30	0	8	0	1	0	1	0	1.81	3.23	0.84
(3V10) (610QA) Fort Wayne East State Boulevard, IN	2,859	2,579	90.21%	280	9.79%	0	0	2,366	0	213	0	145	0	55	0	30	0	50	0		12.11	8.16
(3V10) (610QB) Columbia Place, IN	5	5	100.00%	0	0.00%	0	0	5	0	0	0	0	0	0	0	0	0	0	0			
(3V10) (655) Saginaw, MI HCS	34,442	31,151	90.44%	3,291	9.56%	25	0	29,688	0	1,463	0	905	0	820	0	491	0	1,075	0	2.86	31.88	2.00
(3V10) (655) Saginaw, MI (Aleda E. Lutz)	18,635	15,708	84.29%	2,927	15.71%	0	0	14,740	0	968	0	668	0	741	0	456	0	1,062	0	2.86	35.02	10.50
(3V10) (655GA) Gaylord, MI	960	914	95.21%	46	4.79%	0	0	872	0	42	0	35	0	8	0	2	0	1	0	3.46	9.96	3.32
(3V10) (655GB) Traverse City, MI (Colonel Demas T. Craw)	2,635	2,515	95.45%	120	4.55%	0	0	2,349	0	166	0	81	0	23	0	13	0	3	0	5.37	7.18	1.79
(3V10) (655GC) Oscoda, MI	2,096	2,086	99.52%	10	0.48%	0	0	2,055	0	31	0	8	0	1	0	0	0	1	0	1.36	8.91	2.35
(3V10) (655GD) Alpena, MI (Lieutenant Colonel Clement C. Van Wagoner)	1,489	1,427	95.84%	62	4.16%	0	0	1,390	0	37	0	28	0	23	0	9	0	2	0	4.84	5.36	2.42
(3V10) (655GE) Clare, MI	1,389	1,349	97.12%	40	2.88%	0	0	1,310	0	39	0	30	0	4	0	6	0	0	0	4.47	1.94	3.48
(3V10) (655GF) Bad Axe, MI	1,692	1,691	99.94%	1	0.06%	0	0	1,677	0	14	0	1	0	0	0	0	0	0	0	0.52	0.66	0.82
(3V10) (655GG) Cadillac, MI	1,373	1,340	97.60%	33	2.40%	0	0	1,284	0	56	0	22	0	4	0	4	0	3	0	2.27	9.27	1.15

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(3V10) (655GH) Cheboygan County, MI	523	511	97.71%	12	2.29%	0	0	496	0	15	0	6	0	6	0	0	0	0	0	2.70	14.73	2.04
(3V10) (655GI) Grayling, MI	676	657	97.19%	19	2.81%	0	0	618	0	39	0	11	0	4	0	1	0	3	0	4.98	2.72	2.83
(3V10) (655QA) Saginaw Barnard Road, MI	2,974	2,953	99.29%	21	0.71%	0	0	2,897	0	56	0	15	0	6	0	0	0	0	0		0.00	1.56
(3V12) (550) Danville, IL HCS	34,945	34,087	97.54%	858	2.46%	1	0	32,970	0	1,117	0	529	0	171	0	66	0	92	0	2.40	4.55	1.45
(3V12) (550) Danville, IL	14,042	13,738	97.84%	304	2.16%	0	0	13,302	0	436	0	193	0	76	0	15	0	20	0	1.87	3.46	0.59
(3V12) (550BY) Peoria, IL (Bob Michel)	10,203	9,933	97.35%	270	2.65%	0	0	9,607	0	326	0	155	0	51	0	34	0	30	0	1.94	5.63	2.93
(3V12) (550GA) Decatur, IL	5,304	5,157	97.23%	147	2.77%	0	0	5,000	0	157	0	78	0	21	0	11	0	37	0	2.15	5.88	0.72
(3V12) (550GD) Springfield, IL	3,090	3,034	98.19%	56	1.81%	0	0	2,934	0	100	0	38	0	10	0	5	0	3	0	3.59	4.13	0.98
(3V12) (550GF) Mattoon, IL	833	829	99.52%	4	0.48%	0	0	819	0	10	0	1	0	2	0	0	0	1	0	1.27	2.92	1.66
(3V12) (550GG) Bloomington, IL	1,473	1,396	94.77%	77	5.23%	0	0	1,308	0	88	0	64	0	11	0	1	0	1	0	6.05	4.49	2.44
(3V12) (537) Chicago, IL HCS	57,194	48,566	84.91%	8,628	15.09%	7	0	45,052	0	3,514	0	3,359	0	1,808	0	1,284	0	2,177	0	14.04	21.46	3.11
(3V12) (537) Chicago, IL (Jesse Brown)	45,053	38,363	85.15%	6,690	14.85%	0	0	35,428	0	2,935	0	2,732	0	1,412	0	921	0	1,625	0	15.94	19.00	3.10
(3V12) (537BY) Crown Point, IN (Adam Benjamin Jr.)	9,939	8,127	81.77%	1,812	18.23%	0	0	7,656	0	471	0	537	0	373	0	354	0	548	0	13.60	33.99	3.29
(3V12) (537GA) Chicago Heights, IL	555	551	99.28%	4	0.72%	0	0	527	0	24	0	1	0	0	0	3	0	0	0	5.66		2.48
(3V12) (537GD) Lakeside, IL	1,073	971	90.49%	102	9.51%	0	0	909	0	62	0	75	0	20	0	3	0	4	0	10.68		
(3V12) (537HA) Auburn Gresham, IL	574	554	96.52%	20	3.48%	0	0	532	0	22	0	14	0	3	0	3	0	0	0	6.15		3.89
(3V12) (556) North Chicago, IL HCS	26,838	25,164	93.76%	1,674	6.24%	11	0	23,873	0	1,291	0	808	0	448	0	169	0	249	0	6.10	6.99	4.52
(3V12) (556) North Chicago, IL (Captain James A. Lovell)	24,823	23,187	93.41%	1,636	6.59%	0	0	21,957	0	1,230	0	782	0	440	0	169	0	245	0	7.84	7.00	5.22
(3V12) (556GA) Evanston, IL	348	340	97.70%	8	2.30%	0	0	331	0	9	0	6	0	1	0	0	0	1	0	4.14	3.52	2.69
(3V12) (556GC) McHenry, IL	886	868	97.97%	18	2.03%	0	0	836	0	32	0	11	0	4	0	0	0	3	0	3.32	6.35	2.94
(3V12) (556GD) Kenosha, WI	781	769	98.46%	12	1.54%	0	0	749	0	20	0	9	0	3	0	0	0	0	0	1.24	8.08	1.65
(3V12) (578) Hines, IL HCS	91,875	84,994	92.51%	6,881	7.49%	9	0	81,076	0	3,918	0	2,873	0	1,083	0	641	0	2,284	0	5.91	13.38	3.48
(3V12) (578) Hines, IL (Edward Hines Junior)	73,506	68,280	92.89%	5,226	7.11%	0	0	65,106	0	3,174	0	2,336	0	851	0	464	0	1,575	0	4.55	10.91	2.98
(3V12) (578GA) Joliet, IL	8,805	7,478	84.93%	1,327	15.07%	0	0	7,019	0	459	0	377	0	175	0	148	0	627	0	8.88	40.08	4.48
(3V12) (578GC) Kankakee County, IL	1,113	1,061	95.33%	52	4.67%	0	0	1,016	0	45	0	23	0	7	0	6	0	16	0	4.98	6.66	3.64
(3V12) (578GD) Aurora, IL	2,533	2,431	95.97%	102	4.03%	0	0	2,379	0	52	0	40	0	14	0	8	0	40	0	16.03	3.20	6.97
(3V12) (578GE) Hoffman Estates, IL	2,184	2,156	98.72%	28	1.28%	0	0	2,083	0	73	0	20	0	4	0	0	0	4	0	2.09	2.87	3.23
(3V12) (578GF) LaSalle, IL	1,344	1,232	91.67%	112	8.33%	0	0	1,173	0	59	0	60	0	27	0	13	0	12	0	5.09	11.34	5.11
(3V12) (578GG) Oak Lawn, IL	2,390	2,356	98.58%	34	1.42%	0	0	2,300	0	56	0	17	0	5	0	2	0	10	0	3.74	8.04	4.39
(3V12) (585) Iron Mountain, MI HCS	15,679	14,468	92.28%	1,211	7.72%	9	0	13,645	0	823	0	682	0	299	0	108	0	122	0	2.94	16.75	2.34
(3V12) (585) Iron Mountain, MI (Oscar G. Johnson)	10,639	9,604	90.27%	1,035	9.73%	0	0	8,988	0	616	0	575	0	254	0	88	0	118	0	4.00	16.88	1.21
(3V12) (585GA) Hancock, MI	754	737	97.75%	17	2.25%	0	0	728	0	9	0	5	0	8	0	4	0	0	0	0.58	29.58	0.02
(3V12) (585GB) Rhinelander, WI	746	702	94.10%	44	5.90%	0	0	640	0	62	0	22	0	15	0	6	0	1	0	3.99	14.76	7.60
(3V12) (585GC) Menominee, MI	628	605	96.34%	23	3.66%	0	0	591	0	14	0	10	0	7	0	4	0	2	0	2.91	32.47	1.24
(3V12) (585GD) Ironwood, MI	445	430	96.63%	15	3.37%	0	0	415	0	15	0	12	0	2	0	1	0	0	0	2.54	14.52	0.52
(3V12) (585GF) Manistique, MI	322	308	95.65%	14	4.35%	0	0	296	0	12	0	10	0	2	0	1	0	1	0	7.73	28.00	2.23
(3V12) (585HA) Marquette, MI	1,486	1,435	96.57%	51	3.43%	0	0	1,368	0	67	0	38	0	9	0	4	0	0	0	2.30	8.50	4.72
(3V12) (585HB) Sault Saint Marie, MI	659	647	98.18%	12	1.82%	0	0	619	0	28	0	10	0	2	0	0	0	0	0	2.00	7.44	2.26
(3V12) (607) Madison, WI HCS	35,647	32,205	90.34%	3,442	9.66%	14	0	30,148	0	2,057	0	1,480	0	677	0	359	0	926	0	9.47	17.84	2.82
(3V12) (607) Madison, WI (William S. Middleton)	24,187	21,153	87.46%	3,034	12.54%	0	0	19,557	0	1,596	0	1,273	0	571	0	333	0	857	0	13.44	22.87	2.87
(3V12) (607GC) Janesville, WI	1,836	1,793	97.66%	43	2.34%	0	0	1,715	0	78	0	40	0	3	0	0	0	0	0	5.14	1.80	0.00
(3V12) (607GD) Baraboo, WI	874	862	98.63%	12	1.37%	0	0	846	0	16	0	7	0	2	0	1	0	2	0	4.26	0.71	0.00

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(3V12) (607GE) Beaver Dam, WI	1,315	1,282	97.49%	33	2.51%	0	0	1,229	0	53	0	24	0	6	0	0	0	3	0	7.66	0.64	0.00
(3V12) (607GF) Freeport, IL	780	777	99.62%	3	0.38%	0	0	756	0	21	0	2	0	1	0	0	0	0	0	5.42	1.73	0.00
(3V12) (607GG) Madison West, WI	1,537	1,458	94.86%	79	5.14%	0	0	1,378	0	80	0	47	0	12	0	5	0	15	0	15.19	5.82	2.11
(3V12) (607HA) Rockford, IL	5,118	4,880	95.35%	238	4.65%	0	0	4,667	0	213	0	87	0	82	0	20	0	49	0	6.57	8.23	2.90
(3V12) (676) Tomah, WI HCS	28,421	24,935	87.73%	3,486	12.27%	3	0	23,294	0	1,641	0	1,272	0	510	0	418	0	1,286	0	7.54	45.01	1.81
(3V12) (676) Tomah, WI	14,746	12,497	84.75%	2,249	15.25%	0	0	11,582	0	915	0	687	0	348	0	318	0	896	0	8.81	49.62	2.21
(3V12) (676GA) Wausau, WI	3,207	3,050	95.10%	157	4.90%	0	0	2,930	0	120	0	115	0	33	0	6	0	3	0	5.44	17.59	1.94
(3V12) (676GC) La Crosse, WI	4,376	3,990	91.18%	386	8.82%	0	0	3,668	0	322	0	264	0	57	0	33	0	32	0	9.65	17.03	1.39
(3V12) (676GD) Wisconsin Rapids, WI	5,423	4,760	87.77%	663	12.23%	0	0	4,507	0	253	0	180	0	69	0	60	0	354	0	6.08	37.94	1.30
(3V12) (676GE) Clark County, WI	669	638	95.37%	31	4.63%	0	0	607	0	31	0	26	0	3	0	1	0	1	0	4.86	5.93	1.56
(3V12) (695) Milwaukee, WI HCS	93,464	84,640	90.56%	8,824	9.44%	1	0	79,806	0	4,834	0	3,368	0	1,754	0	1,335	0	2,367	0	10.25	12.40	4.26
(3V12) (695) Milwaukee, WI (Clement J. Zablocki)	63,914	58,996	92.31%	4,918	7.69%	0	0	55,912	0	3,084	0	2,078	0	1,059	0	715	0	1,066	0	11.02	9.04	3.62
(3V12) (695BU) Milwaukee, WI - VADOM	3	3	100.00%	0	0.00%	0	0	3	0	0	0	0	0	0	0	0	0	0	0			
(3V12) (695BY) Appleton, WI (John H. Bradley)	7,797	6,965	89.33%	832	10.67%	0	0	6,463	0	502	0	255	0	69	0	155	0	353	0	11.74	22.31	3.09
(3V12) (695GA) Union Grove, WI	1,115	1,065	95.52%	50	4.48%	0	0	1,015	0	50	0	31	0	15	0	0	0	4	0	5.44	0.00	5.13
(3V12) (695GC) Cleveland, WI	1,930	1,753	90.83%	177	9.17%	0	0	1,625	0	128	0	109	0	32	0	18	0	18	0	10.36		5.35
(3V12) (695GD) Green Bay, WI (Milo C. Huempfner)	18,704	15,857	84.78%	2,847	15.22%	0	0	14,787	0	1,070	0	895	0	579	0	447	0	926	0	9.01	21.03	7.39
(3V12) (695QA) Milwaukee MLK Drive, WI	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(3V15) (589A4) Columbia, MO HCS	78,272	74,306	94.93%	3,966	5.07%	0	0	71,159	0	3,147	0	2,090	0	923	0	461	0	492	0	3.24	5.73	12.07
(3V15) (589A4) Columbia, MO (Harry S. Truman)	52,391	49,254	94.01%	3,137	5.99%	0	0	46,716	0	2,538	0	1,708	0	722	0	325	0	382	0	4.34	5.51	12.89
(3V15) (589BX) Columbia, MO - VADOM	6	6	100.00%	0	0.00%	0	0	6	0	0	0	0	0	0	0	0	0	0	0			
(3V15) (589G8) Jefferson City, MO	6,297	6,005	95.36%	292	4.64%	0	0	5,926	0	79	0	86	0	80	0	62	0	64	0	2.50	7.63	7.90
(3V15) (589GE) Kirksville, MO	2,113	2,089	98.86%	24	1.14%	0	0	2,059	0	30	0	13	0	8	0	1	0	2	0	1.96	4.17	7.38
(3V15) (589GF) Waynesville, MO	4,072	3,888	95.48%	184	4.52%	0	0	3,693	0	195	0	129	0	35	0	13	0	7	0	3.19	12.31	14.74
(3V15) (589GH) Lake of the Ozarks, MO	2,685	2,606	97.06%	79	2.94%	0	0	2,534	0	72	0	44	0	14	0	15	0	6	0	2.34	0.60	14.62
(3V15) (589GX) Mexico, MO	2,120	2,094	98.77%	26	1.23%	0	0	2,062	0	32	0	13	0	7	0	3	0	3	0	1.55	2.00	4.02
(3V15) (589GY) St. James, MO	2,528	2,410	95.33%	118	4.67%	0	0	2,301	0	109	0	59	0	19	0	17	0	23	0	4.63	9.62	3.43
(3V15) (589JA) Sedalia, MO	2,512	2,496	99.36%	16	0.64%	0	0	2,456	0	40	0	11	0	3	0	2	0	0	0	1.87	1.43	5.25
(3V15) (589JD) Marshfield, MO	3,548	3,458	97.46%	90	2.54%	0	0	3,406	0	52	0	27	0	35	0	23	0	5	0	1.76	4.45	14.12
(3V15) (589) Kansas City, MO HCS	76,361	73,053	95.67%	3,308	4.33%	130	0	70,027	0	3,026	0	1,479	0	798	0	378	0	653	0	2.41	5.94	2.98
(3V15) (589) Kansas City, MO	47,093	44,133	93.71%	2,960	6.29%	0	0	41,600	0	2,533	0	1,248	0	752	0	358	0	602	0	4.02	6.27	3.28
(3V15) (589G1) Warrensburg, MO	4,475	4,449	99.42%	26	0.58%	0	0	4,386	0	63	0	17	0	5	0	1	0	3	0	1.15	1.37	5.19
(3V15) (589GB) Belton, MO	2,897	2,826	97.55%	71	2.45%	0	0	2,752	0	74	0	44	0	13	0	3	0	11	0	3.67	0.00	6.14
(3V15) (589GC) Paola, KS	849	826	97.29%	23	2.71%	0	0	800	0	26	0	19	0	4	0	0	0	0	0	3.20	6.67	1.20
(3V15) (589GD) Nevada, MO	1,707	1,688	98.89%	19	1.11%	0	0	1,678	0	10	0	16	0	0	0	1	0	2	0	0.72	7.17	0.65
(3V15) (589GZ) Cameron, MO	1,031	1,000	96.99%	31	3.01%	0	0	970	0	30	0	23	0	6	0	2	0	0	0	3.42	3.00	3.50
(3V15) (589JB) Excelsior Springs, MO	1,884	1,856	98.51%	28	1.49%	0	0	1,818	0	38	0	22	0	4	0	0	0	2	0	2.45	31.00	1.12
(3V15) (589JC) Shawnee, KS	3,469	3,429	98.85%	40	1.15%	0	0	3,341	0	88	0	29	0	5	0	3	0	3	0	1.95	12.10	
(3V15) (589JF) Honor, MO	12,176	12,071	99.14%	105	0.86%	0	0	11,912	0	159	0	56	0	9	0	10	0	30	0	1.76	14.30	1.09
(3V15) (589QA) Overland Park, KS	780	775	99.36%	5	0.64%	0	0	770	0	5	0	5	0	0	0	0	0	0	0		0.40	0.00
(3V15) (589A5) Eastern Kansas HCS	58,668	55,522	94.64%	3,146	5.36%	0	0	53,448	0	2,074	0	1,663	0	569	0	347	0	567	0	2.81	13.36	3.84
(3V15) (589A5) Topeka, KS (Colmery-ONeil)	24,893	23,134	92.93%	1,759	7.07%	0	0	22,037	0	1,097	0	812	0	330	0	235	0	382	0	3.15	18.61	4.43

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(3V15) (589A6) Leavenworth, KS (Dwight D. Eisenhower)	22,811	21,653	94.92%	1,158	5.08%	0	0	20,911	0	742	0	664	0	210	0	106	0	178	0	2.99	8.41	4.56
(3V15) (589BU) Leavenworth, KS - VADOM	10	10	100.00%	0	0.00%	0	0	10	0	0	0	0	0	0	0	0	0	0	0			0.00
(3V15) (589GI) St. Joseph, MO	2,955	2,934	99.29%	21	0.71%	0	0	2,892	0	42	0	10	0	4	0	4	0	3	0	2.11	4.67	1.68
(3V15) (589GJ) Wyandotte County, KS	1,321	1,302	98.56%	19	1.44%	0	0	1,275	0	27	0	17	0	2	0	0	0	0	0	1.71		2.14
(3V15) (589GM) Chanute, KS	314	313	99.68%	1	0.32%	0	0	307	0	6	0	1	0	0	0	0	0	0	0	3.22		0.39
(3V15) (589GP) Garnett, KS	148	147	99.32%	1	0.68%	0	0	147	0	0	0	1	0	0	0	0	0	0	0	1.44		0.00
(3V15) (589GR) Junction City, KS (Lieutenant General Richard J. Seitz-Based)	3,539	3,404	96.19%	135	3.81%	0	0	3,298	0	106	0	114	0	17	0	2	0	2	0	2.30	6.15	1.75
(3V15) (589GU) Lawrence, KS	843	827	98.10%	16	1.90%	0	0	800	0	27	0	12	0	3	0	0	0	1	0	3.54	7.00	0.25
(3V15) (589GV) Fort Scott, KS	662	661	99.85%	1	0.15%	0	0	657	0	4	0	0	0	0	0	0	0	1	0	1.81	0.00	1.12
(3V15) (589JE) Platte City, MO	1,172	1,137	97.01%	35	2.99%	0	0	1,114	0	23	0	32	0	3	0	0	0	0	0	2.40		1.88
(3V15) (589A7) Wichita, KS HCS	49,030	47,096	96.06%	1,934	3.94%	0	0	45,224	0	1,872	0	1,157	0	399	0	173	0	205	0	2.06	6.35	5.62
(3V15) (589A7) Wichita, KS (Robert J. Dole)	34,682	33,056	95.31%	1,626	4.69%	0	0	31,387	0	1,669	0	983	0	347	0	144	0	152	0	2.48	7.33	6.10
(3V15) (589G2) Dodge City, KS	1,484	1,469	98.99%	15	1.01%	0	0	1,449	0	20	0	11	0	0	0	4	0	0	0	1.85	0.10	1.88
(3V15) (589G4) Hays, KS	1,817	1,791	98.57%	26	1.43%	0	0	1,761	0	30	0	5	0	3	0	3	0	15	0	2.74	0.00	2.28
(3V15) (589G5) Parsons, KS	854	840	98.36%	14	1.64%	0	0	821	0	19	0	7	0	2	0	4	0	1	0	1.58	1.00	4.47
(3V15) (589G7) Hutchinson, KS	2,081	2,067	99.33%	14	0.67%	0	0	2,049	0	18	0	6	0	5	0	0	0	3	0	0.68	0.00	0.42
(3V15) (589GW) Salina, KS	3,188	3,172	99.50%	16	0.50%	0	0	3,123	0	49	0	13	0	1	0	1	0	1	0	1.34	0.75	2.98
(3V15) (589QC) South Parklane, KS	4,924	4,701	95.47%	223	4.53%	0	0	4,634	0	67	0	132	0	41	0	17	0	33	0		4.57	
(3V15) (657A5) Marion, IL HCS	53,491	52,128	97.45%	1,363	2.55%	0	0	50,512	0	1,616	0	756	0	266	0	150	0	191	0	2.00	7.12	2.57
(3V15) (657A5) Marion, IL	15,955	15,283	95.79%	672	4.21%	0	0	14,648	0	635	0	403	0	124	0	86	0	59	0	0.82	6.79	1.34
(3V15) (657BW) Marion MH-RRTP	104	103	99.04%	1	0.96%	0	0	101	0	2	0	1	0	0	0	0	0	0	0			1.93
(3V15) (657GJ) Evansville, IN	20,372	19,833	97.35%	539	2.65%	0	0	19,183	0	650	0	241	0	118	0	60	0	120	0	1.49	7.52	6.08
(3V15) (657GK) Mount Vernon, IL	2,572	2,569	99.88%	3	0.12%	0	0	2,546	0	23	0	1	0	1	0	0	0	1	0	2.34	0.00	2.81
(3V15) (657GL) Paducah, KY	3,104	3,084	99.36%	20	0.64%	0	0	3,026	0	58	0	15	0	2	0	1	0	2	0	2.06	14.00	1.28
(3V15) (657GM) Effingham, IL	537	531	98.88%	6	1.12%	0	0	506	0	25	0	6	0	0	0	0	0	0	0	2.87	16.00	0.25
(3V15) (657GO) Madisonville, KY	292	292	100.00%	0	0.00%	0	0	287	0	5	0	0	0	0	0	0	0	0	0	1.92		
(3V15) (657GP) Owensboro, KY	1,368	1,343	98.17%	25	1.83%	0	0	1,310	0	33	0	17	0	3	0	1	0	4	0	3.77	10.29	1.17
(3V15) (657GQ) Vincennes, IN	1,268	1,237	97.56%	31	2.44%	0	0	1,205	0	32	0	16	0	12	0	1	0	2	0	4.72		0.71
(3V15) (657GR) Mayfield, KY	1,532	1,516	98.96%	16	1.04%	0	0	1,486	0	30	0	15	0	0	0	0	0	1	0	1.33		2.41
(3V15) (657GT) Carbondale, IL	2,412	2,402	99.59%	10	0.41%	0	0	2,380	0	22	0	7	0	1	0	1	0	1	0	1.76		0.75
(3V15) (657GU) Harrisburg, IL	1,033	1,033	100.00%	0	0.00%	0	0	1,027	0	6	0	0	0	0	0	0	0	0	0	1.93		0.72
(3V15) (657QD) Heartland Street, IL	2,942	2,902	98.64%	40	1.36%	0	0	2,807	0	95	0	34	0	5	0	0	0	1	0	3.04	9.23	0.87
(3V15) (657A4) Poplar Bluff, MO HCS	28,063	27,261	97.14%	802	2.86%	0	0	26,472	0	789	0	385	0	137	0	140	0	140	0	2.75	9.80	3.20
(3V15) (657A4) Poplar Bluff, MO (John J. Pershing)	12,151	11,550	95.05%	601	4.95%	0	0	11,056	0	494	0	278	0	92	0	117	0	114	0	5.05	10.91	2.40
(3V15) (657GF) West Plains, MO	3,284	3,256	99.15%	28	0.85%	0	0	3,181	0	75	0	13	0	7	0	4	0	4	0	1.09	1.24	5.06
(3V15) (657GG) Paragould, AR	2,372	2,359	99.45%	13	0.55%	0	0	2,322	0	37	0	8	0	0	0	2	0	3	0	1.76	0.00	1.58
(3V15) (657GH) Cape Girardeau, MO	3,900	3,822	98.00%	78	2.00%	0	0	3,697	0	125	0	61	0	9	0	4	0	4	0	1.82	0.46	3.75
(3V15) (657GI) Farmington, MO	4,065	4,035	99.26%	30	0.74%	0	0	3,990	0	45	0	12	0	9	0	3	0	6	0	1.24	2.58	3.46
(3V15) (657GV) Sikeston, MO	1,296	1,253	96.68%	43	3.32%	0	0	1,244	0	9	0	6	0	19	0	10	0	8	0	2.63	0.51	1.31
(3V15) (657GW) Pocahontas, AR	995	986	99.10%	9	0.90%	0	0	982	0	4	0	7	0	1	0	0	0	1	0	0.97	0.00	2.87
(3V15) (657) St. Louis, MO HCS	71,178	64,060	90.00%	7,118	10.00%	84	0	61,019	0	3,041	0	2,550	0	1,110	0	581	0	2,877	0	11.22	30.55	4.50
(3V15) (657) St. Louis John Cochran, MO (John Cochran)	36,572	31,868	87.14%	4,704	12.86%	0	0	30,297	0	1,571	0	1,441	0	646	0	320	0	2,297	0	7.33	39.49	3.27

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(3V15) (657A0) St. Louis Jefferson Barracks, MO	17,983	16,517	91.85%	1,466	8.15%	0	0	15,698	0	819	0	692	0	257	0	171	0	346	0	10.55	25.27	5.00
(3V15) (657BU) St. Louis-Jefferson Barracks, MO - VADOM	9	9	100.00%	0	0.00%	0	0	9	0	0	0	0	0	0	0	0	0	0	0			
(3V15) (657GA) St. Clair County, IL	3,253	2,894	88.96%	359	11.04%	0	0	2,683	0	211	0	160	0	70	0	32	0	97	0	17.50	5.22	0.00
(3V15) (657GB) St. Louis County, MO	3,970	3,922	98.79%	48	1.21%	0	0	3,793	0	129	0	25	0	8	0	6	0	9	0	3.61	0.79	0.00
(3V15) (657GD) St. Charles County, MO	1,759	1,532	87.09%	227	12.91%	0	0	1,460	0	72	0	87	0	77	0	35	0	28	0	22.83	2.18	0.51
(3V15) (657GS) Franklin County, MO	1,361	1,304	95.81%	57	4.19%	0	0	1,242	0	62	0	43	0	10	0	0	0	4	0	5.54	11.63	4.29
(3V15) (657GX) Washington Avenue, MO	1,160	1,103	95.09%	57	4.91%	0	0	1,057	0	46	0	22	0	9	0	8	0	18	0	7.71	0.00	0.44
(3V15) (657GY) Manchester Avenue, MO	770	649	84.29%	121	15.71%	0	0	591	0	58	0	37	0	22	0	3	0	59	0	34.42	0.38	3.73
(3V15) (657PD) St Louis SARRTP	353	353	100.00%	0	0.00%	0	0	353	0	0	0	0	0	0	0	0	0	0	0			
(3V15) (657QA) Olive Street, MO	3,751	3,675	97.97%	76	2.03%	0	0	3,603	0	72	0	40	0	11	0	6	0	19	0	4.89	3.30	0.67
(3V15) (657QB) Washington Boulevard, MO	237	234	98.73%	3	1.27%	0	0	233	0	1	0	3	0	0	0	0	0	0	0			
(4V16) (502) Alexandria, LA HCS	41,403	37,860	91.44%	3,543	8.56%	6	0	35,192	0	2,668	0	1,445	0	414	0	336	0	1,348	0	7.42	20.97	8.74
(4V16) (502) Alexandria, LA	22,024	19,674	89.33%	2,350	10.67%	0	0	18,807	0	867	0	662	0	256	0	231	0	1,201	0	7.82	25.85	3.14
(4V16) (502GA) Jennings, LA	1,499	1,462	97.53%	37	2.47%	0	0	1,436	0	26	0	16	0	3	0	4	0	14	0	3.66	3.38	4.10
(4V16) (502GB) Lafayette, LA	8,454	7,911	93.58%	543	6.42%	0	0	6,875	0	1,036	0	363	0	55	0	33	0	92	0	9.61	5.35	0.40
(4V16) (502GE) Lake Charles, LA (Douglas Fournet)	2,757	2,649	96.08%	108	3.92%	0	0	2,586	0	63	0	29	0	21	0	38	0	20	0	5.33	0.51	3.28
(4V16) (502GF) Fort Polk, LA	3,533	3,340	94.54%	193	5.46%	0	0	2,954	0	386	0	155	0	17	0	9	0	12	0	3.31	2.17	16.80
(4V16) (502GG) Natchitoches, LA	920	901	97.93%	19	2.07%	0	0	879	0	22	0	13	0	5	0	1	0	0	0	2.29	0.14	4.26
(4V16) (502QB) Lafayette Campus B, LA	2,216	1,923	86.78%	293	13.22%	0	0	1,655	0	268	0	207	0	57	0	20	0	9	0			11.67
(4V16) (520) Gulf Coast, MS HCS	93,378	85,859	91.95%	7,519	8.05%	24	0	80,780	0	5,079	0	2,834	0	1,560	0	1,199	0	1,926	0	4.35	24.12	5.47
(4V16) (520) Biloxi, MS	33,783	30,664	90.77%	3,119	9.23%	0	0	28,288	0	2,376	0	1,132	0	602	0	353	0	1,032	0	5.18	28.48	6.34
(4V16) (520BZ) Pensacola, FL	33,638	30,635	91.07%	3,003	8.93%	0	0	28,879	0	1,756	0	1,137	0	620	0	662	0	584	0	5.17	18.79	7.22
(4V16) (520GA) Mobile, AL	12,319	11,611	94.25%	708	5.75%	0	0	11,233	0	378	0	253	0	117	0	85	0	253	0	2.69	29.41	1.31
(4V16) (520GB) Panama City Beach, FL	4,599	4,495	97.74%	104	2.26%	0	0	4,447	0	48	0	23	0	26	0	33	0	22	0	1.30	14.83	0.29
(4V16) (520GC) Eglin Air Force Base, FL	7,650	7,107	92.90%	543	7.10%	0	0	6,660	0	447	0	257	0	186	0	65	0	35	0	4.36	27.83	11.25
(4V16) (520QA) Panama City Beach West, FL	1,389	1,347	96.98%	42	3.02%	0	0	1,273	0	74	0	32	0	9	0	1	0	0	0		8.90	2.27
(4V16) (564) Fayetteville, AR HCS	64,878	61,912	95.43%	2,966	4.57%	2	0	59,638	0	2,274	0	1,516	0	604	0	395	0	451	0	4.70	4.51	2.98
(4V16) (564) Fayetteville, AR	25,974	24,589	94.67%	1,385	5.33%	0	0	23,481	0	1,108	0	791	0	217	0	154	0	223	0	3.90	4.38	2.77
(4V16) (564BY) Springfield, MO (Gene Taylor)	21,595	20,729	95.99%	866	4.01%	0	0	20,018	0	711	0	366	0	161	0	153	0	186	0	6.82	4.14	3.32
(4V16) (564GA) Harrison, AR	1,584	1,548	97.73%	36	2.27%	0	0	1,524	0	24	0	25	0	6	0	2	0	3	0	2.35	0.00	0.27
(4V16) (564GB) Fort Smith, AR	3,383	3,270	96.66%	113	3.34%	0	0	3,148	0	122	0	71	0	29	0	8	0	5	0	3.39	1.65	1.28
(4V16) (564GC) Branson, MO	6,641	6,309	95.00%	332	5.00%	0	0	6,205	0	104	0	116	0	147	0	51	0	18	0	3.34	6.86	1.16
(4V16) (564GD) Ozark, AR	574	512	89.20%	62	10.80%	0	0	470	0	42	0	48	0	9	0	3	0	2	0	7.06	0.00	11.19
(4V16) (564GE) Jay, OK	1,166	1,159	99.40%	7	0.60%	0	0	1,154	0	5	0	5	0	1	0	1	0	0	0	0.55	0.61	0.88
(4V16) (564GF) Joplin, MO	3,398	3,296	97.00%	102	3.00%	0	0	3,187	0	109	0	55	0	15	0	19	0	13	0	4.20	1.19	5.76
(4V16) (564QB) Sunbridge, AR	563	500	88.81%	63	11.19%	0	0	451	0	49	0	39	0	19	0	4	0	1	0		9.66	
(4V16) (580) Houston, TX HCS	176,129	167,578	95.15%	8,551	4.85%	19	0	161,937	0	5,641	0	4,208	0	2,022	0	1,085	0	1,236	0	4.21	5.30	3.09
(4V16) (580) Houston, TX (Michael E. DeBakey)	103,409	97,199	93.99%	6,210	6.01%	0	0	93,625	0	3,574	0	2,968	0	1,510	0	750	0	982	0	5.70	5.18	4.48
(4V16) (580BY) Beaumont, TX	10,588	10,074	95.15%	514	4.85%	0	0	9,883	0	191	0	228	0	141	0	105	0	40	0	5.20	3.86	0.40
(4V16) (580BZ) Lufkin, TX (Charles Wilson)	9,250	8,553	92.46%	697	7.54%	0	0	8,340	0	213	0	255	0	166	0	163	0	113	0	6.40	16.96	2.02
(4V16) (580GC) Galveston County, TX	1,781	1,762	98.93%	19	1.07%	0	0	1,465	0	297	0	17	0	0	0	1	0	1	0	6.90	0.00	0.66
(4V16) (580GD) Conroe, TX	13,146	12,835	97.63%	311	2.37%	0	0	12,466	0	369	0	235	0	42	0	9	0	25	0	1.90	4.37	2.23

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(4V16) (580GE) Katy, TX	10,092	9,891	98.01%	201	1.99%	0	0	9,667	0	224	0	129	0	56	0	6	0	10	0	1.92	3.53	1.03
(4V16) (580GF) Lake Jackson, TX	2,956	2,935	99.29%	21	0.71%	0	0	2,890	0	45	0	15	0	3	0	1	0	2	0	2.97		3.30
(4V16) (580GG) Richmond, TX	5,930	5,821	98.16%	109	1.84%	0	0	5,657	0	164	0	72	0	21	0	0	0	16	0	2.68	2.71	5.60
(4V16) (580GH) Tomball, TX	8,886	8,556	96.29%	330	3.71%	0	0	8,309	0	247	0	186	0	67	0	46	0	31	0	2.99	8.07	1.04
(4V16) (580GJ) Texas City, TX	9,608	9,487	98.74%	121	1.26%	0	0	9,183	0	304	0	85	0	16	0	4	0	16	0	2.51	2.52	0.76
(4V16) (580GL) Sugar Land, TX	483	465	96.27%	18	3.73%	0	0	452	0	13	0	18	0	0	0	0	0	0	0	2.86		0.00
(4V16) (586) Jackson, MS HCS	61,911	58,250	94.09%	3,661	5.91%	2	1	56,378	1	1,872	0	1,513	0	743	0	371	0	1,034	0	3.53	12.83	1.28
(4V16) (586) Jackson, MS (G.V. (Sonny) Montgomery)	42,218	39,220	92.90%	2,998	7.10%	0	1	37,822	1	1,398	0	1,225	0	608	0	257	0	908	0	5.44	12.87	1.07
(4V16) (586GA) Kosciusko, MS	1,867	1,810	96.95%	57	3.05%	0	0	1,787	0	23	0	10	0	7	0	20	0	20	0	1.87	36.25	5.59
(4V16) (586GB) Meridian, MS	2,857	2,830	99.05%	27	0.95%	0	0	2,815	0	15	0	12	0	2	0	1	0	12	0	0.46	42.91	0.37
(4V16) (586GC) Greenville, MS	1,793	1,776	99.05%	17	0.95%	0	0	1,717	0	59	0	12	0	2	0	1	0	2	0	1.61	5.94	1.51
(4V16) (586GD) Hattiesburg, MS	5,569	5,404	97.04%	165	2.96%	0	0	5,271	0	133	0	82	0	30	0	9	0	44	0	3.71	26.38	1.85
(4V16) (586GE) Natchez, MS	1,195	1,189	99.50%	6	0.50%	0	0	1,182	0	7	0	3	0	3	0	0	0	0	0	0.49	41.25	0.60
(4V16) (586GF) Columbus, MS	1,935	1,918	99.12%	17	0.88%	0	0	1,873	0	45	0	6	0	2	0	3	0	6	0	1.56	10.92	2.20
(4V16) (586GG) McComb, MS	1,564	1,563	99.94%	1	0.06%	0	0	1,558	0	5	0	0	0	1	0	0	0	0	0	1.11	0.00	0.00
(4V16) (586QB) Dogwood View Parkway, MS	2,913	2,540	87.20%	373	12.80%	0	0	2,353	0	187	0	163	0	88	0	80	0	42	0		12.25	
(4V16) (598) Little Rock, AR HCS	102,830	92,956	90.40%	9,874	9.60%	16	0	89,247	0	3,709	0	3,103	0	2,082	0	1,565	0	3,124	0	3.49	16.61	6.37
(4V16) (598) Little Rock, AR (John L. McClellan)	41,239	35,057	85.01%	6,182	14.99%	0	0	33,516	0	1,541	0	1,718	0	1,345	0	853	0	2,266	0	3.90	18.75	1.06
(4V16) (598A0) North Little Rock, AR (Eugene J. Towbin Healthcare Center)	32,935	30,842	93.65%	2,093	6.35%	0	0	29,511	0	1,331	0	799	0	425	0	363	0	506	0	3.27	14.38	8.53
(4V16) (598GA) Mountain Home, AR	4,678	4,509	96.39%	169	3.61%	0	0	4,393	0	116	0	57	0	39	0	24	0	49	0	4.71	7.81	3.00
(4V16) (598GB) El Dorado, AR	2,222	2,209	99.41%	13	0.59%	0	0	2,188	0	21	0	5	0	1	0	5	0	2	0	3.57	1.44	0.88
(4V16) (598GC) Hot Springs, AR	6,883	6,532	94.90%	351	5.10%	0	0	6,297	0	235	0	146	0	72	0	48	0	85	0	2.48	11.07	2.30
(4V16) (598GD) Mena, AR	1,000	994	99.40%	6	0.60%	0	0	979	0	15	0	5	0	0	0	0	0	1	0	2.34	1.40	1.34
(4V16) (598GE) Pine Bluff, AR	2,182	2,067	94.73%	115	5.27%	0	0	1,973	0	94	0	81	0	24	0	8	0	2	0	6.45	1.49	5.34
(4V16) (598GF) Searcy, AR	3,821	3,775	98.80%	46	1.20%	0	0	3,686	0	89	0	25	0	15	0	2	0	4	0	1.25	1.85	3.07
(4V16) (598GG) Conway, AR	5,707	5,053	88.54%	654	11.46%	0	0	4,831	0	222	0	216	0	121	0	229	0	88	0	2.78	23.58	9.26
(4V16) (598GH) Russellville, AR	2,163	1,918	88.67%	245	11.33%	0	0	1,873	0	45	0	51	0	40	0	33	0	121	0	12.12	2.23	2.68
(4V16) (629) New Orleans, LA HCS	79,774	73,716	92.41%	6,058	7.59%	14	0	68,542	0	5,174	0	3,088	0	1,234	0	563	0	1,173	0	5.60	12.21	5.69
(4V16) (629) New Orleans, LA	53,204	48,098	90.40%	5,106	9.60%	0	0	44,866	0	3,232	0	2,619	0	1,008	0	477	0	1,002	0	5.70	12.82	5.02
(4V16) (629BY) Baton Rouge, LA	9,748	9,178	94.15%	570	5.85%	0	0	8,359	0	819	0	252	0	151	0	53	0	114	0	7.01	10.56	1.15
(4V16) (629GA) Houma, LA	2,322	2,304	99.22%	18	0.78%	0	0	2,261	0	43	0	11	0	1	0	0	0	6	0	2.23	0.30	1.50
(4V16) (629GB) Hammond, LA	5,182	5,034	97.14%	148	2.86%	0	0	4,534	0	500	0	89	0	41	0	9	0	9	0	6.03	9.12	6.46
(4V16) (629GC) Slidell, LA	3,983	3,886	97.56%	97	2.44%	0	0	3,615	0	271	0	51	0	15	0	15	0	16	0	5.70	1.54	1.59
(4V16) (629GD) St. John, LA	1,378	1,375	99.78%	3	0.22%	0	0	1,351	0	24	0	1	0	0	0	0	0	2	0	3.24		0.00
(4V16) (629GE) Franklin, LA	809	782	96.66%	27	3.34%	0	0	762	0	20	0	8	0	6	0	1	0	12	0	6.83		10.97
(4V16) (629GF) Bogalusa, LA	1,255	1,247	99.36%	8	0.64%	0	0	1,237	0	10	0	1	0	0	0	0	0	7	0	0.87	0.00	3.18
(4V16) (629QA) Baton Rouge South, LA	1,893	1,812	95.72%	81	4.28%	0	0	1,557	0	255	0	56	0	12	0	8	0	5	0		13.71	9.25
(4V16) (667) Shreveport, LA HCS	58,618	54,668	93.26%	3,950	6.74%	2	0	52,562	0	2,106	0	1,860	0	610	0	377	0	1,103	0	2.78	15.68	6.17
(4V16) (667) Shreveport, LA (Overton Brooks)	41,237	37,936	92.00%	3,301	8.00%	0	0	36,276	0	1,660	0	1,416	0	498	0	324	0	1,063	0	2.50	16.33	4.44
(4V16) (667GA) Texarkana, AR	4,667	4,524	96.94%	143	3.06%	0	0	4,442	0	82	0	100	0	19	0	7	0	17	0	2.89	1.18	10.92
(4V16) (667GB) Monroe, LA	5,232	5,201	99.41%	31	0.59%	0	0	5,107	0	94	0	27	0	1	0	1	0	2	0	1.62	0.45	0.27
(4V16) (667GC) Longview, TX	7,482	7,007	93.65%	475	6.35%	0	0	6,737	0	270	0	317	0	92	0	45	0	21	0	4.04	1.19	14.72
(4V17) (549) Dallas, TX HCS	181,214	168,630	93.06%	12,584	6.94%	51	1	162,311	1	6,319	0	5,744	0	2,838	0	1,620	0	2,382	0	4.36	11.64	3.75

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(4V17) (549) Dallas, TX	90,467	83,041	91.79%	7,426	8.21%	0	1	79,248	1	3,793	0	3,494	0	1,750	0	942	0	1,240	0	5.06	10.96	2.58
(4V17) (549A4) Bonham, TX (Sam Rayburn Center)	15,209	14,856	97.68%	353	2.32%	0	0	14,429	0	427	0	187	0	57	0	38	0	71	0	3.02	4.96	1.65
(4V17) (549A5) Garland, TX	3,666	3,600	98.20%	66	1.80%	0	0	3,440	0	160	0	39	0	9	0	5	0	13	0	4.25	0.06	0.20
(4V17) (549BY) Fort Worth, TX	37,836	34,887	92.21%	2,949	7.79%	0	0	33,847	0	1,040	0	1,473	0	689	0	364	0	423	0	4.60	9.84	4.52
(4V17) (549GD) Denton, TX	7,202	6,946	96.45%	256	3.55%	0	0	6,770	0	176	0	94	0	46	0	19	0	97	0	5.76	19.50	4.68
(4V17) (549GE) Decatur, TX	1,591	1,533	96.35%	58	3.65%	0	0	1,504	0	29	0	29	0	10	0	4	0	15	0	4.18	35.00	15.08
(4V17) (549GF) Granbury, TX	1,141	1,094	95.88%	47	4.12%	0	0	1,069	0	25	0	15	0	9	0	11	0	12	0	5.17		51.61
(4V17) (549GH) Greenville, TX	1,930	1,904	98.65%	26	1.35%	0	0	1,887	0	17	0	10	0	4	0	4	0	8	0	2.03	14.00	4.84
(4V17) (549GJ) Sherman, TX	3,521	3,400	96.56%	121	3.44%	0	0	3,302	0	98	0	54	0	25	0	7	0	35	0	4.52		7.93
(4V17) (549GK) Polk Street, TX	3,536	3,433	97.09%	103	2.91%	0	0	3,374	0	59	0	66	0	16	0	8	0	13	0	3.97		0.00
(4V17) (549GL) Plano, TX	5,345	5,280	98.78%	65	1.22%	0	0	5,118	0	162	0	39	0	7	0	7	0	12	0	3.67	15.64	0.63
(4V17) (549GM) Grand Prairie, TX	2,701	2,663	98.59%	38	1.41%	0	0	2,617	0	46	0	29	0	5	0	2	0	2	0	2.08		1.99
(4V17) (549QC) Tyler Broadway, TX	7,069	5,993	84.78%	1,076	15.22%	0	0	5,706	0	287	0	215	0	211	0	209	0	441	0	4.16	55.19	23.87
(4V17) (671) San Antonio, TX HCS	167,567	153,069	91.35%	14,498	8.65%	333	0	145,845	0	7,224	0	6,980	0	3,198	0	1,445	0	2,875	0	3.55	19.34	8.20
(4V17) (671) San Antonio, TX (Audie L. Murphy)	56,014	47,927	85.56%	8,087	14.44%	0	0	44,748	0	3,179	0	3,868	0	2,102	0	903	0	1,214	0	7.49	15.82	9.95
(4V17) (671A4) Kerrville, TX	15,132	14,357	94.88%	775	5.12%	0	0	13,856	0	501	0	343	0	237	0	46	0	149	0	3.64	13.18	2.19
(4V17) (671BU) San Antonio, TX - VADOM	32	32	100.00%	0	0.00%	0	0	32	0	0	0	0	0	0	0	0	0	0	0			0.14
(4V17) (671) San Antonio, TX (Audie L. Murphy)	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2.57	15.54	6.61
	14,772	14,253	96.49%	519	3.51%	0	0	13,706	0	547	0	365	0	100	0	28	0	26	0	2.57	15.54	6.61
(4V17) (671DT) Unknown	42	40	95.24%	2	4.76%	0	0	39	0	1	0	2	0	0	0	0	0	0	0		5.17	
(4V17) (671GB) Victoria, TX	2,942	2,898	98.50%	44	1.50%	0	0	2,765	0	133	0	35	0	4	0	2	0	3	0	5.41	4.38	2.82
(4V17) (671GF) South Bexar County, TX	4,294	4,169	97.09%	125	2.91%	0	0	3,993	0	176	0	90	0	8	0	4	0	23	0	4.60		9.81
(4V17) (671GK) San Antonio Woodcock Drive, TX	15,143	14,766	97.51%	377	2.49%	0	0	14,395	0	371	0	268	0	33	0	13	0	63	0	3.52		3.12
(4V17) (671GL) New Braunfels, TX	5,555	5,260	94.69%	295	5.31%	0	0	5,192	0	68	0	171	0	49	0	25	0	50	0	5.51		
(4V17) (671GN) Seguin, TX	1,240	1,224	98.71%	16	1.29%	0	0	1,218	0	6	0	7	0	5	0	0	0	4	0	2.16		
(4V17) (671GO) North Central Federal, TX	11,623	11,416	98.22%	207	1.78%	0	0	11,174	0	242	0	139	0	33	0	13	0	22	0	1.50	8.08	6.17
(4V17) (671GP) Balcones Heights, TX	16,855	16,111	95.59%	744	4.41%	0	0	15,563	0	548	0	527	0	139	0	38	0	40	0	2.24	1.79	12.05
(4V17) (671GQ) Shavano Park, TX	4,443	4,353	97.97%	90	2.03%	0	0	4,235	0	118	0	78	0	7	0	1	0	4	0	3.08		0.78
(4V17) (671GR) North Bexar, TX	2,499	2,287	91.52%	212	8.48%	0	0	2,139	0	148	0	180	0	10	0	5	0	17	0	6.74		8.73
(4V17) (671PA) San Antonio SARRTP	18	18	100.00%	0	0.00%	0	0	18	0	0	0	0	0	0	0	0	0	0	0			0.00
(4V17) (671QB) Data Point, TX	16,962	13,957	82.28%	3,005	17.72%	0	0	12,771	0	1,186	0	907	0	471	0	367	0	1,260	0		28.52	
(4V17) (674) Temple, TX HCS	172,058	153,619	89.28%	18,439	10.72%	36	1	146,312	0	7,307	0	7,146	0	3,936	0	2,747	0	4,610	1	4.60	18.47	9.43
(4V17) (674) Temple, TX (Olin E. Teague Center)	89,959	79,108	87.94%	10,851	12.06%	0	1	75,092	0	4,016	0	3,771	0	2,440	0	2,017	0	2,623	1	5.01	18.35	12.27
(4V17) (674A4) Waco, TX (Doris Miller)	16,104	14,883	92.42%	1,221	7.58%	0	0	14,196	0	687	0	677	0	212	0	90	0	242	0	5.05	11.43	3.23
(4V17) (674BY) Austin, TX	41,958	36,394	86.74%	5,564	13.26%	0	0	34,496	0	1,898	0	2,195	0	1,138	0	585	0	1,646	0	5.47	20.63	5.82
(4V17) (674GA) Palestine, TX	2,240	2,143	95.67%	97	4.33%	0	0	2,094	0	49	0	56	0	12	0	15	0	14	0	4.59	12.90	3.21
(4V17) (674GB) Brownwood, TX	1,797	1,690	94.05%	107	5.95%	0	0	1,640	0	50	0	35	0	25	0	15	0	32	0	8.58	6.68	3.85
(4V17) (674GC) Bryan, TX	4,521	4,403	97.39%	118	2.61%	0	0	4,267	0	136	0	90	0	13	0	6	0	9	0	1.96	4.86	6.03
(4V17) (674GD) Cedar Park, TX	8,829	8,551	96.85%	278	3.15%	0	0	8,280	0	271	0	199	0	38	0	10	0	31	0	3.28	11.34	4.67
(4V17) (674GF) Temple South General Bruce Drive, TX	5,631	5,442	96.64%	189	3.36%	0	0	5,252	0	190	0	116	0	52	0	9	0	12	0	3.55	8.00	10.54
(4V17) (674HB) LaGrange, TX	1,019	1,005	98.63%	14	1.37%	0	0	995	0	10	0	7	0	6	0	0	0	1	0	1.46		0.63
(4V17) (504) Amarillo, TX HCS	45,536	40,888	89.79%	4,648	10.21%	4	0	39,652	0	1,236	0	1,230	0	817	0	563	0	2,038	0	8.42	28.21	4.09

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(4V17) (504) Amarillo, TX (Thomas E. Creek)	30,982	27,785	89.68%	3,197	10.32%	0	0	26,839	0	946	0	841	0	503	0	372	0	1,481	0	3.95	29.31	5.04
(4V17) (504BY) Lubbock, TX	12,923	11,605	89.80%	1,318	10.20%	0	0	11,365	0	240	0	324	0	280	0	174	0	540	0	13.47	23.99	1.83
(4V17) (504BZ) Clovis, NM	1,431	1,300	90.85%	131	9.15%	0	0	1,253	0	47	0	65	0	34	0	16	0	16	0	11.44		0.76
(4V17) (504GA) Childress, TX	139	137	98.56%	2	1.44%	0	0	137	0	0	0	0	0	0	0	1	0	1	0	1.63		48.13
(4V17) (504HB) Dalhart, TX	61	61	100.00%	0	0.00%	0	0	58	0	3	0	0	0	0	0	0	0	0	0	3.78		2.33
(4V17) (519) Big Spring, TX HCS	18,039	16,871	93.53%	1,168	6.47%	128	0	16,260	0	611	0	499	0	333	0	151	0	185	0	2.94	13.09	4.46
(4V17) (519) Big Spring, TX (George H. OBrien, Jr.)	7,818	6,991	89.42%	827	10.58%	0	0	6,682	0	309	0	348	0	241	0	116	0	122	0	3.51	13.92	5.81
(4V17) (519GA) Permian Basin, TX (Wilson and Young Medal of Honor)	1,495	1,462	97.79%	33	2.21%	0	0	1,430	0	32	0	12	0	9	0	3	0	9	0	2.11	6.18	3.46
(4V17) (519GB) Hobbs, NM	845	834	98.70%	11	1.30%	0	0	816	0	18	0	4	0	2	0	1	0	4	0	4.11		2.19
(4V17) (519GD) Fort Stockton, TX	155	153	98.71%	2	1.29%	0	0	149	0	4	0	0	0	0	0	0	0	2	0	4.85		
(4V17) (519HC) Abilene, TX	4,788	4,605	96.18%	183	3.82%	0	0	4,451	0	154	0	89	0	50	0	19	0	25	0	2.88	9.81	6.15
(4V17) (519HF) San Angelo, TX	2,938	2,826	96.19%	112	3.81%	0	0	2,732	0	94	0	46	0	31	0	12	0	23	0	2.56	25.97	2.62
(4V17) (756) El Paso, TX HCS	47,474	45,987	96.87%	1,487	3.13%	2	0	44,439	0	1,548	0	969	0	301	0	104	0	113	0	3.05	3.57	7.51
(4V17) (756) El Paso, TX	31,459	30,659	97.46%	800	2.54%	0	0	29,760	0	899	0	575	0	131	0	51	0	43	0	1.98	3.63	4.61
(4V17) (756GA) Las Cruces, NM	3,369	3,272	97.12%	97	2.88%	0	0	3,154	0	118	0	54	0	27	0	5	0	11	0	3.94	3.53	2.84
(4V17) (756GB) El Paso Eastside, TX	5,093	4,823	94.70%	270	5.30%	0	0	4,518	0	305	0	118	0	70	0	29	0	53	0	6.34	5.12	13.80
(4V17) (756GC) El Paso Westside, TX	3,514	3,484	99.15%	30	0.85%	0	0	3,413	0	71	0	29	0	0	0	1	0	0	0	2.24	1.46	3.68
(4V17) (756GD) El Paso Northeast, TX	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(4V17) (756QA) El Paso South Central, TX	2,906	2,634	90.64%	272	9.36%	0	0	2,519	0	115	0	176	0	72	0	18	0	6	0			7.10
(4V17) (756QB) El Paso Central, TX	1,132	1,114	98.41%	18	1.59%	0	0	1,074	0	40	0	17	0	1	0	0	0	0	0		2.83	
(4V17) (740) Texas Valley Coastal Bend HCS	57,212	55,021	96.17%	2,191	3.83%	3	0	53,381	0	1,640	0	1,228	0	459	0	158	0	346	0	2.74	9.20	2.15
(4V17) (740) Harlingen, TX	12,766	12,098	94.77%	668	5.23%	0	0	11,554	0	544	0	359	0	146	0	42	0	121	0	1.17	10.02	1.79
(4V17) (740GA) Harlingen Treasure Hills, TX	8,603	8,452	98.24%	151	1.76%	0	0	8,191	0	261	0	96	0	34	0	6	0	15	0	3.35	3.48	0.00
(4V17) (740GB) McAllen, TX	15,634	15,354	98.21%	280	1.79%	0	0	15,013	0	341	0	215	0	23	0	8	0	34	0	1.82	4.82	1.14
(4V17) (740GC) Corpus Christi, TX	7,143	6,935	97.09%	208	2.91%	0	0	6,823	0	112	0	117	0	53	0	20	0	18	0	3.80	0.28	0.00
(4V17) (740GD) Laredo, TX	4,166	4,119	98.87%	47	1.13%	0	0	4,080	0	39	0	25	0	7	0	5	0	10	0	2.64	1.47	1.38
(4V17) (740GH) South Enterprize, TX	8,385	7,548	90.02%	837	9.98%	0	0	7,206	0	342	0	416	0	196	0	77	0	148	0	0.00	16.87	4.10
(4V17) (740GI) Old Brownsville, TX	515	515	100.00%	0	0.00%	0	0	514	0	1	0	0	0	0	0	0	0	0	0			0.61
(4V19) (623) Muskogee, OK HCS	62,500	58,312	93.30%	4,188	6.70%	3	0	55,896	0	2,416	0	1,885	0	896	0	868	0	539	0	2.65	11.61	5.57
(4V19) (623) Muskogee, OK (Jack C. Montgomery)	25,571	23,606	92.32%	1,965	7.68%	0	0	22,472	0	1,134	0	972	0	518	0	250	0	225	0	2.42	9.08	3.87
(4V19) (623BY) Tulsa, OK (Ernest Childers)	22,944	21,273	92.72%	1,671	7.28%	0	0	20,597	0	676	0	502	0	308	0	597	0	264	0	2.85	17.95	4.00
(4V19) (623GA) McAlester, OK	1,650	1,619	98.12%	31	1.88%	0	0	1,564	0	55	0	25	0	3	0	0	0	3	0	1.75	8.93	3.26
(4V19) (623GB) Vinita, OK	2,879	2,834	98.44%	45	1.56%	0	0	2,798	0	36	0	35	0	4	0	1	0	5	0	0.98	4.33	5.54
(4V19) (623GC) McCurtain County, OK	922	870	94.36%	52	5.64%	0	0	800	0	70	0	43	0	6	0	0	0	3	0	9.05	35.00	0.00
(4V19) (623QA) Muskogee East, OK	1,187	1,152	97.05%	35	2.95%	0	0	1,113	0	39	0	21	0	7	0	6	0	1	0			1.89
(4V19) (623QB) Tulsa Eleventh Street, OK	4,824	4,524	93.78%	300	6.22%	0	0	4,173	0	351	0	236	0	46	0	10	0	8	0		2.90	7.15
(4V19) (623QC) Yale Avenue, OK	2,523	2,434	96.47%	89	3.53%	0	0	2,379	0	55	0	51	0	4	0	4	0	30	0		4.70	
(4V19) (635) Oklahoma City, OK HCS	101,395	92,281	91.01%	9,114	8.99%	72	0	88,329	0	3,952	0	3,701	0	2,346	0	955	0	2,112	0	3.65	15.83	5.14
(4V19) (635) Oklahoma City, OK	54,811	47,647	86.93%	7,164	13.07%	0	0	45,484	0	2,163	0	2,699	0	1,901	0	775	0	1,789	0	4.96	17.61	5.00
(4V19) (635GA) Lawton, OK	11,611	11,362	97.86%	249	2.14%	0	0	10,711	0	651	0	182	0	38	0	9	0	20	0	4.31	3.21	6.04
(4V19) (635GB) Wichita Falls, TX	3,816	3,783	99.14%	33	0.86%	0	0	3,734	0	49	0	17	0	7	0	1	0	8	0	1.95	3.71	1.79
(4V19) (635GC) Blackwell, OK	333	330	99.10%	3	0.90%	0	0	325	0	5	0	2	0	0	0	0	0	1	0	1.00		

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(4V19) (635GD) Ada, OK	1,923	1,913	99.48%	10	0.52%	0	0	1,890	0	23	0	8	0	0	0	1	0	1	0	0.77		7.29
(4V19) (635GE) Stillwater, OK	1,233	1,205	97.73%	28	2.27%	0	0	1,186	0	19	0	17	0	6	0	0	0	5	0	3.42		1.37
(4V19) (635GF) Altus, OK	985	979	99.39%	6	0.61%	0	0	972	0	7	0	4	0	1	0	0	0	1	0	0.60		5.62
(4V19) (635GG) Enid, OK	665	649	97.59%	16	2.41%	0	0	646	0	3	0	1	0	0	0	0	0	15	0	7.39		2.28
(4V19) (635GH) Clinton, OK	915	905	98.91%	10	1.09%	0	0	897	0	8	0	5	0	2	0	2	0	1	0	0.97	17.63	1.00
(4V19) (635GI) Norman, OK	871	850	97.59%	21	2.41%	0	0	821	0	29	0	14	0	4	0	1	0	2	0	3.57	8.10	1.00
(4V19) (635GJ) Yukon, OK	773	765	98.97%	8	1.03%	0	0	752	0	13	0	6	0	1	0	0	0	1	0	1.43	3.75	0.57
(4V19) (635HB) Ardmore, OK	1,475	1,471	99.73%	4	0.27%	0	0	1,451	0	20	0	2	0	0	0	2	0	0	0	1.70	0.00	3.86
(4V19) (635QA) North May, OK	4,469	4,261	95.35%	208	4.65%	0	0	4,097	0	164	0	86	0	86	0	17	0	19	0	4.87	0.00	11.76
(4V19) (635QB) South Oklahoma City, OK	10,000	9,510	95.10%	490	4.90%	0	0	9,264	0	246	0	233	0	163	0	34	0	60	0	3.50	7.95	7.16
(4V19) (635QC) Fourteenth Street, OK	287	286	99.65%	1	0.35%	0	0	286	0	0	0	1	0	0	0	0	0	0	0	0.39		
(4V19) (635QD) Lawton North, OK	6,650	5,808	87.34%	842	12.66%	0	0	5,286	0	522	0	408	0	136	0	109	0	189	0		13.48	
(4V19) (635QE) Tinker, OK	578	557	96.37%	21	3.63%	0	0	527	0	30	0	16	0	1	0	4	0	0	0	1.35	11.14	
(4V19) (436) Montana HCS	46,567	43,705	93.85%	2,862	6.15%	5	0	42,322	0	1,383	0	1,260	0	688	0	392	0	522	0	1.95	18.09	5.51
(4V19) (436) Fort Harrison, MT	13,672	12,479	91.27%	1,193	8.73%	0	0	11,954	0	525	0	462	0	294	0	136	0	301	0	3.31	17.28	7.74
(4V19) (436A4) Miles City CLC, MT	285	275	96.49%	10	3.51%	0	0	249	0	26	0	6	0	3	0	1	0	0	0	5.04	9.20	4.20
(4V19) (436GA) Anaconda, MT	1,293	1,272	98.38%	21	1.62%	0	0	1,257	0	15	0	11	0	5	0	3	0	2	0	2.08	6.85	0.97
(4V19) (436GB) Great Falls, MT	3,385	3,340	98.67%	45	1.33%	0	0	3,290	0	50	0	33	0	4	0	5	0	3	0	1.15	16.63	4.76
(4V19) (436GC) Missoula, MT (David J. Thatcher)	6,771	6,490	95.85%	281	4.15%	0	0	6,338	0	152	0	93	0	82	0	80	0	26	0	1.65	29.30	6.50
(4V19) (436GD) Bozeman, MT (Travis W. Atkins)	1,714	1,638	95.57%	76	4.43%	0	0	1,582	0	56	0	37	0	14	0	9	0	16	0	2.88	24.44	1.26
(4V19) (436GF) Kalispell, MT	5,141	4,979	96.85%	162	3.15%	0	0	4,891	0	88	0	85	0	34	0	22	0	21	0	1.13	26.12	5.97
(4V19) (436GH) Billings Majestic Lane, MT (Benjamin Charles Steele)	5,373	4,505	83.85%	868	16.15%	0	0	4,265	0	240	0	388	0	212	0	127	0	141	0		17.00	4.22
(4V19) (436GI) Glasgow, MT	331	327	98.79%	4	1.21%	0	0	324	0	3	0	3	0	1	0	0	0	0	0	0.70	21.75	3.11
(4V19) (436GJ) Miles City, MT	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			0.00
(4V19) (436GK) Glendive, MT	354	353	99.72%	1	0.28%	0	0	344	0	9	0	1	0	0	0	0	0	0	0	0.31	20.50	1.50
(4V19) (436GL) Cut Bank, MT	273	272	99.63%	1	0.37%	0	0	268	0	4	0	0	0	1	0	0	0	0	0	0.87	0.67	0.00
(4V19) (436GM) Lewistown, MT	356	348	97.75%	8	2.25%	0	0	337	0	11	0	5	0	3	0	0	0	0	0	1.50	10.77	0.00
(4V19) (436GN) Billings Spring Creek Lane, MT (Dr. Joseph Medicine Crow)	5,368	5,293	98.60%	75	1.40%	0	0	5,168	0	125	0	57	0	8	0	4	0	6	0	1.94	8.18	1.82
(4V19) (436HC) Havre, MT (Merril Lundman)	394	384	97.46%	10	2.54%	0	0	379	0	5	0	7	0	2	0	0	0	1	0	0.84	101.00	10.97
(4V19) (436QA) Hamilton, MT	1,231	1,222	99.27%	9	0.73%	0	0	1,199	0	23	0	4	0	2	0	1	0	2	0	3.95	12.81	0.70
(4V19) (436QB) Plentywood, MT	23	22	95.65%	1	4.35%	0	0	20	0	2	0	1	0	0	0	0	0	0	0	5.69	7.67	0.00
(4V19) (436QC) Helena, MT	602	505	83.89%	97	16.11%	0	0	456	0	49	0	67	0	23	0	4	0	3	0			
(4V19) (442) Cheyenne, WY HCS	18,998	16,057	84.52%	2,941	15.48%	68	0	14,997	0	1,060	0	1,089	0	412	0	335	0	1,105	0	11.76	24.70	5.17
(4V19) (442) Cheyenne, WY	11,530	9,864	85.55%	1,666	14.45%	0	0	9,210	0	654	0	586	0	186	0	146	0	748	0	11.76	21.29	5.39
(4V19) (442GB) Sidney, NE	244	218	89.34%	26	10.66%	0	0	213	0	5	0	17	0	6	0	1	0	2	0	12.04	8.19	0.00
(4V19) (442GC) Fort Collins, CO	2,048	1,919	93.70%	129	6.30%	0	0	1,805	0	114	0	92	0	30	0	2	0	5	0	0.00	5.71	4.77
(4V19) (442GD) Loveland, CO	4,877	3,781	77.53%	1,096	22.47%	0	0	3,515	0	266	0	377	0	188	0	184	0	347	0	13.53	46.11	5.24
(4V19) (442HK) Wheatland, WY - Mobile	32	29	90.63%	3	9.38%	0	0	27	0	2	0	3	0	0	0	0	0	0	0	5.50		
(4V19) (442QA) Rawlins, WY	145	137	94.48%	8	5.52%	0	0	127	0	10	0	7	0	0	0	1	0	0	0	3.60	12.46	6.00
(4V19) (442QB) Torrington, WY - Mobile	59	52	88.14%	7	11.86%	0	0	47	0	5	0	4	0	2	0	1	0	0	0	6.40		37.50
(4V19) (442QD) Laramie, WY - Mobile	39	37	94.87%	2	5.13%	0	0	33	0	4	0	2	0	0	0	0	0	0	0	6.11		0.00
(4V19) (442QE) Sterling, CO	24	20	83.33%	4	16.67%	0	0	20	0	0	0	1	0	0	0	0	0	3	0	42.00		3.50
(4V19) (554) Aurora, CO HCS	94,019	80,966	86.12%	13,053	13.88%	59	0	75,257	0	5,709	0	5,723	0	3,648	0	1,733	0	1,949	0	6.96	15.67	11.47

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(4V19) (554) Aurora, CO (Rocky Mountain Regional)	44,673	36,789	82.35%	7,884	17.65%	0	0	33,832	0	2,957	0	3,077	0	2,209	0	1,164	0	1,434	0	6.58	17.69	4.34
(4V19) (5549AB) Pueblo CLC, CO - CLC	1	0	0.00%	1	100.00%	0	0	0	0	0	0	1	0	0	0	0	0	0	0			
(4V19) (554BU) Valor Point, CO - VADOM	2	2	100.00%	0	0.00%	0	0	2	0	0	0	0	0	0	0	0	0	0	0			
(4V19) (554GB) Aurora, CO	2,949	2,818	95.56%	131	4.44%	0	0	2,718	0	100	0	91	0	17	0	7	0	16	0	4.42		9.23
(4V19) (554GC) Golden, CO	5,947	5,142	86.46%	805	13.54%	0	0	4,692	0	450	0	492	0	218	0	62	0	33	0	7.90	25.80	10.82
(4V19) (554GD) Pueblo, CO (PFC James Dunn)	7,534	7,008	93.02%	526	6.98%	0	0	6,682	0	326	0	333	0	95	0	45	0	53	0	8.43	11.58	1.57
(4V19) (554GE) Colorado Springs, CO (PFC Floyd K. Lindstrom)	21,592	18,697	86.59%	2,895	13.41%	0	0	17,336	0	1,361	0	1,270	0	889	0	365	0	371	0	7.96	16.33	22.32
(4V19) (554GF) Alamosa, CO	630	618	98.10%	12	1.90%	0	0	582	0	36	0	9	0	3	0	0	0	0	0	3.31	4.78	3.08
(4V19) (554GG) La Junta, CO	387	372	96.12%	15	3.88%	0	0	338	0	34	0	12	0	1	0	2	0	0	0	6.82	12.35	0.13
(4V19) (554GH) Lamar, CO	407	403	99.02%	4	0.98%	0	0	391	0	12	0	2	0	0	0	0	0	2	0	4.00	0.09	0.00
(4V19) (554GI) Burlington, CO	347	347	100.00%	0	0.00%	0	0	344	0	3	0	0	0	0	0	0	0	0	0	2.48	0.00	
(4V19) (554GJ) Denver East 9th Avenue, CO	1,164	1,090	93.64%	74	6.36%	0	0	990	0	100	0	65	0	7	0	1	0	1	0	7.27		0.00
(4V19) (554GK) Union Boulevard, CO	1,493	1,452	97.25%	41	2.75%	0	0	1,375	0	77	0	26	0	8	0	1	0	6	0	5.40	1.37	
(4V19) (554QA) York Street, CO	70	70	100.00%	0	0.00%	0	0	70	0	0	0	0	0	0	0	0	0	0	0		0.00	
(4V19) (554QB) Jewell, CO	6,714	6,063	90.30%	651	9.70%	0	0	5,833	0	230	0	334	0	199	0	85	0	33	0		3.84	
(4V19) (554QC) Salida, CO	109	95	87.16%	14	12.84%	0	0	72	0	23	0	11	0	2	0	1	0	0	0	12.19	18.17	1.40
(4V19) (575) Grand Junction, CO HCS	12,370	11,353	91.78%	1,017	8.22%	26	0	10,418	0	935	0	574	0	186	0	93	0	164	0	5.68	13.85	7.14
(4V19) (575) Grand Junction, CO	10,975	10,116	92.17%	859	7.83%	0	0	9,265	0	851	0	503	0	140	0	77	0	139	0	5.03	14.11	4.78
(4V19) (575GA) Montrose, CO	635	584	91.97%	51	8.03%	0	0	554	0	30	0	19	0	18	0	4	0	10	0	6.42	13.80	0.14
(4V19) (575GB) Craig, CO (Major William Edward Adams)	171	143	83.63%	28	16.37%	0	0	125	0	18	0	16	0	3	0	3	0	6	0	23.16	12.86	0.33
(4V19) (575QA) Glenwood Springs, CO	287	232	80.84%	55	19.16%	0	0	219	0	13	0	20	0	19	0	7	0	9	0	5.93	11.10	31.81
(4V19) (575QB) Moab, UT	287	267	93.03%	20	6.97%	0	0	244	0	23	0	15	0	5	0	0	0	0	0	6.20	3.49	3.00
(4V19) (575QC) Grand Junction, CO - Mobile	15	11	73.33%	4	26.67%	0	0	11	0	0	0	1	0	1	0	2	0	0	0	20.20		
(4V19) (660) Salt Lake City, UT HCS	50,006	44,929	89.85%	5,077	10.15%	31	0	42,279	0	2,650	0	2,532	0	1,008	0	572	0	965	0	10.37	13.34	2.44
(4V19) (660) Salt Lake City, UT (George E. Wahlen)	39,599	35,520	89.70%	4,079	10.30%	0	0	33,498	0	2,022	0	2,053	0	769	0	483	0	774	0	14.15	12.54	1.08
(4V19) (660GA) Pocatello, ID	1,870	1,691	90.43%	179	9.57%	0	0	1,573	0	118	0	94	0	47	0	20	0	18	0	3.81	37.49	8.72
(4V19) (660GB) Ogden, UT	2,236	1,941	86.81%	295	13.19%	0	0	1,762	0	179	0	126	0	78	0	35	0	56	0	11.45	27.27	20.49
(4V19) (660GD) Roosevelt, UT	563	547	97.16%	16	2.84%	0	0	539	0	8	0	1	0	0	0	1	0	14	0	10.55		
(4V19) (660GE) Orem, UT	1,235	1,081	87.53%	154	12.47%	0	0	1,031	0	50	0	71	0	51	0	13	0	19	0	18.46	18.05	4.55
(4V19) (660GG) St. George, UT	1,607	1,465	91.16%	142	8.84%	0	0	1,344	0	121	0	57	0	13	0	7	0	65	0	9.99	31.78	8.01
(4V19) (660GJ) South Jordan, UT	990	922	93.13%	68	6.87%	0	0	866	0	56	0	41	0	16	0	6	0	5	0	6.70	11.91	0.27
(4V19) (660GK) Elko, NV	37	34	91.89%	3	8.11%	0	0	26	0	8	0	1	0	1	0	1	0	0	0	13.81		94.50
(4V19) (660QA) Idaho Falls, ID	1,826	1,693	92.72%	133	7.28%	0	0	1,605	0	88	0	84	0	31	0	5	0	13	0	4.33	5.00	29.40
(4V19) (660QB) Price, UT	43	35	81.40%	8	18.60%	0	0	35	0	0	0	4	0	2	0	1	0	1	0	21.18		0.00
(4V19) (666) Sheridan, WY HCS	7,676	7,344	95.67%	332	4.33%	41	0	6,963	0	381	0	189	0	60	0	35	0	48	0	4.47	11.03	3.80
(4V19) (666) Sheridan, WY	2,687	2,492	92.74%	195	7.26%	0	0	2,272	0	220	0	111	0	41	0	23	0	20	0	6.61	11.50	3.49
(4V19) (666GB) Casper, WY	2,724	2,693	98.86%	31	1.14%	0	0	2,648	0	45	0	18	0	5	0	2	0	6	0	2.05	5.82	3.77
(4V19) (666GC) Riverton, WY	394	365	92.64%	29	7.36%	0	0	335	0	30	0	8	0	3	0	3	0	15	0	15.72	8.50	7.48
(4V19) (666GD) Cody, WY	414	387	93.48%	27	6.52%	0	0	366	0	21	0	18	0	2	0	2	0	5	0	7.07		12.25
(4V19) (666GE) Gillette, WY	392	368	93.88%	24	6.12%	0	0	354	0	14	0	14	0	7	0	3	0	0	0	5.06	0.00	5.33
(4V19) (666GF) Rock Springs, WY	681	664	97.50%	17	2.50%	0	0	622	0	42	0	13	0	2	0	2	0	0	0	3.66	17.27	3.38
(4V19) (666QA) Afton, WY	279	273	97.85%	6	2.15%	0	0	266	0	7	0	5	0	0	0	0	0	1	0	4.84		

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(4V19) (666QB) Evanston, WY	88	87	98.86%	1	1.14%	0	0	86	0	1	0	1	0	0	0	0	0	0	0	1.36	0.00	
(4V19) (666QC) Worland, WY	17	15	88.24%	2	11.76%	0	0	14	0	1	0	1	0	0	0	0	0	1	0	19.07	4.50	
(5V20) (463) Anchorage, AK HCS	7,407	6,852	92.51%	555	7.49%	3	0	6,304	0	548	0	301	0	115	0	40	0	99	0	4.79	23.80	4.64
(5V20) (463) Anchorage, AK	4,846	4,415	91.11%	431	8.89%	0	0	4,009	0	406	0	237	0	92	0	32	0	70	0	3.31	23.21	5.36
(5V20) (463BU) Anchorage, AK - VADOM	22	22	100.00%	0	0.00%	0	0	22	0	0	0	0	0	0	0	0	0	0	0			0.00
(5V20) (463GA) Fairbanks, AK	981	938	95.62%	43	4.38%	0	0	857	0	81	0	29	0	6	0	0	0	8	0	2.45	50.33	2.81
(5V20) (463GB) Kenai, AK	475	434	91.37%	41	8.63%	0	0	429	0	5	0	14	0	8	0	4	0	15	0	14.87	10.48	0.00
(5V20) (463GC) Mat-Su, AK	680	655	96.32%	25	3.68%	0	0	619	0	36	0	12	0	7	0	3	0	3	0	4.66	16.42	2.33
(5V20) (463GD) Homer, AK	117	110	94.02%	7	5.98%	0	0	107	0	3	0	3	0	1	0	0	0	3	0	8.27		0.00
(5V20) (463GE) Juneau, AK	286	278	97.20%	8	2.80%	0	0	261	0	17	0	6	0	1	0	1	0	0	0	2.78	112.00	
(5V20) (531) Boise, ID HCS	33,616	30,420	90.49%	3,196	9.51%	9	1	28,847	1	1,573	0	1,679	0	662	0	378	0	477	0	6.38	11.19	5.91
(5V20) (531) Boise, ID	29,619	26,950	90.99%	2,669	9.01%	0	1	25,521	1	1,429	0	1,522	0	511	0	258	0	378	0	5.62	10.64	5.23
(5V20) (531GE) Twin Falls, ID	853	834	97.77%	19	2.23%	0	0	822	0	12	0	8	0	8	0	2	0	1	0	1.74	8.24	0.66
(5V20) (531GG) Caldwell, ID	2,703	2,206	81.61%	497	18.39%	0	0	2,083	0	123	0	144	0	142	0	117	0	94	0	14.19	19.58	19.03
(5V20) (531GH) Eastern Oregon, OR	89	88	98.88%	1	1.12%	0	0	87	0	1	0	1	0	0	0	0	0	0	0	0.91		0.00
(5V20) (531GI) Mountain Home, ID	293	286	97.61%	7	2.39%	0	0	281	0	5	0	3	0	0	0	0	0	4	0	1.13	0.31	1.38
(5V20) (531GJ) Salmon, ID	59	56	94.92%	3	5.08%	0	0	53	0	3	0	1	0	1	0	1	0	0	0	7.26	0.00	0.00
(5V20) (648) Portland, OR HCS	59,636	50,350	84.43%	9,286	15.57%	12	0	46,634	0	3,716	0	3,811	0	1,555	0	1,134	0	2,786	0	6.06	33.49	1.75
(5V20) (648) Portland, OR	33,138	27,399	82.68%	5,739	17.32%	0	0	25,059	0	2,340	0	2,632	0	983	0	488	0	1,636	0	13.95	28.56	1.22
(5V20) (648A4) Portland Vancouver, WA	10,980	9,347	85.13%	1,633	14.87%	0	0	8,849	0	498	0	438	0	291	0	465	0	439	0	6.51	36.68	3.35
(5V20) (648BU) Vancouver, WA - VADOM	6	6	100.00%	0	0.00%	0	0	6	0	0	0	0	0	0	0	0	0	0	0			
(5V20) (648GA) Bend, OR (Robert D. Maxwell)	2,898	2,394	82.61%	504	17.39%	0	0	2,228	0	166	0	148	0	77	0	31	0	248	0	7.72	50.95	1.38
(5V20) (648GB) Salem, OR	4,914	3,932	80.02%	982	19.98%	0	0	3,673	0	259	0	324	0	136	0	126	0	396	0	5.12	48.65	0.34
(5V20) (648GD) North Coast, OR	75	74	98.67%	1	1.33%	0	0	74	0	0	0	1	0	0	0	0	0	0	0	0.21		34.00
(5V20) (648GE) Fairview, OR	1,748	1,673	95.71%	75	4.29%	0	0	1,579	0	94	0	66	0	5	0	3	0	1	0	6.51	27.61	2.54
(5V20) (648GF) Hillsboro, OR	1,941	1,747	90.01%	194	9.99%	0	0	1,557	0	190	0	99	0	45	0	10	0	40	0	7.54	43.09	1.59
(5V20) (648GG) West Linn, OR	2,396	2,333	97.37%	63	2.63%	0	0	2,244	0	89	0	47	0	5	0	6	0	5	0	2.62	14.18	1.09
(5V20) (648GH) Newport, OR	142	124	87.32%	18	12.68%	0	0	114	0	10	0	16	0	2	0	0	0	0	0	10.33		
(5V20) (648GI) Portland 1st Avenue, OR	267	239	89.51%	28	10.49%	0	0	217	0	22	0	16	0	5	0	3	0	4	0	11.57		0.58
(5V20) (648GJ) The Dalles, OR (Loren R. Kaufman)	1,131	1,082	95.67%	49	4.33%	0	0	1,034	0	48	0	24	0	6	0	2	0	17	0	5.92	17.85	22.13
(5V20) (653) Roseburg, OR HCS	32,542	29,344	90.17%	3,198	9.83%	27	0	28,220	0	1,124	0	1,204	0	854	0	429	0	711	0	8.75	20.66	2.44
(5V20) (653) Roseburg, OR	11,649	10,095	86.66%	1,554	13.34%	0	0	9,685	0	410	0	597	0	346	0	149	0	462	0	18.04	30.74	4.40
(5V20) (653BY) Eugene, OR	17,987	16,410	91.23%	1,577	8.77%	0	0	15,754	0	656	0	557	0	497	0	275	0	248	0	6.10	13.88	2.58
(5V20) (653GA) North Bend, OR	1,451	1,390	95.80%	61	4.20%	0	0	1,344	0	46	0	46	0	9	0	5	0	1	0	4.46	11.00	0.00
(5V20) (653GB) Brookings, OR	741	739	99.73%	2	0.27%	0	0	729	0	10	0	2	0	0	0	0	0	0	0	1.14		0.89
(5V20) (653QA) Downtown Eugene, OR	714	710	99.44%	4	0.56%	0	0	708	0	2	0	2	0	2	0	0	0	0	0			1.01
(5V20) (663) Puget Sound, WA HCS	82,292	74,376	90.38%	7,916	9.62%	43	1	69,029	0	5,347	0	4,321	0	2,064	1	738	0	793	0	7.00	9.64	6.28
(5V20) (663) Seattle, WA	39,616	35,603	89.87%	4,013	10.13%	0	0	32,883	0	2,720	0	2,305	0	955	0	337	0	416	0	6.88	9.67	6.04
(5V20) (663A4) American Lake, WA	31,578	28,422	90.01%	3,156	9.99%	0	1	26,582	0	1,840	0	1,485	0	942	1	381	0	348	0	6.21	10.74	6.45
(5V20) (663GA) Bellevue, WA	9	9	100.00%	0	0.00%	0	0	9	0	0	0	0	0	0	0	0	0	0	0			0.00
(5V20) (663GB) Silverdale, WA	4,481	4,212	94.00%	269	6.00%	0	0	3,951	0	261	0	191	0	55	0	11	0	12	0	9.73	4.14	0.00
(5V20) (663GC) Mount Vernon, WA	4,293	3,942	91.82%	351	8.18%	0	0	3,594	0	348	0	233	0	97	0	5	0	16	0	5.38	9.13	1.15
(5V20) (663GD) South Sound, WA	1,409	1,332	94.54%	77	5.46%	0	0	1,195	0	137	0	65	0	10	0	2	0	0	0	6.19		7.23

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(5V20) (663GE) North Olympic Peninsula, WA	819	769	93.89%	50	6.11%	0	0	728	0	41	0	42	0	5	0	2	0	1	0	5.24	5.94	0.00
(5V20) (663HK) Puget Sound, WA - Mobile	87	87	100.00%	0	0.00%	0	0	87	0	0	0	0	0	0	0	0	0	0	0		0.03	
(5V20) (668) Spokane, WA HCS	628	619	98.57%	9	1.43%	13	0	604	0	15	0	1	0	1	0	1	0	6	0	7.70	12.02	8.92
(5V20) (668) Spokane, WA (Mann-Grandstaff)	589	580	98.47%	9	1.53%	0	0	575	0	5	0	1	0	1	0	1	0	6	0	0.92	12.13	10.59
(5V20) (668GA) Wenatchee, WA	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0		0.00	
(5V20) (668GB) Coeur d Alene, ID	15	15	100.00%	0	0.00%	0	0	14	0	1	0	0	0	0	0	0	0	0	0	0.00		3.00
(5V20) (668HK) Spokane, WA - Mobile	23	23	100.00%	0	0.00%	0	0	14	0	9	0	0	0	0	0	0	0	0	0	11.87		
(5V20) (687) Walla Walla, WA HCS	14,694	13,812	94.00%	882	6.00%	6	0	13,265	0	547	0	383	0	121	0	57	0	321	0	5.69	18.43	5.35
(5V20) (687) Walla Walla, WA (Jonathan M. Wainwright)	11,106	10,436	93.97%	670	6.03%	0	0	10,000	0	436	0	279	0	87	0	40	0	264	0	4.03	18.70	5.58
(5V20) (687GA) Richland, WA	1,456	1,421	97.60%	35	2.40%	0	0	1,398	0	23	0	20	0	4	0	5	0	6	0	1.74	3.38	7.66
(5V20) (687GB) Lewiston, ID	832	742	89.18%	90	10.82%	0	0	697	0	45	0	34	0	18	0	5	0	33	0	18.32	13.00	1.19
(5V20) (687GC) La Grande, OR	387	382	98.71%	5	1.29%	0	0	380	0	2	0	5	0	0	0	0	0	0	0	0.98		0.00
(5V20) (687HA) Yakima, WA	904	825	91.26%	79	8.74%	0	0	784	0	41	0	42	0	12	0	7	0	18	0	15.45	0.27	
(5V20) (687QB) Morrow County, OR	8	5	62.50%	3	37.50%	0	0	5	0	0	0	3	0	0	0	0	0	0	0	27.80		
(5V20) (687QC) Wallowa County, OR	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(5V20) (692) White City, OR HCS	7,818	6,653	85.10%	1,165	14.90%	14	0	6,137	0	516	0	571	0	243	0	128	0	223	0	28.72	15.08	1.83
(5V20) (692) White City, OR	6,610	5,571	84.28%	1,039	15.72%	0	0	5,143	0	428	0	493	0	223	0	108	0	215	0	34.56	16.52	1.94
(5V20) (692GA) Klamath Falls, OR	675	647	95.85%	28	4.15%	0	0	617	0	30	0	22	0	1	0	5	0	0	0	8.61	1.82	0.64
(5V20) (692GB) Grants Pass, OR	533	435	81.61%	98	18.39%	0	0	377	0	58	0	56	0	19	0	15	0	8	0	24.08	6.56	1.83
(5V21) (358) Manila, PI HCS	6,907	5,621	81.38%	1,286	18.62%	6	1	5,018	1	603	0	246	0	114	0	126	0	800	0	37.47	40.43	35.67
(5V21) (358) Manila, PH	6,907	5,621	81.38%	1,286	18.62%	0	1	5,018	1	603	0	246	0	114	0	126	0	800	0	37.47	40.43	35.67
(5V21) (459) Honolulu, HI HCS	37,502	34,530	92.08%	2,972	7.92%	21	0	33,113	0	1,417	0	1,195	0	753	0	330	0	694	0	3.70	25.72	2.82
(5V21) (459) Honolulu, HI (Spark M. Matsunaga)	24,073	21,864	90.82%	2,209	9.18%	0	0	21,066	0	798	0	852	0	598	0	254	0	505	0	2.68	26.09	0.86
(5V21) (459GA) Maui, HI	2,451	2,268	92.53%	183	7.47%	0	0	2,173	0	95	0	60	0	27	0	18	0	78	0	10.03	33.23	4.75
(5V21) (459GB) Hilo, HI	2,273	2,055	90.41%	218	9.59%	0	0	1,908	0	147	0	107	0	47	0	23	0	41	0	6.78	31.89	6.81
(5V21) (459GC) Kailua-Kona, HI	1,830	1,700	92.90%	130	7.10%	0	0	1,654	0	46	0	55	0	25	0	11	0	39	0	11.40	17.67	2.66
(5V21) (459GD) Lihue, HI	2,125	2,041	96.05%	84	3.95%	0	0	1,925	0	116	0	36	0	25	0	11	0	12	0	3.69	18.03	2.80
(5V21) (459GE) Guam, GU	2,340	2,292	97.95%	48	2.05%	0	0	2,225	0	67	0	23	0	8	0	6	0	11	0	2.57	20.97	3.09
(5V21) (459GF) American Samoa, AS (Faleomavaega Eni Faauaa Hunkin)	429	419	97.67%	10	2.33%	0	0	404	0	15	0	6	0	2	0	1	0	1	0	2.94	11.94	0.51
(5V21) (459GG) Leeward Oahu, HI	1,785	1,697	95.07%	88	4.93%	0	0	1,570	0	127	0	56	0	20	0	6	0	6	0	7.83		4.35
(5V21) (459GH) Saipan, MP	120	119	99.17%	1	0.83%	0	0	118	0	1	0	0	0	0	0	0	0	1	0	0.01	10.64	1.88
(5V21) (459QB) Molokai, HI	76	75	98.68%	1	1.32%	0	0	70	0	5	0	0	0	1	0	0	0	0	0	3.49	0.00	0.00
(5V21) (570) Fresno, CA HCS	33,774	30,640	90.72%	3,134	9.28%	6	0	28,903	0	1,737	0	1,288	0	508	0	401	0	937	0	1.15	21.62	8.35
(5V21) (570) Fresno, CA	31,527	28,526	90.48%	3,001	9.52%	0	0	26,895	0	1,631	0	1,220	0	487	0	366	0	928	0	0.76	22.20	9.11
(5V21) (570GA) Merced, CA	901	844	93.67%	57	6.33%	0	0	798	0	46	0	14	0	6	0	32	0	5	0	7.57	12.78	0.60
(5V21) (570GB) Tulare, CA	972	921	94.75%	51	5.25%	0	0	868	0	53	0	45	0	2	0	2	0	2	0	3.81	16.22	0.98
(5V21) (570GC) Oakhurst, CA	374	349	93.32%	25	6.68%	0	0	342	0	7	0	9	0	13	0	1	0	2	0	3.19	8.56	0.00
(5V21) (612A4) N. California HCS	122,048	107,311	87.93%	14,737	12.07%	30	1	101,776	1	5,535	0	5,678	0	3,104	0	2,224	0	3,731	0	6.43	15.18	6.32
(5V21) (612A4) Sacramento, CA	43,173	36,556	84.67%	6,617	15.33%	0	1	34,732	1	1,824	0	2,472	0	1,651	0	995	0	1,499	0	11.30	14.96	10.01
(5V21) (612B4) Redding, CA	9,599	8,770	91.36%	829	8.64%	0	0	8,466	0	304	0	364	0	191	0	157	0	117	0	1.08	8.00	7.28
(5V21) (612BY) Oakland, CA	4,227	3,493	82.64%	734	17.36%	0	0	3,157	0	336	0	374	0	124	0	82	0	154	0	6.68	22.41	0.00
(5V21) (612GD) Fairfield, CA	3,283	2,919	88.91%	364	11.09%	0	0	2,615	0	304	0	165	0	42	0	61	0	96	0	8.16	18.10	6.99

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(5V21) (612GE) Mare Island, CA	6,335	5,779	91.22%	556	8.78%	0	0	5,461	0	318	0	177	0	40	0	16	0	323	0	3.19	19.08	1.18
(5V21) (612GF) Martinez, CA	19,904	16,967	85.24%	2,937	14.76%	0	0	15,888	0	1,079	0	1,017	0	636	0	524	0	760	0	8.63	19.70	4.74
(5V21) (612GG) Chico, CA	9,372	8,927	95.25%	445	4.75%	0	0	8,493	0	434	0	173	0	63	0	123	0	86	0	5.28	7.69	0.73
(5V21) (612GH) McClellan Park, CA	16,853	15,288	90.71%	1,565	9.29%	0	0	14,711	0	577	0	572	0	226	0	209	0	558	0	5.70	13.58	8.09
(5V21) (612GI) Yuba City, CA	1,985	1,919	96.68%	66	3.32%	0	0	1,867	0	52	0	47	0	11	0	6	0	2	0	3.50	2.51	1.88
(5V21) (612GJ) Yreka, CA	468	458	97.86%	10	2.14%	0	0	427	0	31	0	6	0	1	0	0	0	3	0	8.43	0.29	
(5V21) (612GK) Sierra Foothills, CA	2,180	2,109	96.74%	71	3.26%	0	0	2,032	0	77	0	46	0	23	0	1	0	1	0	5.46	0.40	0.62
(5V21) (612QB) Twenty First Street, CA	1,064	1,040	97.74%	24	2.26%	0	0	1,031	0	9	0	12	0	2	0	4	0	6	0			1.66
(5V21) (612QC) Cypress Avenue, CA	3,350	2,835	84.63%	515	15.37%	0	0	2,648	0	187	0	252	0	94	0	44	0	125	0		18.98	
(5V21) (612QD) Howe Road, CA	255	251	98.43%	4	1.57%	0	0	248	0	3	0	1	0	0	0	2	0	1	0			
(5V21) (640) Palo Alto, CA HCS	58,360	47,312	81.07%	11,048	18.93%	19	1	42,813	1	4,499	0	4,276	0	1,819	0	1,045	0	3,908	0	4.67	38.64	4.68
(5V21) (640) Palo Alto, CA	23,490	19,843	84.47%	3,647	15.53%	0	1	18,053	1	1,790	0	1,588	0	665	0	504	0	890	0	3.09	23.86	0.38
(5V21) (640A0) Menlo Park, CA	1,500	1,425	95.00%	75	5.00%	0	0	1,345	0	80	0	60	0	8	0	3	0	4	0		7.21	3.14
(5V21) (640A4) Livermore, CA	10,010	7,172	71.65%	2,838	28.35%	0	0	6,463	0	709	0	806	0	609	0	246	0	1,177	0	2.44	54.75	6.34
(5V21) (640BY) San Jose, CA	6,152	4,572	74.32%	1,580	25.68%	0	0	3,996	0	576	0	520	0	117	0	98	0	845	0	5.22	73.37	10.06
(5V21) (640GA) Capitola, CA	156	150	96.15%	6	3.85%	0	0	143	0	7	0	2	0	0	0	1	0	3	0	4.40	14.43	
(5V21) (640GB) Sonora, CA	716	678	94.69%	38	5.31%	0	0	619	0	59	0	32	0	3	0	0	0	3	0	7.82	6.56	6.14
(5V21) (640GC) Fremont, CA	620	606	97.74%	14	2.26%	0	0	577	0	29	0	6	0	2	0	2	0	4	0	5.90	24.00	3.06
(5V21) (640HA) Stockton, CA	3,639	3,140	86.29%	499	13.71%	0	0	2,870	0	270	0	323	0	86	0	28	0	62	0	7.51	31.79	2.04
(5V21) (640HB) Modesto, CA	3,305	2,836	85.81%	469	14.19%	0	0	2,437	0	399	0	307	0	82	0	31	0	49	0	10.05	11.45	4.37
(5V21) (640HC) Monterey, CA (Major General William H. Gourley)	8,772	6,890	78.55%	1,882	21.45%	0	0	6,310	0	580	0	632	0	247	0	132	0	871	0	4.35	47.71	4.72
(5V21) (654) Reno, NV HCS	49,980	42,823	85.68%	7,157	14.32%	21	0	39,664	0	3,159	0	2,970	0	2,054	0	893	0	1,240	0	6.20	22.85	13.26
(5V21) (654) Reno, NV (Ioannis A. Lougaris)	26,607	22,289	83.77%	4,318	16.23%	0	0	20,390	0	1,899	0	2,029	0	1,125	0	494	0	670	0	4.57	19.05	13.14
(5V21) (654GB) Carson Valley, NV	2,404	2,292	95.34%	112	4.66%	0	0	2,190	0	102	0	67	0	22	0	6	0	17	0	5.65	26.67	23.25
(5V21) (654GC) Lahontan Valley, NV	2,120	2,017	95.14%	103	4.86%	0	0	1,943	0	74	0	79	0	15	0	4	0	5	0	3.97	3.89	16.17
(5V21) (654GD) Diamond View, CA	864	858	99.31%	6	0.69%	0	0	835	0	23	0	4	0	0	0	0	0	2	0	1.46	252.00	34.44
(5V21) (654GE) Reno East, NV	5,053	4,916	97.29%	137	2.71%	0	0	4,761	0	155	0	94	0	21	0	5	0	17	0	3.75	30.13	4.67
(5V21) (654GF) North Reno, NV	4,351	3,514	80.76%	837	19.24%	0	0	3,149	0	365	0	317	0	384	0	56	0	80	0	15.13	40.48	2.25
(5V21) (654QA) Kietzke, NV	3,639	2,661	73.12%	978	26.88%	0	0	2,497	0	164	0	224	0	342	0	295	0	117	0		24.69	
(5V21) (654QB) Capitol Hill, NV	93	89	95.70%	4	4.30%	0	0	80	0	9	0	1	0	3	0	0	0	0	0	8.70		
(5V21) (654QC) Winnemucca, NV	220	173	78.64%	47	21.36%	0	0	141	0	32	0	38	0	3	0	1	0	5	0	19.96	53.20	8.60
(5V21) (654QD) Virginia Street, NV	4,629	4,014	86.71%	615	13.29%	0	0	3,678	0	336	0	117	0	139	0	32	0	327	0		27.61	
(5V21) (662) San Francisco, CA HCS	42,365	37,815	89.26%	4,550	10.74%	49	0	35,416	0	2,399	0	2,136	0	938	0	471	0	1,005	0	5.93	20.92	3.69
(5V21) (662) San Francisco, CA	31,104	27,501	88.42%	3,603	11.58%	0	0	25,722	0	1,779	0	1,629	0	701	0	373	0	900	0	6.26	23.03	2.55
(5V21) (662GA) Santa Rosa, CA	5,187	4,552	87.76%	635	12.24%	0	0	4,217	0	335	0	313	0	157	0	81	0	84	0	6.62	18.72	13.59
(5V21) (662GC) Eureka, CA	1,898	1,803	94.99%	95	5.01%	0	0	1,700	0	103	0	44	0	42	0	7	0	2	0	4.05	8.66	1.33
(5V21) (662GD) Ukiah, CA	932	843	90.45%	89	9.55%	0	0	779	0	64	0	66	0	15	0	5	0	3	0	6.11	8.69	2.13
(5V21) (662GE) San Bruno, CA	1,008	982	97.42%	26	2.58%	0	0	952	0	30	0	12	0	6	0	1	0	7	0	2.80	5.32	0.80
(5V21) (662GF) San Francisco Downtown, CA	659	633	96.05%	26	3.95%	0	0	609	0	24	0	17	0	5	0	2	0	2	0	5.76	2.86	1.91
(5V21) (662GG) Clearlake, CA	1,577	1,501	95.18%	76	4.82%	0	0	1,437	0	64	0	55	0	12	0	2	0	7	0	5.89	9.68	3.79
(5V21) (593) Las Vegas, NV HCS	114,652	95,970	83.71%	18,682	16.29%	27	0	89,190	0	6,780	0	7,474	0	3,058	0	2,951	0	5,199	0	10.04	30.90	5.39
(5V21) (593) North Las Vegas, NV	72,138	55,877	77.46%	16,261	22.54%	0	0	51,384	0	4,493	0	6,094	0	2,547	0	2,731	0	4,889	0	22.81	32.16	5.82
(5V21) (593GC) Pahrump, NV	2,145	2,109	98.32%	36	1.68%	0	0	2,075	0	34	0	22	0	10	0	3	0	1	0	1.71	16.25	1.88

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(5V21) (593GD) Northwest Las Vegas, NV	11,984	11,061	92.30%	923	7.70%	0	0	10,353	0	708	0	470	0	250	0	101	0	102	0	12.03	2.21	5.22
(5V21) (593GE) Southeast Las Vegas, NV	11,193	10,654	95.18%	539	4.82%	0	0	9,935	0	719	0	340	0	83	0	33	0	83	0	8.38	1.27	6.15
(5V21) (593GF) Southwest Las Vegas, NV	9,629	9,128	94.80%	501	5.20%	0	0	8,717	0	411	0	265	0	111	0	46	0	79	0	7.85	2.77	4.90
(5V21) (593GG) Northeast Las Vegas, NV	5,889	5,558	94.38%	331	5.62%	0	0	5,246	0	312	0	214	0	49	0	32	0	36	0	7.78	4.54	5.37
(5V21) (593GH) Laughlin, NV (Master Chief Petty Officer Jesse Dean)	1,474	1,384	93.89%	90	6.11%	0	0	1,286	0	98	0	68	0	8	0	5	0	9	0	6.27	4.73	4.29
(5V21) (593QC) West Cheyenne, NV	200	199	99.50%	1	0.50%	0	0	194	0	5	0	1	0	0	0	0	0	0	0			2.12
(5V22) (501) New Mexico HCS	72,106	62,204	86.27%	9,902	13.73%	10	0	58,825	0	3,379	0	3,152	0	1,823	0	1,177	0	3,750	0	10.35	30.00	10.97
(5V22) (501) Albuquerque, NM (Raymond G. Murphy)	59,346	49,993	84.24%	9,353	15.76%	0	0	47,082	0	2,911	0	2,969	0	1,765	0	1,140	0	3,479	0	8.74	30.73	11.71
(5V22) (501G2) Las Vegas, NM	939	925	98.51%	14	1.49%	0	0	915	0	10	0	7	0	1	0	0	0	6	0	2.10	0.00	0.00
(5V22) (501GA) Artesia, NM	614	588	95.77%	26	4.23%	0	0	540	0	48	0	19	0	2	0	1	0	4	0	6.83	2.33	23.94
(5V22) (501GB) Farmington, NM	1,628	1,569	96.38%	59	3.62%	0	0	1,498	0	71	0	34	0	14	0	1	0	10	0	4.08	0.11	6.75
(5V22) (501GC) Silver City, NM	175	170	97.14%	5	2.86%	0	0	149	0	21	0	5	0	0	0	0	0	0	0	6.97	0.40	
(5V22) (501GD) Gallup, NM	440	435	98.86%	5	1.14%	0	0	430	0	5	0	2	0	1	0	0	0	2	0	1.76	0.31	
(5V22) (501GE) Espanola, NM	941	757	80.45%	184	19.55%	0	0	733	0	24	0	0	0	0	0	2	0	182	0	92.78	0.00	1.00
(5V22) (501GH) Truth or Consequences, NM	467	466	99.79%	1	0.21%	0	0	460	0	6	0	1	0	0	0	0	0	0	0	0.66	0.41	0.00
(5V22) (501GI) Alamogordo, NM	1,548	1,523	98.39%	25	1.61%	0	0	1,487	0	36	0	11	0	6	0	5	0	3	0	2.72	0.00	
(5V22) (501GJ) Durango, CO	1,006	993	98.71%	13	1.29%	0	0	987	0	6	0	5	0	2	0	1	0	5	0	2.74	0.02	1.27
(5V22) (501GK) Santa Fe, NM	1,806	1,745	96.62%	61	3.38%	0	0	1,696	0	49	0	19	0	6	0	13	0	23	0	8.83	1.26	1.98
(5V22) (501GM) Northwest Metro, NM	2,701	2,560	94.78%	141	5.22%	0	0	2,403	0	157	0	75	0	24	0	14	0	28	0	8.91	8.00	1.00
(5V22) (501GN) Taos, NM	390	375	96.15%	15	3.85%	0	0	341	0	34	0	5	0	2	0	0	0	8	0	12.12	0.00	
(5V22) (501HB) Raton, NM	105	105	100.00%	0	0.00%	0	0	104	0	1	0	0	0	0	0	0	0	0	0	2.00	0.39	
(5V22) (644) Phoenix, AZ HCS	130,385	117,811	90.36%	12,574	9.64%	14	0	111,066	0	6,745	0	7,161	0	2,064	0	950	0	2,399	0	2.89	18.08	9.92
(5V22) (644) Phoenix, AZ (Carl T. Hayden)	69,431	60,010	86.43%	9,421	13.57%	0	0	55,504	0	4,506	0	5,241	0	1,583	0	719	0	1,878	0	1.87	17.95	10.35
(5V22) (644BY) Southeast Gilbert, AZ	26,035	24,474	94.00%	1,561	6.00%	0	0	23,303	0	1,171	0	869	0	228	0	141	0	323	0	3.08	25.75	9.74
(5V22) (644GA) Northwest Surprise, AZ	11,695	11,163	95.45%	532	4.55%	0	0	10,863	0	300	0	416	0	56	0	11	0	49	0	2.07	9.98	4.39
(5V22) (644GB) Show Low, AZ	1,545	1,353	87.57%	192	12.43%	0	0	1,289	0	64	0	63	0	40	0	17	0	72	0	7.48	19.20	33.82
(5V22) (644GC) Southwest Phoenix, AZ	4,938	4,732	95.83%	206	4.17%	0	0	4,600	0	132	0	153	0	27	0	12	0	14	0	2.50	20.83	6.97
(5V22) (644GD) Payson, AZ	562	526	93.59%	36	6.41%	0	0	489	0	37	0	23	0	9	0	0	0	4	0	6.84	0.00	7.54
(5V22) (644GE) Thunderbird, AZ	4,249	4,085	96.14%	164	3.86%	0	0	3,868	0	217	0	107	0	22	0	20	0	15	0	4.97	8.75	3.49
(5V22) (644GF) Globe, AZ	446	412	92.38%	34	7.62%	0	0	401	0	11	0	16	0	9	0	6	0	3	0	3.10	14.87	24.57
(5V22) (644GG) Northeast Phoenix, AZ	2,911	2,700	92.75%	211	7.25%	0	0	2,566	0	134	0	122	0	54	0	18	0	17	0	3.47	18.61	14.73
(5V22) (644GH) Phoenix Midtown, AZ	8,573	8,356	97.47%	217	2.53%	0	0	8,183	0	173	0	151	0	36	0	6	0	24	0	2.82	8.43	6.70
(5V22) (649) Northern Arizona HCS	25,948	23,986	92.44%	1,962	7.56%	15	0	23,066	0	920	0	652	0	405	0	222	0	683	0	3.73	33.44	8.16
(5V22) (649) Prescott, AZ (Bob Stump)	14,545	12,978	89.23%	1,567	10.77%	0	0	12,502	0	476	0	430	0	337	0	185	0	615	0	3.70	34.26	8.39
(5V22) (649GA) Kingman, AZ	3,572	3,452	96.64%	120	3.36%	0	0	3,341	0	111	0	60	0	23	0	15	0	22	0	3.13	15.18	6.71
(5V22) (649GB) Flagstaff, AZ	1,291	1,228	95.12%	63	4.88%	0	0	1,138	0	90	0	33	0	8	0	13	0	9	0	7.69	2.78	2.07
(5V22) (649GC) Lake Havasu City, AZ	3,595	3,559	99.00%	36	1.00%	0	0	3,493	0	66	0	17	0	7	0	1	0	11	0	2.08	5.33	5.20
(5V22) (649GD) Anthem, AZ	736	689	93.61%	47	6.39%	0	0	615	0	74	0	40	0	4	0	1	0	2	0	3.28	46.00	7.16
(5V22) (649GE) Cottonwood, AZ	2,128	2,008	94.36%	120	5.64%	0	0	1,915	0	93	0	71	0	24	0	6	0	19	0	5.09	0.00	13.56
(5V22) (649QA) Chinle, AZ	51	45	88.24%	6	11.76%	0	0	43	0	2	0	0	0	0	0	1	0	5	0	39.53		0.00
(5V22) (649QB) Holbrook, AZ	25	22	88.00%	3	12.00%	0	0	14	0	8	0	1	0	2	0	0	0	0	0	19.46		0.00
(5V22) (649QD) Page, AZ	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			0.00

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(5V22) (649QF) Tuba City, AZ	4	4	100.00%	0	0.00%	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0.00		
(5V22) (678) Southern Arizona HCS	80,934	74,247	91.74%	6,687	8.26%	5	1	70,418	1	3,829	0	2,970	0	1,238	0	618	0	1,861	0	3.84	13.63	3.26
(5V22) (678) Tucson, AZ	60,226	54,170	89.94%	6,056	10.06%	0	0	51,240	0	2,930	0	2,548	0	1,120	0	582	0	1,806	0	3.55	14.46	3.96
(5V22) (678GA) Sierra Vista, AZ	6,356	6,115	96.21%	241	3.79%	0	0	5,832	0	283	0	183	0	24	0	1	0	33	0	5.39	9.72	4.61
(5V22) (678GB) Yuma, AZ	5,323	5,304	99.64%	19	0.36%	0	1	5,154	1	150	0	12	0	1	0	3	0	3	0	1.86	1.73	2.22
(5V22) (678GC) Casa Grande, AZ	2,979	2,774	93.12%	205	6.88%	0	0	2,596	0	178	0	119	0	64	0	13	0	9	0	4.67	12.95	1.37
(5V22) (678GD) Safford, AZ	427	421	98.59%	6	1.41%	0	0	416	0	5	0	5	0	0	0	0	0	1	0	1.52	0.00	1.13
(5V22) (678GE) Green Valley, AZ	527	517	98.10%	10	1.90%	0	0	475	0	42	0	8	0	1	0	0	0	1	0	5.33	0.00	0.54
(5V22) (678GF) Northwest Tucson, AZ	3,209	3,070	95.67%	139	4.33%	0	0	2,875	0	195	0	90	0	25	0	18	0	6	0	7.90	7.43	0.71
(5V22) (678GG) Southeast Tucson, AZ	1,887	1,876	99.42%	11	0.58%	0	0	1,830	0	46	0	5	0	3	0	1	0	2	0	3.03	3.97	0.22
(5V22) (600) Long Beach, CA HCS	92,233	82,774	89.74%	9,459	10.26%	7	1	78,407	1	4,367	0	3,633	0	2,262	0	1,034	0	2,530	0	5.33	22.16	6.87
(5V22) (600) Long Beach, CA (Tibor Rubin)	73,090	64,201	87.84%	8,889	12.16%	0	1	60,376	1	3,825	0	3,310	0	2,141	0	977	0	2,461	0	6.82	22.81	7.20
(5V22) (600GA) Anaheim, CA	2,899	2,773	95.65%	126	4.35%	0	0	2,615	0	158	0	67	0	30	0	12	0	17	0	4.00		40.28
(5V22) (600GB) Santa Ana, CA	5,842	5,548	94.97%	294	5.03%	0	0	5,303	0	245	0	180	0	55	0	30	0	29	0	2.98	11.11	12.42
(5V22) (600GC) Cabrillo, CA	122	120	98.36%	2	1.64%	0	0	120	0	0	0	0	0	0	0	2	0	0	0	0.87		14.38
(5V22) (600GD) Santa Fe Springs, CA	2,692	2,675	99.37%	17	0.63%	0	0	2,651	0	24	0	10	0	2	0	1	0	4	0	1.93	372.50	1.24
(5V22) (600GE) Laguna Hills, CA	4,494	4,410	98.13%	84	1.87%	0	0	4,372	0	38	0	24	0	33	0	10	0	17	0	3.48	0.00	0.31
(5V22) (600GF) Gardena, CA	3,094	3,047	98.48%	47	1.52%	0	0	2,970	0	77	0	42	0	1	0	2	0	2	0	1.22	12.99	2.01
(5V22) (605) Loma Linda, CA HCS	128,285	119,123	92.86%	9,162	7.14%	43	0	113,192	0	5,931	0	4,621	0	1,727	0	1,057	0	1,757	0	2.29	11.84	6.00
(5V22) (605) Loma Linda, CA (Jerry L. Pettis)	43,982	38,497	87.53%	5,485	12.47%	0	0	35,751	0	2,746	0	2,117	0	1,132	0	819	0	1,417	0	48.75	14.60	2.14
(5V22) (605BZ) Loma Linda Redlands, CA	49,418	46,402	93.90%	3,016	6.10%	0	0	43,992	0	2,410	0	2,025	0	527	0	220	0	244	0	2.41	7.58	7.54
(5V22) (605GA) Victorville, CA	5,960	5,773	96.86%	187	3.14%	0	0	5,564	0	209	0	149	0	19	0	8	0	11	0	1.92		7.15
(5V22) (605GB) Murrieta, CA	8,780	8,635	98.35%	145	1.65%	0	0	8,493	0	142	0	97	0	9	0	5	0	34	0	2.93	0.99	3.51
(5V22) (605GC) Palm Desert, CA	9,416	9,326	99.04%	90	0.96%	0	0	9,112	0	214	0	64	0	6	0	1	0	19	0	1.40	2.53	5.34
(5V22) (605GD) Corona, CA	3,898	3,720	95.43%	178	4.57%	0	0	3,606	0	114	0	133	0	31	0	2	0	12	0	3.36		4.18
(5V22) (605GE) Rancho Cucamonga, CA	6,825	6,764	99.11%	61	0.89%	0	0	6,668	0	96	0	36	0	3	0	2	0	20	0	2.05	0.58	2.57
(5V22) (605QA) Blythe, CA	6	6	100.00%	0	0.00%	0	0	6	0	0	0	0	0	0	0	0	0	0	0			0.00
(5V22) (664) San Diego, CA HCS	90,709	79,173	87.28%	11,536	12.72%	18	0	74,700	0	4,473	0	4,635	0	2,854	0	1,446	0	2,601	0	2.30	19.72	4.28
(5V22) (664) San Diego, CA	63,607	54,958	86.40%	8,649	13.60%	0	0	52,214	0	2,744	0	3,274	0	2,130	0	1,165	0	2,080	0	1.47	20.89	1.32
(5V22) (664BY) Mission Valley, CA	10,660	9,789	91.83%	871	8.17%	0	0	8,947	0	842	0	428	0	318	0	58	0	67	0	2.39	17.67	5.57
(5V22) (664GA) Imperial Valley, CA	559	559	100.00%	0	0.00%	0	0	553	0	6	0	0	0	0	0	0	0	0	0	1.08	0.00	0.00
(5V22) (664GB) Oceanside, CA	10,821	9,241	85.40%	1,580	14.60%	0	0	8,624	0	617	0	703	0	307	0	178	0	392	0	7.13	16.61	6.86
(5V22) (664GC) Chula Vista, CA	3,611	3,282	90.89%	329	9.11%	0	0	3,079	0	203	0	149	0	89	0	41	0	50	0	13.56	12.67	7.89
(5V22) (664GD) Escondido, CA	1,387	1,280	92.29%	107	7.71%	0	0	1,219	0	61	0	81	0	10	0	4	0	12	0	10.84		5.18
(5V22) (664QA) Rio, CA	64	64	100.00%	0	0.00%	0	0	64	0	0	0	0	0	0	0	0	0	0	0			
(5V22) (691) Greater Los Angeles, CA HCS	101,545	88,704	87.35%	12,841	12.65%	67	0	82,077	0	6,627	0	6,040	0	3,071	0	1,545	0	2,185	0	7.41	11.59	10.63
(5V22) (691) West Los Angeles, CA	42,654	36,893	86.49%	5,761	13.51%	0	0	34,212	0	2,681	0	2,930	0	1,244	0	597	0	990	0	4.39	10.53	24.37
(5V22) (691A4) Sepulveda, CA	26,031	21,879	84.05%	4,152	15.95%	0	0	20,004	0	1,875	0	1,617	0	1,174	0	572	0	789	0	8.31	14.41	8.19
(5V22) (691GB) Santa Barbara, CA	457	437	95.62%	20	4.38%	0	0	421	0	16	0	12	0	3	0	2	0	3	0	3.50	41.09	0.69
(5V22) (691GD) Bakersfield, CA	5,240	4,702	89.73%	538	10.27%	0	0	4,426	0	276	0	185	0	72	0	133	0	148	0	15.31	3.82	1.82
(5V22) (691GE) Los Angeles, CA	10,266	9,556	93.08%	710	6.92%	0	0	9,025	0	531	0	353	0	125	0	72	0	160	0	5.76	11.00	3.25
(5V22) (691GF) East Los Angeles, CA	1,436	1,416	98.61%	20	1.39%	0	0	1,371	0	45	0	18	0	1	0	1	0	0	0	1.07	2.42	3.40
(5V22) (691GG) Antelope Valley, CA	1,994	1,788	89.67%	206	10.33%	0	0	1,589	0	199	0	133	0	52	0	14	0	7	0	5.61	9.07	4.71

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(5V22) (691GK) San Luis Obispo, CA	1,050	954	90.86%	96	9.14%	0	0	896	0	58	0	84	0	9	0	3	0	0	0	6.10	12.73	4.34
(5V22) (691GL) Santa Maria, CA	4,598	3,713	80.75%	885	19.25%	0	0	3,237	0	476	0	402	0	314	0	136	0	33	0	7.40	18.70	8.38
(5V22) (691GM) Oxnard, CA	5,924	5,511	93.03%	413	6.97%	0	0	5,281	0	230	0	273	0	72	0	15	0	53	0	8.64	8.36	3.99
(5V22) (691GP) San Gabriel Valley, CA	1,895	1,855	97.89%	40	2.11%	0	0	1,615	0	240	0	33	0	5	0	0	0	2	0	1.98	5.38	3.37
(3V23) (437) Fargo, ND HCS	36,008	34,140	94.81%	1,868	5.19%	12	2	32,736	2	1,404	0	972	0	373	0	151	0	372	0	2.46	8.58	4.00
(3V23) (437) Fargo, ND	28,004	26,289	93.88%	1,715	6.12%	0	2	25,070	2	1,219	0	868	0	342	0	144	0	361	0	3.39	8.52	4.54
(3V23) (437GA) Grafton, ND	330	325	98.48%	5	1.52%	0	0	322	0	3	0	4	0	0	0	1	0	0	0	0.80	17.89	0.50
(3V23) (437GB) Bismarck, ND	1,448	1,392	96.13%	56	3.87%	0	0	1,323	0	69	0	30	0	15	0	4	0	7	0	2.39	15.22	2.66
(3V23) (437GC) Fergus Falls, MN	965	961	99.59%	4	0.41%	0	0	954	0	7	0	2	0	1	0	0	0	1	0	0.31	6.29	0.78
(3V23) (437GD) Minot, ND	1,063	1,047	98.49%	16	1.51%	0	0	1,020	0	27	0	10	0	4	0	1	0	1	0	2.11	2.73	1.24
(3V23) (437GE) Bemidji, MN	1,567	1,530	97.64%	37	2.36%	0	0	1,497	0	33	0	29	0	5	0	1	0	2	0	1.74	1.16	6.72
(3V23) (437GF) Williston, ND	512	507	99.02%	5	0.98%	0	0	502	0	5	0	3	0	2	0	0	0	0	0	1.05	4.00	1.33
(3V23) (437GI) Grand Forks, ND	1,044	1,033	98.95%	11	1.05%	0	0	1,016	0	17	0	10	0	1	0	0	0	0	0	1.15	2.68	1.55
(3V23) (437GJ) Dickinson, ND	472	458	97.03%	14	2.97%	0	0	442	0	16	0	14	0	0	0	0	0	0	0	2.89	0.67	3.92
(3V23) (437GK) Jamestown, ND	317	312	98.42%	5	1.58%	0	0	307	0	5	0	2	0	3	0	0	0	0	0	1.56	7.20	0.21
(3V23) (437GL) Devils Lake, ND	234	234	100.00%	0	0.00%	0	0	232	0	2	0	0	0	0	0	0	0	0	0	0.89	1.10	0.00
(3V23) (437QA) North Fargo, ND	52	52	100.00%	0	0.00%	0	0	51	0	1	0	0	0	0	0	0	0	0	0	0.05		
(3V23) (438) Sioux Falls, SD HCS	35,176	33,239	94.49%	1,937	5.51%	1	0	31,431	0	1,808	0	1,025	0	432	0	223	0	257	0	4.98	8.90	2.93
(3V23) (438) Sioux Falls, SD (Royal C. Johnson)	26,391	24,909	94.38%	1,482	5.62%	0	0	23,707	0	1,202	0	783	0	336	0	162	0	201	0	3.42	8.78	3.27
(3V23) (438GA) Spirit Lake, IA	1,509	1,374	91.05%	135	8.95%	0	0	1,251	0	123	0	78	0	21	0	17	0	19	0	10.79	8.06	4.22
(3V23) (438GC) Sioux City, SD	4,727	4,525	95.73%	202	4.27%	0	0	4,155	0	370	0	90	0	52	0	31	0	29	0	6.12	11.28	1.35
(3V23) (438GD) Aberdeen, SD	1,054	1,007	95.54%	47	4.46%	0	0	970	0	37	0	32	0	7	0	4	0	4	0	4.77	5.75	0.86
(3V23) (438GE) Wagner, SD	152	117	76.97%	35	23.03%	0	0	92	0	25	0	23	0	10	0	1	0	1	0	22.53	0.50	
(3V23) (438GF) Watertown, SD	1,343	1,307	97.32%	36	2.68%	0	0	1,256	0	51	0	19	0	6	0	8	0	3	0	3.60	5.76	2.81
(3V23) (568) Black Hills, SD HCS	19,511	16,882	86.53%	2,629	13.47%	0	0	16,014	0	868	0	797	0	474	0	301	0	1,057	0	7.36	33.54	2.16
(3V23) (568) Fort Meade, SD	11,147	9,636	86.44%	1,511	13.56%	0	0	9,138	0	498	0	389	0	200	0	154	0	768	0	5.93	33.05	2.08
(3V23) (568A4) Hot Springs, SD	3,937	3,395	86.23%	542	13.77%	0	0	3,225	0	170	0	127	0	121	0	83	0	211	0	2.84	37.37	1.04
(3V23) (568GA) Rapid City, SD	3,501	2,953	84.35%	548	15.65%	0	0	2,775	0	178	0	266	0	147	0	61	0	74	0	17.97	29.06	2.47
(3V23) (568GB) Pierre, SD	533	526	98.69%	7	1.31%	0	0	524	0	2	0	4	0	0	0	2	0	1	0	0.12	58.67	0.00
(3V23) (568HA) Newcastle, WY	20	16	80.00%	4	20.00%	0	0	13	0	3	0	2	0	1	0	0	0	1	0	27.90		
(3V23) (568HB) Gordon, NE	23	23	100.00%	0	0.00%	0	0	23	0	0	0	0	0	0	0	0	0	0	0	1.13		
(3V23) (568HF) Pine Ridge, SD	14	10	71.43%	4	28.57%	0	0	10	0	0	0	2	0	2	0	0	0	0	0	19.85		
(3V23) (568HH) Scottsbluff, NE	298	285	95.64%	13	4.36%	0	0	268	0	17	0	7	0	3	0	1	0	2	0	3.24	19.31	1.67
(3V23) (568HJ) Mission, SD	6	6	100.00%	0	0.00%	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0.00		
(3V23) (568HP) Winner, SD	32	32	100.00%	0	0.00%	0	0	32	0	0	0	0	0	0	0	0	0	0	0	0.00		0.00
(3V23) (618) Minneapolis, MN HCS	101,147	89,837	88.82%	11,310	11.18%	151	0	83,698	0	6,139	0	4,091	0	1,843	0	1,184	0	4,192	0	11.33	22.85	4.34
(3V23) (618) Minneapolis, MN	69,815	61,551	88.16%	8,264	11.84%	0	0	56,860	0	4,691	0	2,952	0	1,410	0	820	0	3,082	0	12.06	22.68	4.41
(3V23) (618BY) Twin Ports, WI	8,262	7,454	90.22%	808	9.78%	0	0	7,149	0	305	0	248	0	83	0	188	0	289	0	5.75	23.32	5.74
(3V23) (618GA) St. James, MN	540	539	99.81%	1	0.19%	0	0	536	0	3	0	0	0	1	0	0	0	0	0	0.73	0.14	12.57
(3V23) (618GB) Hibbing, MN	1,398	1,376	98.43%	22	1.57%	0	0	1,287	0	89	0	16	0	2	0	1	0	3	0	4.74	1.10	8.32
(3V23) (618GD) Maplewood, MN	2,608	2,327	89.23%	281	10.77%	0	0	2,061	0	266	0	213	0	30	0	17	0	21	0	9.00	23.19	3.33
(3V23) (618GE) Chippewa Valley, WI	3,788	3,600	95.04%	188	4.96%	0	0	3,496	0	104	0	108	0	36	0	15	0	29	0	13.87	0.54	3.04
(3V23) (618GG) Rochester, MN	2,905	2,851	98.14%	54	1.86%	0	0	2,764	0	87	0	32	0	13	0	6	0	3	0	3.52	0.58	4.50

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(3V23) (618GH) Hayward, WI	236	229	97.03%	7	2.97%	0	0	222	0	7	0	5	0	0	0	1	0	1	0	2.99	0.00	6.29
(3V23) (618GI) Northwest Metro, MN	6,294	4,811	76.44%	1,483	23.56%	0	0	4,422	0	389	0	387	0	237	0	119	0	740	0	33.62	52.16	4.68
(3V23) (618GJ) Shakopee, MN	824	774	93.93%	50	6.07%	0	0	740	0	34	0	21	0	10	0	12	0	7	0	13.04	0.00	3.25
(3V23) (618GK) Albert Lea, MN	571	561	98.25%	10	1.75%	0	0	541	0	20	0	9	0	1	0	0	0	0	0	4.63	0.19	1.21
(3V23) (618GL) Minneapolis Harmon Place, MN	210	206	98.10%	4	1.90%	0	0	204	0	2	0	4	0	0	0	0	0	0	0	7.83	5.44	
(3V23) (618GM) Rice Lake, WI	1,750	1,657	94.69%	93	5.31%	0	0	1,553	0	104	0	64	0	17	0	3	0	9	0	13.08	1.09	3.88
(3V23) (618GN) Mankato, MN (Lyle C. Pearson)	1,596	1,560	97.74%	36	2.26%	0	0	1,526	0	34	0	26	0	3	0	1	0	6	0	5.30	0.98	1.42
(3V23) (618QA) Fort Snelling, MN	143	143	100.00%	0	0.00%	0	0	142	0	1	0	0	0	0	0	0	0	0	0		0.25	
(3V23) (618QB) Ely, MN	207	198	95.65%	9	4.35%	0	0	195	0	3	0	6	0	0	0	1	0	2	0	11.78	1.03	1.00
(3V23) (636A6) Central Iowa HCS	32,264	28,381	87.96%	3,883	12.04%	0	1	26,727	1	1,654	0	1,813	0	907	0	446	0	717	0	9.45	15.94	5.21
(3V23) (636A6) Des Moines, IA	23,108	19,939	86.29%	3,169	13.71%	0	1	18,680	1	1,259	0	1,545	0	812	0	366	0	446	0	8.58	15.45	6.67
(3V23) (636BU) Des Moines, IA - VADOM	13	13	100.00%	0	0.00%	0	0	13	0	0	0	0	0	0	0	0	0	0	0			
(3V23) (636GC) Mason City, IA	2,538	2,354	92.75%	184	7.25%	0	0	2,225	0	129	0	78	0	38	0	24	0	44	0	4.08	28.11	5.85
(3V23) (636GD) Marshalltown, IA	891	869	97.53%	22	2.47%	0	0	855	0	14	0	17	0	4	0	0	0	1	0	0.71	7.35	0.15
(3V23) (636GK) Fort Dodge, IA	2,758	2,567	93.07%	191	6.93%	0	0	2,466	0	101	0	33	0	16	0	26	0	116	0	11.76	20.42	
(3V23) (636GM) Carroll, IA	1,377	1,155	83.88%	222	16.12%	0	0	1,070	0	85	0	70	0	19	0	26	0	107	0	24.37	23.43	0.00
(3V23) (636GR) Knoxville, IA	1,190	1,095	92.02%	95	7.98%	0	0	1,030	0	65	0	70	0	18	0	4	0	3	0	2.41	16.26	0.89
(3V23) (636GX) Fort Dodge North, IA	288	288	100.00%	0	0.00%	0	0	287	0	1	0	0	0	0	0	0	0	0	0			0.47
(3V23) (636QB) Des Moines Center Street, IA	101	101	100.00%	0	0.00%	0	0	101	0	0	0	0	0	0	0	0	0	0	0			
(3V23) (636A8) Iowa City, IA HCS	51,187	45,158	88.22%	6,029	11.78%	0	0	42,487	0	2,671	0	2,411	0	1,176	0	725	0	1,717	0	7.99	29.88	5.49
(3V23) (636A8) Iowa City, IA	18,826	15,328	81.42%	3,498	18.58%	0	0	14,020	0	1,308	0	1,308	0	780	0	525	0	885	0	12.09	26.77	12.57
(3V23) (636GF) Quad Cities, IA	8,372	7,866	93.96%	506	6.04%	0	0	7,592	0	274	0	138	0	43	0	61	0	264	0	6.79	31.70	2.94
(3V23) (636GG) Quincy, IL	2,555	2,298	89.94%	257	10.06%	0	0	2,222	0	76	0	97	0	92	0	21	0	47	0	9.95	10.77	13.72
(3V23) (636GH) Waterloo, IA	3,186	2,934	92.09%	252	7.91%	0	0	2,788	0	146	0	118	0	67	0	29	0	38	0	11.57	3.83	5.82
(3V23) (636GI) Galesburg, IL (Lane A. Evans)	1,894	1,743	92.03%	151	7.97%	0	0	1,592	0	151	0	123	0	17	0	4	0	7	0	8.57	3.47	4.75
(3V23) (636GJ) Dubuque, IA	2,364	2,118	89.59%	246	10.41%	0	0	1,958	0	160	0	181	0	39	0	13	0	13	0	12.39	2.97	5.08
(3V23) (636GN) Cedar Rapids, IA	3,242	3,063	94.48%	179	5.52%	0	0	2,896	0	167	0	116	0	24	0	14	0	25	0	4.47	2.26	10.33
(3V23) (636GS) Ottumwa, IA	2,236	2,214	99.02%	22	0.98%	0	0	2,193	0	21	0	18	0	2	0	0	0	2	0	2.76	3.33	1.94
(3V23) (636GT) Sterling, IL	1,477	1,400	94.79%	77	5.21%	0	0	1,336	0	64	0	44	0	15	0	6	0	12	0	4.57	10.83	10.60
(3V23) (636GU) Decorah, IA	997	923	92.58%	74	7.42%	0	0	893	0	30	0	14	0	6	0	13	0	41	0	3.34	35.48	2.22
(3V23) (636GW) Coralville, IA	2,723	2,601	95.52%	122	4.48%	0	0	2,538	0	63	0	88	0	20	0	7	0	7	0	3.03	0.00	3.27
(3V23) (636QC) Linn County, IA	23	23	100.00%	0	0.00%	0	0	23	0	0	0	0	0	0	0	0	0	0	0			0.05
(3V23) (636QG) Iowa City, IA - Mobile	136	117	86.03%	19	13.97%	0	0	84	0	33	0	9	0	1	0	6	0	3	0		19.21	
(3V23) (636QI) Davenport, IA	430	421	97.91%	9	2.09%	0	0	407	0	14	0	4	0	3	0	0	0	2	0			6.81
(3V23) (636QJ) Iowa City South Clinton Street, IA	2,726	2,109	77.37%	617	22.63%	0	0	1,945	0	164	0	153	0	67	0	26	0	371	0		69.82	11.14
(3V23) (636) Nebraska-W Iowa HCS	70,583	64,154	90.89%	6,429	9.11%	38	1	60,601	1	3,553	0	2,860	0	1,548	0	817	0	1,204	0	5.70	14.00	6.79
(3V23) (636) Omaha, NE	41,712	37,860	90.77%	3,852	9.23%	0	0	35,584	0	2,276	0	1,742	0	917	0	458	0	735	0	5.30	13.08	9.01
(3V23) (636A4) Grand Island, NE	12,089	11,441	94.64%	648	5.36%	0	1	10,952	1	489	0	373	0	116	0	30	0	129	0	5.71	7.90	3.68
(3V23) (636A5) Lincoln, NE	9,271	7,665	82.68%	1,606	17.32%	0	0	7,106	0	559	0	582	0	469	0	299	0	256	0	8.45	32.39	4.50
(3V23) (636BX) Omaha, NE - VADOM	1	1	100.00%	0	0.00%	0	0	1	0	0	0	0	0	0	0	0	0	0	0			
(3V23) (636GA) Norfolk, NE	1,428	1,410	98.74%	18	1.26%	0	0	1,380	0	30	0	9	0	1	0	1	0	7	0	2.15	4.90	1.91
(3V23) (636GB) North Platte, NE	927	855	92.23%	72	7.77%	0	0	795	0	60	0	47	0	13	0	8	0	4	0	8.70	9.62	6.09
(3V23) (636GL) Bellevue, NE	3,493	3,332	95.39%	161	4.61%	0	0	3,272	0	60	0	61	0	17	0	13	0	70	0	3.99	9.64	3.86

Pending Appointment and Electronic Wait List Summary -National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date For the period ending: 3/15/2021	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
(3V23) (636GP) Shenandoah, IA	741	694	93.66%	47	6.34%	0	0	648	0	46	0	26	0	13	0	5	0	3	0	6.77	5.41	13.52
(3V23) (636GQ) Holdrege, NE	860	835	97.09%	25	2.91%	0	0	802	0	33	0	20	0	2	0	3	0	0	0	3.26	3.46	4.42
(3V23) (636QA) Omaha Dorcas Street, NE	61	61	100.00%	0	0.00%	0	0	61	0	0	0	0	0	0	0	0	0	0	0			
(3V23) (656) St. Cloud, MN HCS	44,573	40,467	90.79%	4,106	9.21%	0	0	37,908	0	2,559	0	1,560	0	818	0	422	0	1,306	0	4.74	22.50	5.36
(3V23) (656) St. Cloud, MN	36,937	33,242	90.00%	3,695	10.00%	0	0	30,982	0	2,260	0	1,406	0	744	0	366	0	1,179	0	5.98	22.98	5.24
(3V23) (656GA) Brainerd, MN	5,189	4,824	92.97%	365	7.03%	0	0	4,582	0	242	0	116	0	70	0	55	0	124	0	3.40	19.17	8.55
(3V23) (656GB) Montevideo, MN	765	734	95.95%	31	4.05%	0	0	697	0	37	0	27	0	3	0	0	0	1	0	3.46	14.04	9.94
(3V23) (656GC) Alexandria, MN (Max J. Beilke)	1,682	1,667	99.11%	15	0.89%	0	0	1,647	0	20	0	11	0	1	0	1	0	2	0	1.76	4.34	1.42

Grand Total	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
National: 3/15/2021	9,663,913	8,853,543	91.61%	810,370	8.39%	4,409	30	8,406,886	23	446,657	1	352,644	1	165,675	1	95,200	0	196,851	4	4.68	15.42	5.49
National: 3/1/2021	9,484,933	8,685,557	91.57%	799,376	8.43%	4,921	34	8,251,965	28	433,592	3	341,335	0	161,365	0	96,546	0	200,130	3	4.55	15.85	5.58
National: 2/15/2021	9,751,468	8,938,722	91.67%	812,746	8.33%	4,526	46	8,493,531	32	445,191	6	340,144	2	165,008	0	100,179	0	207,415	6	4.45	15.92	5.68
National: 2/1/2021	9,267,777	8,484,140	91.54%	783,637	8.46%	6,696	25	8,078,141	19	405,999	1	312,677	0	162,344	0	99,378	1	209,238	4	4.45	16.50	5.79
National: 1/15/2021	8,788,420	7,988,029	90.89%	800,391	9.11%	5,645	33	7,593,651	21	394,378	0	318,352	3	166,427	0	99,772	3	215,840	6	4.66	18.10	6.13
National: 1/1/2021	8,751,120	7,902,603	90.30%	848,517	9.70%	2,824	31	7,491,632	12	410,971	2	345,412	0	174,961	3	101,399	0	226,745	14	4.90	19.10	6.21
National: 12/15/2020	8,187,237	7,399,883	90.38%	787,354	9.62%	2,552	39	7,036,810	16	363,073	1	310,094	3	160,464	1	93,430	0	223,366	18	4.88	19.39	6.21
National: 12/1/2020	8,479,082	7,673,758	90.50%	805,324	9.50%	2,475	37	7,277,551	16	396,207	0	320,261	2	160,731	0	92,426	2	231,906	17	4.93	19.27	6.07
National: 11/15/2020	8,730,978	7,909,818	90.59%	821,160	9.41%	2,274	1,194	7,494,674	174	415,144	56	328,641	117	158,865	78	92,259	118	241,395	651	5.06	19.28	5.82
National: 11/1/2020	8,715,496	7,902,066	90.67%	813,430	9.33%	2,217	2,675	7,498,932	307	403,134	92	320,747	237	152,660	377	92,189	181	247,834	1,481	5.09	19.46	5.57
National: 10/15/2020	8,409,648	7,620,943	90.62%	788,705	9.38%	2,007	5,282	7,223,886	417	397,057	332	299,779	978	145,678	533	91,609	328	251,639	2,694	5.11	20.07	5.45
National: 10/1/2020	8,324,111	7,548,410	90.68%	775,701	9.32%	2,107	6,254	7,172,426	606	375,984	718	283,322	967	142,876	527	92,898	452	256,605	2,984	5.07	20.30	5.25
National: 9/15/2020	8,216,233	7,438,303	90.53%	777,930	9.47%	8,367	7,741	7,069,593	1,191	368,710	796	272,072	961	141,464	641	96,829	527	267,565	3,625	5.07	21.04	5.13
National: 9/1/2020	8,199,233	7,419,116	90.49%	780,117	9.51%	7,835	7,806	7,064,930	1,208	354,186	630	263,677	887	142,360	756	100,887	628	273,193	3,697	5.02	21.20	5.04
National: 8/15/2020	8,406,774	7,608,763	90.51%	798,011	9.49%	7,626	7,743	7,250,233	1,142	358,530	707	261,620	888	145,116	685	109,616	711	281,659	3,610	5.04	21.13	4.94
National: 8/1/2020	8,436,894	7,631,106	90.45%	805,788	9.55%	8,202	7,389	7,283,430	1,172	347,676	565	252,881	944	147,147	712	119,678	595	286,082	3,401	5.06	21.08	4.84
National: 7/15/2020	8,322,260	7,502,474	90.15%	819,786	9.85%	8,141	8,125	7,164,601	1,171	337,873	736	238,992	868	153,765	942	140,697	683	286,332	3,725	5.13	21.26	4.88
National: 7/1/2020	8,499,192	7,642,380	89.92%	856,812	10.08%	7,552	8,200	7,311,807	1,308	330,573	686	234,358	911	171,189	813	167,504	904	283,761	3,578	5.27	21.11	4.90
National: 6/24/2020	8,565,143	7,688,438	89.76%	876,705	10.24%	7,631	8,222	7,365,758	1,288	322,680	629	230,387	996	183,998	878	182,626	928	279,694	3,503	5.32	21.10	4.91
National: 6/15/2020	8,802,601	7,883,010	89.55%	919,591	10.45%	6,763	8,277	7,578,217	1,330	304,793	491	227,585	1,161	225,526	869	208,546	914	257,934	3,512	5.40	20.47	5.07
National: 6/1/2020	8,840,910	7,915,556	89.53%	925,354	10.47%	7,139	8,266	7,611,919	1,233	303,637	624	228,918	1,047	232,414	1,153	209,731	829	254,291	3,380	5.40	20.29	5.12
National: 5/15/2020	9,065,046	8,131,827	89.71%	933,219	10.29%	7,743	8,523	7,830,019	1,489	301,808	723	233,325	1,182	255,701	1,136	209,379	776	234,814	3,217	5.36	19.19	5.40
National: 5/1/2020	9,215,475	8,307,085	90.14%	908,390	9.86%	8,844	8,402	8,015,211	1,400	291,874	669	240,903	1,475	258,532	917	198,043	722	210,912	3,219	5.12	17.78	5.70
National: 4/15/2020	9,365,539	8,518,654	90.96%	846,885	9.04%	9,474	8,479	8,220,289	1,326	298,365	832	267,094	1,453	241,485	977	166,837	596	171,469	3,295	4.69	15.37	6.06
National: 4/1/2020	9,849,963	9,052,563	91.90%	797,400	8.10%	10,201	8,890	8,699,794	1,685	352,769	1,231	322,680	1,259	217,439	904	125,632	555	131,649	3,256	4.15	12.64	6.19
National: 3/15/2020	11,578,742	10,813,387	93.39%	765,355	6.61%	5,610	7,931	10,253,719	1,477	559,668	823	406,945	1,192	173,368	680	83,399	613	101,643	3,146	3.74	9.83	5.96
National: 3/1/2020	11,713,586	10,943,528	93.43%	770,058	6.57%	5,170	7,720	10,375,597	1,264	567,931	839	415,271	1,034	169,789	718	83,312	589	101,686	3,276	3.73	9.76	5.98
National: 2/15/2020	11,638,843	10,871,430	93.41%	767,413	6.59%	4,931	8,024	10,293,498	1,375	577,932	815	411,839	948	169,989	905	84,157	694	101,428	3,287	3.78	9.83	6.07
National: 2/1/2020	11,579,389	10,820,031	93.44%	759,358	6.56%	3,304	8,442	10,259,651	1,346	560,380	915	399,253	1,051	172,792	836	85,248	763	102,065	3,531	3.78	9.85	6.16
National: 1/15/2020	11,431,460	10,637,440	93.05%	794,020	6.95%	3,774	9,061	10,083,880	1,316	553,560	762	421,406	1,252	181,772	1,064	88,402	909	102,440	3,758	3.90	10.23	6.52
National: 1/1/2020	11,357,822	10,542,625	92.82%	815,197	7.18%	4,033	9,231	9,965,853	1,074	576,772	1,071	436,280	1,188	185,512	1,160	89,790	989	103,615	3,749	4.00	10.47	6.74
National: 12/15/2019	10,997,321	10,222,962	92.96%	774,359	7.04%	4,479	8,966	9,682,561	1,271	540,401	779	409,990	1,410	177,868	1,125	86,554	820	99,947	3,561	3.93	10.30	6.62
National: 12/1/2019	11,336,062	10,560,438	93.16%	775,624	6.84%	4,523	9,148	9,983,501	1,197	576,937	852	411,971	1,483	178,810	1,163	85,701	910	99,142	3,543	3.90	10.12	6.35
National: 11/15/2019	11,093,728	10,347,312	93.27%	746,416	6.73%	4,289	9,736	9,779,903	1,453	567,409	1,094	398,441	1,579	169,505	1,142	82,311	1,046	96,159	3,422	3.90	10.02	6.21
National: 11/1/2019	11,151,358	10,420,370	93.44%	730,988	6.56%	4,249	9,523	9,861,357	1,582	559,013	965	394,108	1,540	161,984	1,243	79,868	979	95,028	3,214	3.87	9.85	5.93
National: 10/15/2019	11,125,371	10,400,893	93.49%	724,478	6.51%	4,109	9,399	9,819,371	1,511	581,522	1,027	392,288	1,574	160,241	1,323	77,331	999	94,618	2,965	3.94	9.86	5.91
National: 10/1/2019	11,132,447	10,421,823	93.62%	710,624	6.38%	3,977	9,393	9,855,351	1,705	566,472	908	382,723	1,721	158,228	1,264	75,194	889	94,479	2,906	3.89	9.75	5.76
National: 9/15/2019	11,363,005	10,635,394	93.60%	727,611	6.40%	3,870	9,086	10,049,154	1,598	586,240	1,136	395,028	1,664	159,909	1,186	76,651	638	96,023	2,864	3.99	9.73	5.67
National: 9/1/2019	11,350,354	10,619,229	93.56%	731,125	6.44%	3,495	8,918	10,032,374	1,845	586,855	1,054	397,379	1,586	159,453	1,086	77,693	632	96,600	2,715	4.04	9.77	5.58
National: 8/15/2019	11,056,943	10,343,648	93.55%	713,295	6.45%	2,980	8,604	9,772,297	1,591	571,351	1,257	380,916	1,487	159,427	895	77,823	719	95,129	2,655	4.02	9.80	5.55
National: 8/1/2019	11,034,946	10,324,205	93.56%	710,741	6.44%	3,008	8,512	9,757,254	1,612	566,951	1,117	373,522	1,446	162,548	930	79,348	708	95,323	2,699	3.99	9.84	5.44
National: 7/15/2019	10,992,848	10,258,942	93.32%	733,906	6.68%	3,232	10,258	9,681,790	1,656	577,152	1,207	388,401	1,698	168,391	1,194	81,761	813	95,353	3,690	4.03	10.06	5.56
National: 7/1/2019	10,978,049	10,237,460	93.25%	740,589	6.75%	3,649	10,930	9,660,653	2,106	576,807	1,195	391,601	1,677	170,665	1,192	83,013	944	95,310	3,816	4.01	10.12	5.55
National: 6/16/2019	10,929,102	10,182,674	93.17%	746,428	6.83%	4,245	11,024	9,603,760	2,048	578,914	1,153	395,757	1,790	171,064	1,076	83,987	915	95,620	4,042	4.10	10.20	5.51
National: 6/1/2019	11,203,827	10,434,248	93.13%	769,579	6.87%	7,863	11,834	9,837,564	1,951	596,684	1,451	410,870	1,806	174,437	1,377	85,708	923	98,564	4,326	4.13	10.24	5.43
National: 5/15/2019	10,886,574	10,141,879	93.16%	744,695	6.84%	3,388	12,028	9,562,402	2,174	579,477	1,458	394,695	1,747	168,367	1,371	83,963	981	97,670	4,297	4.14	10.27	5.37
National: 5/1/2019	10,961,193	10,220,027	93.24%	741,166	6.76%	3,769	12,003	9,642,927	2,012	577,100	1,361	391,796	1,890	168,287	1,325	83,232	907	97,851	4,508	4.14	10.20	5.29

Grand Total	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
National: 4/15/2019	10,972,866	10,230,227	93.23%	742,639	6.77%	3,308	11,836	9,651,313	1,959	578,914	1,243	395,557	1,860	167,976	1,300	81,059	826	98,047	4,648	4.14	10.19	5.28
National: 4/1/2019	10,921,147	10,177,852	93.19%	743,295	6.81%	3,300	11,874	9,611,411	2,061	566,441	1,199	398,132	1,860	168,020	1,204	79,019	832	98,124	4,718	4.15	10.19	5.26
National: 3/15/2019	10,837,159	10,091,609	93.12%	745,550	6.88%	3,938	12,035	9,513,374	1,973	578,235	1,332	400,085	1,917	168,236	1,148	78,631	881	98,598	4,784	4.21	10.33	5.43
National: 3/1/2019	10,769,089	10,025,043	93.09%	744,046	6.91%	4,168	12,206	9,460,866	1,920	564,177	1,529	399,782	1,850	165,838	1,226	79,054	929	99,372	4,752	4.21	10.37	5.51
National: 2/15/2019	10,727,516	9,982,663	93.06%	744,853	6.94%	4,238	12,400	9,411,439	2,102	571,224	1,405	395,755	1,793	169,268	1,163	79,874	1,041	99,956	4,896	4.23	10.45	5.61
National: 2/1/2019	10,676,810	9,940,095	93.10%	736,715	6.90%	4,293	12,817	9,390,068	1,969	550,027	1,574	382,505	1,813	173,368	1,289	80,634	1,089	100,208	5,083	4.21	10.48	5.67
National: 1/15/2019	10,550,715	9,796,498	92.85%	754,217	7.15%	3,829	14,147	9,252,587	2,176	543,911	1,265	392,997	2,200	177,628	1,756	82,748	1,263	100,844	5,487	4.26	10.74	6.08
National: 1/1/2019	10,704,776	9,902,087	92.50%	802,689	7.50%	4,093	14,581	9,328,846	2,064	573,241	1,598	425,598	2,318	188,456	1,751	86,087	1,283	102,548	5,567	4.36	11.06	6.31
National: 12/15/2018	10,596,756	9,817,998	92.65%	778,758	7.35%	3,612	14,611	9,259,684	2,439	558,314	1,680	410,013	2,298	184,576	1,572	84,930	1,155	99,239	5,467	4.30	10.88	6.13
National: 12/1/2018	10,648,534	9,881,302	92.79%	767,232	7.21%	4,380	15,047	9,315,168	2,348	566,134	1,711	404,814	2,348	182,529	1,703	83,951	1,220	95,938	5,717	4.26	10.72	5.98
National: 11/15/2018	10,389,469	9,642,091	92.81%	747,378	7.19%	3,409	15,283	9,068,623	2,630	573,468	1,653	399,599	2,239	174,513	1,595	81,400	1,316	91,866	5,850	4.31	10.67	6.01
National: 11/1/2018	10,430,700	9,704,256	93.04%	726,444	6.96%	3,487	15,359	9,145,544	2,561	558,712	1,631	391,872	2,232	166,858	1,619	78,460	1,340	89,254	5,976	4.24	10.39	5.79
National: 10/15/2018	10,433,737	9,714,884	93.11%	718,853	6.89%	3,629	16,625	9,135,472	2,540	579,412	1,549	390,883	2,592	166,088	2,067	75,380	1,382	86,502	6,495	4.25	10.31	5.74
National: 10/1/2018	10,420,885	9,713,057	93.21%	707,828	6.79%	3,629	15,552	9,144,488	2,451	568,569	1,426	386,103	2,643	163,526	1,860	73,225	1,385	84,974	5,787	4.18	10.17	5.68
National: 9/15/2018	10,614,542	9,898,920	93.26%	715,622	6.74%	3,629	16,027	9,316,482	2,470	582,438	1,765	395,813	2,653	161,931	1,743	73,361	1,272	84,517	6,124	4.19	10.11	5.58
National: 9/1/2018	10,618,324	9,908,063	93.31%	710,261	6.69%	3,629	17,327	9,326,770	3,054	581,293	1,911	393,545	2,691	160,104	1,889	72,822	1,158	83,790	6,624	4.18	10.07	5.51
National: 8/15/2018	10,535,058	9,834,583	93.35%	700,475	6.65%	3,650	19,044	9,250,826	3,782	583,757	2,230	386,256	2,628	159,710	2,000	72,086	1,386	82,423	7,018	4.22	10.09	5.41
National: 8/1/2018	10,489,290	9,794,085	93.37%	695,205	6.63%	3,973	19,187	9,220,590	3,944	573,495	2,274	382,998	2,804	159,382	1,766	72,046	1,459	80,779	6,940	4.18	10.10	5.32
National: 7/15/2018	10,433,332	9,731,231	93.27%	702,101	6.73%	5,273	18,466	9,153,411	3,730	577,820	1,945	391,282	2,553	160,867	1,804	71,793	1,358	78,159	7,076	4.20	10.18	5.32
National: 7/1/2018	10,389,124	9,694,697	93.32%	694,427	6.68%	4,580	16,976	9,123,324	3,050	571,373	1,678	387,898	2,184	159,125	1,821	70,887	1,349	76,517	6,894	4.19	10.14	5.27
National: 6/15/2018	10,317,842	9,641,275	93.44%	676,567	6.56%	4,776	16,240	9,078,056	2,670	563,219	1,533	380,741	2,364	154,033	1,616	68,772	1,341	73,021	6,716	4.17	10.00	5.08
National: 6/1/2018	10,086,361	9,438,791	93.58%	647,570	6.42%	5,060	15,976	8,896,281	2,117	542,510	1,624	366,907	2,536	146,134	1,658	65,506	1,303	69,023	6,738	4.10	9.83	4.98
National: 5/15/2018	9,902,438	9,291,922	93.83%	610,516	6.17%	5,045	15,733	8,751,332	2,319	540,590	1,598	347,460	2,196	136,718	1,570	61,107	1,472	65,231	6,578	4.08	9.63	4.83
National: 5/1/2018	9,959,866	9,366,287	94.04%	593,579	5.96%	4,469	15,899	8,827,509	2,359	538,778	1,513	338,269	2,286	133,962	1,710	58,708	1,361	62,640	6,670	4.10	9.39	4.70
National: 4/15/2018	9,191,237	8,741,702	95.11%	449,535	4.89%	4,598	15,830	8,273,900	2,303	467,802	1,584	259,226	2,193	97,554	1,889	42,740	1,023	50,015	6,838	4.00	7.96	4.52
National: 4/1/2018	10,072,702	9,487,014	94.19%	585,688	5.81%	4,468	16,075	8,939,526	2,451	547,488	1,452	343,923	2,332	130,459	1,695	52,669	1,164	58,637	6,981	4.13	9.08	4.41
National: 3/15/2018	9,685,050	9,132,281	94.29%	552,769	5.71%	4,435	16,331	8,589,608	2,638	542,673	1,561	324,467	2,418	122,733	1,412	49,858	1,414	55,711	6,888	4.17	8.97	4.36
National: 3/1/2018	9,590,907	9,053,783	94.40%	537,124	5.60%	4,635	16,291	8,533,804	2,451	519,979	1,832	315,519	2,199	117,541	1,581	48,962	1,378	55,102	6,850	4.19	8.86	4.30
National: 2/15/2018	9,525,326	8,996,942	94.45%	528,384	5.55%	5,091	17,150	8,476,365	2,796	520,577	1,907	307,218	1,873	117,154	1,789	48,864	1,535	55,148	7,250	4.22	8.82	4.29
National: 2/1/2018	9,456,691	8,931,091	94.44%	525,600	5.56%	5,095	18,090	8,436,197	3,042	494,894	1,560	299,175	2,157	119,773	1,953	50,476	1,764	56,176	7,614	4.26	8.83	4.33
National: 1/15/2018	9,586,328	9,008,273	93.97%	578,055	6.03%	5,707	19,155	8,479,022	2,485	529,251	1,277	333,155	2,972	130,181	2,356	55,220	1,784	59,499	8,281	4.60	9.27	4.75
National: 1/1/2018	9,533,544	8,925,588	93.62%	607,956	6.38%	5,506	19,765	8,387,210	2,541	538,378	1,676	351,858	3,169	136,808	2,300	58,193	1,853	61,097	8,226	4.79	9.59	4.95
National: 12/15/2017	9,160,395	8,591,282	93.79%	569,113	6.21%	4,295	20,835	8,082,539	3,165	508,743	2,313	322,026	3,063	132,281	2,216	56,619	1,899	58,187	8,179	4.78	9.43	4.91
National: 12/1/2017	9,160,450	8,600,192	93.88%	560,258	6.12%	4,686	21,895	8,101,997	3,981	498,195	2,283	315,069	3,019	131,646	2,297	56,533	2,178	57,010	8,137	4.76	9.35	4.81
National: 11/15/2017	9,154,233	8,596,360	93.91%	557,873	6.09%	5,482	22,403	8,064,859	3,886	531,501	2,545	320,503	3,240	128,444	2,525	55,449	2,920	53,477	7,287	4.85	9.31	4.77
National: 11/1/2017	9,184,572	8,631,848	93.98%	552,724	6.02%	4,878	22,113	8,114,577	3,625	511,879	2,245	318,765	3,275	123,829	2,923	53,624	2,877	51,742	7,168	4.76	8.29	4.44
National: 10/15/2017	9,508,369	8,940,061	94.02%	568,308	5.98%	4,759	23,275	8,265,423	3,620	565,959	2,656	328,754	3,482	126,159	3,803	52,056	2,635	51,153	7,079	4.86	9.20	4.41
National: 10/1/2017	9,348,715	8,801,626	94.15%	547,089	5.85%	4,636	23,147	8,252,016	4,137	549,610	2,047	324,222	3,900	123,558	3,779	49,846	2,454	49,463	6,830	4.81	9.00	4.56
National: 9/15/2017	9,051,453	8,516,453	94.09%	535,000	5.91%	4,519	23,669	7,974,409	3,687	542,044	2,878	320,877	4,897	118,015	3,310	48,532	1,918	47,576	6,979	4.83	9.06	4.61
National: 9/1/2017	9,089,856	8,560,222	94.17%	529,634	5.83%	4,046	23,819	8,026,624	4,574	533,598	2,904	319,626	4,873	115,895	3,125	47,684	1,524	46,429	6,819	4.77	8.97	4.45
National: 8/15/2017	8,958,717	8,436,837	94.17%	521,880	5.83%	4,105	23,384	7,892,680	4,634	544,157	3,429	314,030	4,527	114,830	2,293	46,322	1,690	46,698	6,811	4.86	8.98	4.44
National: 8/1/2017	8,900,173	8,387,264	94.24%	512,909	5.76%	3,838	23,344	7,859,351	5,334	527,913	2,748	306,044	4,382	114,888	2,150	46,141	1,802	45,836	6,928	4.81	8.91	4.34
National: 7/15/2017	9,024,312	8,493,349	94.12%	530,963	5.88%	3,550	22,424	7,942,174	4,770	551,175	3,683	318,862	3,118	119,335	2,241	46,890	1,945	45,876	6,667	4.90	8.99	4.36
National: 7/1/2017	8,936,368	8,412,893	94.14%	523,475	5.86%	3,665	20,755	7,875,844	4,924	537,049	2,370	312,589	2,749	118,175	2,304	46,857	1,892	45,854	6,516	4.91	8.93	4.32
National: 6/15/2017	8,591,321	8,088,703	94.15%	502,618	5.85%	3,985	20,260	7,570,141	3,800	518,562	2,121	297,199	3,318	114,596	2,594	46,104	1,861	44,719	6,566	4.96	8.90	4.27
National: 6/1/2017	8,542,067	8,041,987	94.15%	500,080	5.85%	3,813	21,043	7,534,005	3,873	507,982	2,382	295,514	3,625	113,309	2,799	46,617	1,978	44,640	6,305	4.99	8.87	4.18
National: 5/15/2017	8,481,214	7,993,925	94.25%	487,289	5.75%	4,149	21,439	7,476,821	4,034	517,104	2,531	286,344	4,021	110,792	2,805	46,293	1,719	43,860	6,320	4.96	8.80	4.04

Grand Total	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
National: 5/1/2017	8,428,815	7,949,787	94.32%	479,028	5.68%	4,283	21,891	7,448,568	4,401	501,219	2,457	280,265	4,341	109,615	2,793	46,035	1,545	43,113	6,349	4.93	8.71	3.93
National: 4/15/2017	8,592,740	8,102,024	94.29%	490,716	5.71%	4,244	22,383	7,574,365	4,664	527,659	3,292	290,487	3,999	111,567	2,541	45,541	1,554	43,121	6,271	4.96	8.74	3.96
National: 4/1/2017	8,526,221	8,032,851	94.21%	493,370	5.79%	4,701	23,131	7,527,950	5,227	504,901	3,222	293,352	4,327	111,665	2,350	44,848	1,748	43,505	6,196	4.97	8.73	3.92
National: 3/15/2017	8,120,079	7,633,349	94.01%	486,730	5.99%	4,353	22,840	7,116,603	4,623	516,746	3,459	289,205	3,773	110,216	2,520	43,953	1,959	43,356	6,434	5.09	9.00	4.06
National: 3/1/2017	8,014,137	7,529,677	93.95%	484,460	6.05%	4,629	22,651	7,040,550	4,899	489,127	3,198	287,091	3,217	109,349	2,824	44,372	1,837	43,648	6,607	5.10	9.02	4.06
National: 2/15/2017	7,892,670	7,413,763	93.93%	478,907	6.07%	4,767	23,600	6,923,443	4,873	490,320	2,785	279,397	3,006	110,121	3,498	45,268	2,203	44,121	7,150	5.13	9.12	4.08
National: 2/1/2017	7,801,469	7,321,910	93.85%	479,559	6.15%	5,250	23,684	6,860,408	4,533	461,502	2,450	273,225	3,587	113,850	3,295	47,111	2,457	45,373	7,294	5.19	9.25	4.04
National: 1/15/2017	7,851,338	7,329,914	93.36%	521,424	6.64%	6,388	24,607	6,834,653	4,174	495,261	2,396	298,712	4,910	123,886	3,409	50,829	2,361	47,997	7,281	5.53	9.77	4.34
National: 1/1/2017	7,745,629	7,198,625	92.94%	547,004	7.06%	4,543	26,990	6,712,340	3,973	486,285	3,470	314,413	4,527	129,605	3,780	53,535	2,645	49,451	8,506	5.73	10.12	4.46
National: 12/15/2016	7,349,955	6,830,422	92.93%	519,533	7.07%	3,882	27,130	6,368,051	5,074	462,371	3,032	292,045	4,379	126,169	3,609	53,067	2,483	48,252	8,481	5.77	10.17	4.50
National: 12/1/2016	7,328,991	6,810,179	92.92%	518,812	7.08%	4,385	27,634	6,349,203	4,663	460,976	3,170	288,790	4,923	128,663	3,774	53,218	2,594	48,141	8,415	5.83	10.21	4.46
National: 11/15/2016	7,256,452	6,737,465	92.85%	518,987	7.15%	4,570	28,914	6,257,160	4,917	480,305	3,637	294,025	5,353	125,582	3,825	52,978	2,870	46,402	8,302	6.00	10.25	4.51
National: 11/1/2016	7,268,886	6,751,345	92.88%	517,541	7.12%	4,403	29,108	6,289,262	5,452	462,083	3,275	297,081	5,514	122,996	3,894	52,684	2,702	44,780	8,267	5.99	10.10	4.47
National: 10/15/2016	7,415,824	6,884,899	92.84%	530,925	7.16%	4,429	29,238	6,372,612	5,155	512,287	4,294	308,324	5,179	126,865	3,964	52,388	2,191	43,348	8,371	6.20	10.18	4.49
National: 10/1/2016	7,359,282	6,837,227	92.91%	522,055	7.09%	4,274	29,938	6,349,398	6,043	487,829	3,732	304,104	5,454	125,792	3,785	50,425	2,332	41,734	8,519	6.15	10.03	4.37
National: 9/15/2016	6,984,247	6,476,585	92.73%	507,662	7.27%	3,775	30,488	5,995,861	5,652	480,724	4,015	296,275	5,802	122,375	3,722	49,868	2,433	39,144	8,795	6.31	10.21	4.42
National: 9/1/2016	6,908,055	6,401,680	92.67%	506,375	7.33%	4,022	32,073	5,939,364	6,325	462,316	4,102	295,426	5,929	122,874	3,865	49,645	2,371	38,430	9,394	6.36	10.21	4.43
National: 8/15/2016	6,803,336	6,292,976	92.50%	510,360	7.50%	0	33,373	5,814,689	6,918	478,287	4,158	296,700	5,903	126,697	3,976	49,810	2,840	37,153	9,567	6.57	10.36	4.47
National: 8/1/2016	6,710,914	6,197,722	92.35%	513,192	7.65%	4,330	34,656	5,738,357	7,781	459,365	3,712	296,322	6,360	129,843	4,263	50,665	2,817	36,362	9,715	6.63	10.46	4.43
National: 7/15/2016	6,637,517	6,111,240	92.07%	526,277	7.93%	4,254	35,894	5,641,123	7,196	470,117	5,115	305,194	5,918	135,446	4,348	50,308	3,301	35,329	9,929	6.84	10.71	4.58
National: 7/1/2016	6,574,400	6,048,688	92.00%	525,712	8.00%	3,843	36,281	5,594,340	8,081	454,348	4,654	303,984	6,227	136,962	3,889	50,076	3,408	34,690	9,908	6.91	10.69	4.63
National: 6/15/2016	6,455,383	5,940,432	92.02%	514,951	7.98%	3,617	36,616	5,485,676	8,174	454,756	4,293	298,442	6,001	134,627	4,797	48,720	3,416	33,162	9,905	6.99	10.60	4.64
National: 6/1/2016	6,421,794	5,914,378	92.10%	507,416	7.90%	3,689	36,865	5,470,931	7,535	443,447	5,139	296,114	6,123	132,145	5,083	47,527	3,349	31,630	9,462	6.95	10.48	4.62
National: 5/15/2016	6,689,547	6,183,667	92.44%	505,880	7.56%	3,965	36,630	5,713,141	8,715	470,526	4,218	297,013	6,891	131,214	4,690	46,672	2,880	30,981	9,104	6.89	10.15	4.43
National: 5/1/2016	6,703,520	6,208,830	92.62%	494,690	7.38%	3,938	36,010	5,751,861	7,769	456,969	4,555	292,486	7,157	127,501	4,719	44,608	2,761	30,095	9,015	6.80	9.90	4.23
National: 4/15/2016	6,460,487	5,978,104	92.53%	482,383	7.47%	4,233	36,251	5,523,546	7,999	454,558	5,146	289,675	6,891	121,927	4,247	41,265	2,806	29,516	9,076	6.92	9.94	4.19
National: 4/1/2016	6,457,830	5,973,074	92.49%	484,756	7.51%	3,837	37,560	5,541,689	8,576	431,385	5,400	293,627	7,126	121,932	4,392	39,006	3,038	30,191	8,883	6.96	9.89	4.03
National: 3/15/2016	6,353,299	5,870,724	92.40%	482,575	7.60%	3,197	38,264	5,416,038	8,546	454,686	4,645	291,867	7,000	120,651	4,687	38,717	3,633	31,340	9,741	7.16	10.04	4.25
National: 3/1/2016	6,312,188	5,831,434	92.38%	480,754	7.62%	3,227	38,834	5,403,345	8,508	428,089	4,600	288,862	6,788	119,999	5,359	39,445	3,647	32,448	9,910	7.19	9.99	4.26
National: 2/15/2016	6,468,615	5,965,113	92.22%	503,502	7.78%	3,378	43,493	5,501,989	9,352	463,124	4,731	299,239	7,540	128,507	6,560	42,248	5,008	33,508	10,280	7.41	10.19	4.56
National: 2/1/2016	6,196,280	5,695,137	91.91%	501,143	8.09%	3,111	44,756	5,278,182	9,423	416,955	5,487	287,852	8,588	134,374	6,646	44,556	4,527	34,361	10,071	7.50	10.49	4.89
National: 1/15/2016	6,139,100	5,612,888	91.43%	526,212	8.57%	3,170	47,298	5,179,700	9,841	433,188	5,271	298,643	10,300	144,074	7,340	47,949	4,340	35,546	9,997	7.83	11.02	5.36
National: 1/1/2016	6,289,103	5,719,216	90.94%	569,887	9.06%	2,792	49,631	5,296,021	8,833	423,195	8,104	323,953	10,721	156,932	6,793	51,639	4,926	37,363	10,098	8.06	11.36	5.53
National: 12/15/2015	5,954,375	5,409,820	90.85%	544,555	9.15%	10,863	48,888	5,007,168	11,405	402,652	6,247	305,781	11,000	152,587	6,867	50,208	4,340	35,979	9,007	8.20	11.47	5.55
National: 12/1/2015	6,019,856	5,477,103	90.98%	542,753	9.02%	10,834	47,765	5,067,603	10,303	409,500	7,729	303,423	10,118	153,424	6,969	50,471	4,439	35,435	8,190	8.09	11.37	5.47
National: 11/15/2015	6,309,735	5,797,727	91.89%	512,008	8.11%	11,094	47,496	5,366,472	12,144	431,255	7,215	297,290	10,226	142,494	6,517	45,251	3,795	26,973	7,465	7.37	10.56	4.76
National: 11/1/2015	6,089,177	5,593,520	91.86%	495,657	8.14%	3,467	46,146	5,195,594	11,866	397,926	6,340	290,867	10,562	135,141	6,755	44,007	3,940	25,642	6,603	7.21	10.49	4.86
National: 10/15/2015	6,098,397	5,612,186	92.03%	486,211	7.97%	3,345	42,281	5,187,606	10,490	424,580	7,795	288,580	8,842	130,769	5,371	42,419	4,043	24,443	5,620	7.11	10.39	4.90
National: 10/1/2015	6,089,828	5,621,662	92.31%	468,166	7.69%	3,093	40,956	5,225,957	11,183	395,705	7,277	277,586	8,680	126,745	5,026	40,343	3,817	23,492	4,871	6.84	10.05	4.70
National: 9/15/2015	6,059,608	5,604,332	92.49%	455,276	7.51%	2,927	40,548	5,196,875	10,802	407,457	7,173	270,881	9,091	121,696	5,837	40,296	3,115	22,403	4,518	6.79	9.89	4.68
National: 9/1/2015	6,052,480	5,604,401	92.60%	448,079	7.40%	3,158	40,489	5,213,827	11,485	390,574	7,360	267,265	8,638	119,347	5,892	39,689	2,505	21,778	4,603	6.75	9.73	4.61
National: 8/15/2015	6,252,087	5,797,944	92.74%	454,143	7.26%	2,835	40,067	5,382,599	11,730	415,345	7,112	273,057	9,382	119,990	4,737	39,345	2,535	21,751	4,501	6.81	9.54	4.58
National: 8/1/2015	6,228,657	5,786,543	92.90%	442,114	7.10%	2,852	40,622	5,390,680	11,846	395,863	7,062	266,162	10,249	116,485	4,241	38,365	2,761	21,102	4,368	6.77	9.29	4.54
National: 7/15/2015	5,921,350	5,452,402	92.08%	468,948	7.92%	3,093	40,730	5,042,679	11,405	409,723	8,549	278,047	8,519	121,120	4,992	42,735	2,660	27,046	4,506	7.70	9.98	5.30
National: 7/1/2015	5,979,472	5,515,532	92.24%	463,940	7.76%	2,943	39,098	5,118,404	12,623	397,128	7,480	274,691	7,033	120,842	4,641	41,992	2,656	26,415	4,581	7.77	9.74	5.20
National: 6/15/2015	5,829,959	5,391,010	92.47%	438,949	7.53%	3,546	34,867	5,002,619	11,083	388,391	4,732	259,209	7,821	115,068	4,185	39,622	2,585	25,050	4,451	7.87	9.50	5.06
National: 6/1/2015	5,810,529	5,380,664	92.60%	429,865	7.40%	3,338	33,008	5,009,630	9,315	371,034	5,003	255,330	7,631	111,673	4,253	38,530	2,547	24,332	4,258	7.79	9.23	5.01

Grand Total	1. Total Appts Scheduled	2. Appts Scheduled 30 Days or Under	3. Percent Appts Scheduled 30 Days or Under	4. Appts Scheduled Over 30 Days	5. Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7. EWL Count	8. Appts Between 0-14 Days	9. EWL 0-14 Days	10. Appts Between 15-30 Days	11. EWL 15-30 days	12. Appts Between 31-60 Days	13. EWL 31-60 Days	14. Appts Between 61-90 Days	15. EWL 61-90 Days	16. Appts Between 91-120 Days	17. EWL 91-120 Days	18. Appts Beyond 120 Days	19. EWL Greater than 120 Days	20. PC Avg Wait Time	21. SC Avg Wait Time	22. MH Avg Wait Time
National: 5/15/2015	5,849,122	5,422,044	92.70%	427,078	7.30%	2,804	30,520	5,041,721	8,849	380,323	5,584	256,092	6,228	109,604	3,584	37,576	2,298	23,806	3,914	7.80	9.10	4.94
National: 5/1/2015	5,929,069	5,505,238	92.85%	423,831	7.15%	3,004	30,503	5,142,201	9,183	363,037	4,550	253,090	6,382	108,602	3,676	37,705	2,293	24,434	4,379	7.79	8.88	4.89
National: 4/15/2015	6,071,867	5,637,883	92.85%	433,984	7.15%	2,976	32,232	5,249,965	7,530	387,918	5,403	261,135	6,503	106,985	4,730	37,568	2,311	28,296	5,655	7.99	8.92	5.01
National: 4/1/2015	6,019,386	5,587,546	92.83%	431,840	7.17%	3,111	30,810	5,219,325	7,715	368,221	5,049	260,710	6,531	105,945	4,095	36,026	2,234	29,159	5,096	7.94	8.77	4.95
National: 3/15/2015	6,070,418	5,693,118	93.78%	377,300	6.22%	3,097	31,116	5,312,480	7,637	380,638	5,038	240,243	7,245	92,247	3,483	27,716	2,365	17,094	5,348	6.92	7.93	4.26
National: 3/1/2015	6,016,497	5,653,700	93.97%	362,797	6.03%	3,335	31,957	5,299,721	7,380	353,979	6,424	231,147	6,786	88,279	3,933	26,632	2,274	16,739	5,160	6.76	7.68	4.17
National: 2/15/2015	5,961,339	5,605,068	94.02%	356,271	5.98%	3,271	30,601	5,241,043	8,237	364,025	5,321	224,943	5,844	88,190	3,885	26,878	2,414	16,260	4,900	6.76	7.66	4.22
National: 2/1/2015	5,959,465	5,606,612	94.08%	352,853	5.92%	3,005	27,431	5,270,319	6,886	336,293	4,635	217,808	5,555	91,656	3,631	27,355	2,461	16,034	4,263	6.70	7.58	4.22
National: 1/15/2015	5,684,461	5,324,120	93.66%	360,341	6.34%	2,698	25,812	4,992,744	6,446	331,376	4,177	218,959	5,712	97,214	3,350	27,871	2,541	16,297	3,586	6.97	7.89	4.54
National: 1/1/2015	5,806,214	5,417,200	93.30%	389,014	6.70%	2,381	24,929	5,098,776	5,740	318,424	4,800	237,424	5,405	105,583	3,501	29,141	2,095	16,866	3,388	7.14	8.07	4.70
National: 12/15/2014	5,632,971	5,251,303	93.22%	381,668	6.78%	2,349	24,048	4,946,249	7,362	305,054	3,486	231,808	5,226	105,509	3,450	29,025	1,384	15,326	3,140	7.19	8.04	4.70
National: 12/1/2014	5,737,248	5,358,850	93.40%	378,398	6.60%	2,509	23,088	5,046,896	6,704	311,954	3,887	230,177	5,383	105,697	2,817	28,651	1,315	13,873	2,982	6.95	7.83	4.61
National: 11/15/2014	5,908,192	5,527,871	93.56%	380,321	6.44%	2,256	21,641	5,204,700	5,994	323,171	4,073	236,207	5,140	102,553	2,264	28,337	1,515	13,224	2,655	6.88	7.62	4.45
National: 11/1/2014	5,980,644	5,603,781	93.70%	376,863	6.30%	653	21,242	5,298,117	6,149	305,664	4,239	236,748	4,406	97,032	2,120	28,052	1,622	15,031	2,706	6.71	7.49	4.27
National: 10/15/2014	5,885,354	5,515,980	93.72%	369,374	6.28%	1,830	22,083	5,195,338	6,677	320,642	4,128	231,824	3,823	95,790	2,970	26,688	1,706	15,072	2,779	6.73	7.49	4.28
National: 10/1/2014	5,913,070	5,557,674	93.99%	355,396	6.01%	2,013	21,252	5,261,245	6,477	296,429	3,403	221,446	3,777	93,862	2,955	25,529	1,860	14,559	2,780	6.43	7.21	4.11

FOOTNOTES

*Preferred Date (PD): The date for the appointment that is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen by a health care provider capable of furnishing the hospital
care or medical services required by the veteran. Also referred to as the date the Veteran indicates they want to be seen.
* Clinically Indicated Date (CID): The date the provider indicates a patient should return for a future appointment.
1. Total Appointments Scheduled: Every scheduled appointment at that facility except surgery and procedures.
2. Appointments scheduled 30 Days or under: Number of appointments scheduled between 0-30 days of the preferred date.
3. Percent of Appointments Scheduled 30 Days or under: The percent of total appointments scheduled within 30 days, not including EWL count [Appointments between 0-14 Days + Appointments between 15-30 Days /Total Appointments].
4. Appointments scheduled over 30 Days: Number of appointments scheduled greater than 30 days of the preferred date.
5. Percent of Appointments Scheduled over 30 Days: The percent of total appointments scheduled beyond 30 days, not including EWL count. [Appointments between 31-60 Days + Appointments between 61-90 Days + Appointments between 91-120 Days/Total Appointments].
6. New Enrollee Appointment Request (NEAR) List: Total number of newly enrolled Veterans that have requested an appointment during the enrollment process during the past 10 years for whom an appointment has not yet been scheduled.
7. Electronic Wait List (EWL) Count: Total number of all patients for whom appointments cannot be scheduled in 90 days or less. [EWL<14 Days + EWL 15-30 Days + EWL 31-60 Days = EWL 91-120 Days + EWL>120 Days].
8. Appointments between 0-14 Days: Number of appointments scheduled between 0-14 days of the preferred date.
9. EWL Less Than or Equal to 14 Days: Number of patients who have been waiting on the EWL less than or equal to 14 days to be scheduled from the preferred date of their appointment request.
10. Appointments between 15-30 Days: Number of appointments scheduled between 15-30 days of the preferred date.
11. EWL 15-30 Days: Number of patients who have been waiting on the EWL between 15-30 days to be scheduled from the preferred date of their appointment request.
12. Appointments between 31-60 Days: Number of appointments scheduled between 31-60 days of the preferred date.
13. EWL 31-60 Days: Number of patients who have been waiting on the EWL between 31-60 days to be scheduled from the preferred date of their appointment request..
14. Appointments between 61-90 Days: Number of appointments scheduled between 61-90 days of the preferred date.
15. EWL 61-90 Days: Number of patients who have been waiting on the EWL between 61-90 days to be scheduled from the preferred date of their appointment request.
16. Appointments between 91-120 Days: Number of appointments scheduled between 91-120 days of the preferred date.
17. EWL 91-120 Days: Number of patients who have been waiting on the EWL between 91 and 120 days to be scheduled from the preferred date of their appointment request.
18. Appointments Greater Than 120 Days: Number of appointments scheduled greater than 120 days of the preferred date.
19. EWL Greater Than 120 Days: Number of patients who have been waiting on the EWL greater than 120 days to be scheduled from the preferred date of their appointment request.
20. PROSPECTIVE: PC Avg Wait Time: Average (Avg) waiting time for a future Primary Care (PC) appointment.
21. PROSPECTIVE: SC Avg Wait Time: Average (Avg) waiting time for a future Specialty Care (SC) appointment.
22. PROSPECTIVE: MH Avg Wait Time: Average (Avg) waiting time for a future Mental Health (MH) appointment.
NOTE: The zero means there are no patients or appointments in that category.
NOTE: The blank cells mean that there is no data – for example, is the Average MH wait Time is blank, that means that the station didn't have any MH Appts pending from which to calculate an average.
Additional definitions:

1. Pending Appointment: The date an appointment is scheduled, but not yet completed.
2. Create Date: The date the appointment entry itself was created, or made.

NOTE: The Data Source for this report was altered to use the Corporate Data Warehouse on 4/1/2015. The new data source is displayed in the data beginning 4/1/2015.

VA | U.S. Department of Veterans Affairs

Fact Sheet

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

Patient Access Progress Update
Release 162 – March 25, 2021

Summary

In keeping with the commitment to improve transparency in Department of Veterans Affairs' (VA) processes and in accordance with Section 206 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), VA today is releasing the latest update of facility-level patient access data, which highlights notable access improvements. In this release, VA is providing two reports:

1. Completed Appointments (As of February 2021)*
2. Pending Appointments (Snapshot of data on March 15, 2021)*

Notable Improvements:

1. In February 2021, VA completed more than 5,072,000 appointments.
2. VA completed 95.12% of appointments in February 2021 within 30 days of the clinically indicated or Veteran's preferred date.
3. From June 1, 2014, to March 15, 2021, the clinical electronic wait list (EWL) went from 56,271 appointments to 42— a 99.93% reduction.

As a High Reliability Organization (HRO), VA is committed to exploring all processes that contribute to improvement in timely healthcare delivery to our Veterans. This includes improving processes related to tracking and managing facility-level Veteran access data.

VA recently enhanced its public website, www.accesstocare.va.gov providing a clearer picture of access to healthcare at the Veterans Health Administration, with tools Veterans and their caregivers can use to plan for their health care needs. With VA's continued improvements, implementation of the MISSION Act and increased telehealth availability, Veterans have more options today, including in-person and virtual care in VA or care in the community. VA continues to deliver safe, high-quality and timely care to Veterans.

VA is no longer updating the Patient Access Data Report such that this is the last distribution of the Patient Access Progress Update Release. For current wait times and other relevant access data, please visit accesstocare.va.gov.

*Both reports are created using "Wait Times Calculated Using Preferred Date," which utilizes the date a Veteran prefers to be seen or the date determined to be medically necessary by their clinical provider.

From: (b)(6)
To: (b)(6)
(b)(6) Jensen, Jon M.; Johnson, Glenn (SES); Kirsh, Susan R.; (b)(6)
(b)(6) OCLA Health Team; (b)(6) VACO); (b)(6)
(b)(6) Tallman, Gary; (b)(6)
(b)(6)
Subject: HOLD FOR TOMORROW 3-25-2021: Green Light Data Release 162
Date: Wednesday, March 24, 2021 9:48:22 AM
Attachments: DR162.032021.Public Data - Pending Appointments.pdf
DR162.032021.Public Data - Completed Appointments.pdf
Data Release 162 Fact Sheet FINAL 032325.docx

All – Please hold on releasing for today. The attached green light notification is for tomorrow, March 25, not today?

Note: You have one extra day to prepare since it is the FINAL.

My apologies for any confusion.

Regards – (b)(6)

(b)(6)
(b)(6) *Office of Media Relations*
U.S. Department of Veterans Affairs
(b)(6) *@va.gov*
Desk: (b)(6)
Cell:

From: (b)(6) @va.gov>
Sent: Wednesday, March 24, 2021 9:06 AM
To: (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov> (b)(6) @va.gov; (b)(6) @va.gov> (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov> (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; Jensen, Jon M. (b)(6) @va.gov>; Johnson, Glenn (SES) (b)(6) @va.gov>; Kirsh, Susan R. (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) (b)(6) @va.gov>; OCLA Health Team (b)(6) @va.gov>; (b)(6)

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Subject: Green Light Data Release 162

Good morning,

Please proceed with notifications according to the timeline below, using the attached notification text (Fact Sheet). Do not proceed with notifications until the prior action has been taken.

Thank you!

3:45 PM

- VHA posts data online
- VHA notifies field of release

4:00 PM (Simultaneously)

- OCLA and OM notify 8 corners
- VSO Liaison notifies VSO community
- IGA notifies State and Local DVA and governments
- NGO Liaison notifies NGO community

(b)(6)
(b)(6) *Office of Media Relations*
U.S. Department of Veterans Affairs
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Desk: (b)(6)
Cell:

Attachment A: Clinic Grid Management

To facilitate VHA moving forward and to better assess and manage clinic access, each medical center is requested to review all clinic profiles. Clinic Profiles are to accurately reflect appointment slot availability of that clinic. The OVAC National Clinic Profile Management team will be working closely with field sites to focus on the following elements:

1. Ensure clinic profiles are established for each clinical service for all modalities of care, including in-person, telephone, and video.

2. Work with local Clinic Profile Managers to:

    a. Set-up new and/or modify existing clinics with appropriate scheduling grids/lengths of appointments to allow for the efficient scheduling of appointments and proper workload capture. If changes are required to the count vs. non-count status, primary stop or secondary stop code assignments, a new clinic should be established. Do not change these parameters on existing clinics.

    b. Maximize the number of bookable appointment slots in all outpatient clinic profile grids. CVT clinics are to be set up with a minimum of one clinic slot. Clinic Profile Managers can add additional slots as demand evolves.

    c. Reduce the number of "add/edits" (i.e. creating "new visits") in CPRS for outpatient appointments. Documentation should be attached to the prescheduled appointment made in the appropriate clinic location.

3. Use of pre-scheduled appointments is preferred clinic management. This allows for accurate capture of wait times and is a Veteran-centric practice. The Veteran has advanced knowledge of the appointment type and can plan accordingly, receives reminders of the appointment, is less likely to no-show, and can review, re-book, or cancel the appointment online.

4. Assistance is available to create or modify clinic profiles. Sites requesting assistance are asked to complete the request form found here: https://dvagov.sharepoint.com/:b:/s/ClinicProfileManagementGuide30/ESn5ZwwITEBOnw3t8stRnc0Bbmax7YsL0wuHcZVBzdIKyA?e=ciM2pW

Attachment B: Virtual Care Scheduling Standardization

To provide Veterans a consistent, safe, and secure video experience, VA Video Connect (VVC) remains the video telehealth platform of choice for conducting video visits to home.

NOTE: The continued use of non-VVC video telehealth platforms is supported in certain circumstances during the COVID-19 pandemic as outlined below in paragraph 3.

1. Video to home visits using VVC are to be scheduled by scheduling staff in a designated video clinic with the secondary stop code of 179. ***NOTE:*** There are exceptions to the use of 179 secondary stops codes for national centers delivering video care to the home. Additional telehealth clinic stop code guidance is available at: Telehealth Coding Document

2. VVC is to be used for all pre-scheduled video visits to home. Clinicians should make every effort to communicate video to home appointments to schedulers in advance to allow appropriate scheduling activities.

3. Non-VVC video telehealth platforms may be used if VVC or VVC scheduling (Virtual Care Manager [VCM] or Telehealth Management Program [TMP]) is not available or if VVC cannot support a required use case or clinical need. When Non-VVC video telehealth platforms are used, these video telehealth visits must be appointed to the same video clinic used for VVC.

4. Refer to VHA Telehealth Service COVID-19 Alternative Technologies SharePoint site for specific guidance on non-VVC platforms. Link: https://vaww.telehealth.va.gov/technology/covid19-tech.asp

Attachment C: COVID-19 Related Consults and RTC Orders Management Including Community Care Requirements Around Wait Time Eligibility

The Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) have partnered to provide the below consult and appointment scheduling guidance post COVID-19 surge and is to be followed as VA Medical Centers (VAMCs) activate their Moving Forward Plan (MFP).

Interim guidance allows for the Patient Indicated Date (PID) to be updated, based on clinical review, in both Consults and RTC Orders post COVID-19 surge if the scheduling of the appointment was impacted by COVID19. This an exception to the current guidance as outlined in VHA Directives 1230 (2), Scheduling Processes and Procedures and 1232(2), Consult Processes and Procedures.

Each medical center service must have a documented plan on the clinical review and communication strategy of how and when schedulers are to appoint Veterans as the facility moves forward. The updated PID must be documented in CPRS, by a clinical staff member following the guidance outlined below, in order to be used for community care wait time eligibility determination.

Community care wait time eligibility criteria for consults and RTC orders impacted by COVID19 are outlined below.

1. When VAMCs activate their MFP and schedule Veterans for new and established VA appointments, the below wait time community care eligibility criteria apply. Note documentation requirements are outlined in #3 below.
    a. Consults:
        i. A Veteran is eligible for community care under the Wait Time Standard (WTS) if:
            - The clinician reviews a consult whose appointment was originally cancelled or not scheduled due to COVID-19 AND assigns/documents an updated patient indicated date (PID). If the new PID is within 20/28 days of the original file entry date of the consult AND a VA appointment cannot be scheduled within the WTS, the Veteran is eligible for community care.
            - The consult PID was not updated or the updated PID was not documented AND the original PID was within the community care WTS and there is no VA appointment availability within 20/28 days of the consult file entry date.

ii. A Veteran is not wait time eligible for community care if:

- A new PID is assigned and it is outside 20/28 days of the consult file entry date.
- A new PID was not assigned and the original PID was outside of 20/28 days of the consult file entry date.

b. Unscheduled RTC Orders or cancelled follow-up appointments:

i. A Veteran is wait time eligible when scheduling/rescheduling the appointment if:

- The appointment was cancelled by clinic or the RTC order was not scheduled, the original PID was within 20/28 days of the create date of the order, there is no appointment availably WTS, AND there is no documented evidence of an updated PID or new RTC order.
- The provider submits a new RTC order or documents a new PID in CPRS for a previously cancelled appointment, the PID is within 20/28 days of the create date of the order, AND there is no VA appointment availability within community care WTS.
- A Veteran is not wait time eligible when scheduling/rescheduling the appointment if:
- The appointment was cancelled by clinic or the RTC order was not scheduled, the original PID is outside 20/28 days of the RTC order create date AND there is no evidence of a documented updated PID or new RTC order.
- The provider submits a new RTC order or documents a new PID in CPRS for a previously cancelled appointment, the PID is outside 20/28 days of the RTC order create date.
- The provider submits a new RTC order or documents a new PID in CPRS for a previously cancelled appointment, the PID is within 20/28 days of the RTC order create date AND there is VA appointment availability within community care WTS.

2. Additional guidance on the above process can be found in chapter 6, section 6A of the Office of Community Care Field Guidebook. https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

3. Implementation of the MFP will vary across the medical centers. Each facility must have a documented plan for the review and scheduling/rescheduling of Veterans in each service. Following clinical review, communication of the PID to be used in scheduling/rescheduling an appointment may be accomplished in one or two methods as documented in the individual service plan:

    a. PID documented in the medical record:

        i. Consults: Via the consult toolbox (recommended) or in the consult comments

        ii. RTC: New RTC order entered by the provider

        iii. PID verbally communicated: Updated PID is communicated verbally from the provider to the scheduler and documented by scheduling staff in the appointment comments.

    b. Note that community care wait time eligibility is dependent the providers' documented PID in the medical record. In the absence of a documented updated PID, wait time eligibility is based on the original PID.

4. The interim guidance outlined in this memorandum specifically allows for the PID to be updated in both Consults and RTC Orders following clinical review and provides flexibility in communication of the updated PID as outlined in #3. This is an exception to the current guidance as outlined in VHA Directive 1232(2), Consult Processes and Procedures.

    a. Consults:

        i. All Consults related to COVID-19 are strongly encouraged to have an updated PID in addition to the priority group assignment documented by the receiving clinical team member to align with the Veteran safety principals as outlined in the MFP. Each COVID-19-related consult request should be reviewed for clinical appropriateness and safety, regardless of the file entry date and original PID.

        ii. Updated PIDs are to be documented in the scheduling instructions field of the Consult Toolbox COVID-19 tab options or Consult Comments.

iii. Consults with a PID updated and documented in the consult are scheduled using VistA Scheduling (not VS GUI) in order to capture the most current PID.

iv. If there is no documented evidence of a new PID, the original PID is used when rescheduling. The appointment is scheduled following verbal PID order of the provider or clinical designee. Scheduling staff will enter in the appointment comments: New PID (date), per clinician verbal order.

b. RTC Orders and follow up appointments:

i. In cases where the provider documents a new PID in CPRS, the updated PID is used when scheduling. The scheduler will notate in the appointment comments: New PID (date), per provider documentation. The impacted appointment request is to be rescheduled using VistA Scheduling (not VS GUI) in order to capture the most current PID.

ii. If there is no documented evidence of a new PID, the original PID is used when rescheduling. The appointment is scheduled in VS GUI following verbal PID order of the provider or clinical designee. Scheduling staff will enter: PID (date) per clinician verbal order.

iii. No changes in process occurs when a new RTC order is issued and the original order is cancelled.

Department of Veterans Affairs

Memorandum

Date: July 7, 2020

From: Assistant Under Secretary for Health for Operations (10N)

Subject: Outpatient Appointment Scheduling Management Moving Forward Post COVID-19 (VIEWS# 03014105)

To: Veterans Integrated Service Network Directors (10N1-23)

1. The Office of Veterans Access to Care (OVAC), the Office of Connected Care and the Office of Community Care (OCC) have partnered to provide guidance for Outpatient Appointment Scheduling Management Moving Forward Post COVID-19. The outpatient appointment scheduling procedures includes:

- Clinic profile requirements
- Video to home scheduling
- Community care wait time eligibility for COVID-19 impacted consults and Return to Clinic (RTC) orders management

2. Veterans Affairs Central Office will hold a high-level informational session to discuss Outpatient Appointment Scheduling Management Moving Forward Post COVID-19 and provide several national trainings during their regularly scheduled calls (See attached list). Additional information will be provided during the trainings. The recommended audience to attend the high-level information session includes: Referral Coordination Initiative Sponsors, Group Practice Managers, and facility outpatient clinical and scheduling leadership.

3. For any questions regarding clinic grid, consult or scheduling, please contact OVAC at (b)(6) @va.gov or (b)(6) National Telehealth Scheduling (b)(6) @va.gov. For any community care eligibility questions, please contact OCC Clinical Integration Leadership at (b)(6) @va.gov

(b)(6)

for
Renee Oshinski

Attachments

Department of Veterans Affairs

Memorandum

Date: September 15, 2020

From: Assistant Under Secretary for Health for Operations

Subj: Changes to Consult/Referral Management during COVID-19

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)

1. The purpose of this memorandum is to provide guidance to Department of Veterans Affairs Medical Centers (VAMC) about clinical consult/referral management during the ongoing COVID-19 pandemic and to specifically address the following:
    a. Clarification of file entry date (FED), patient indicated date (PID) and wait time (WT) eligibility for community care for open consults/referrals;
    b. Unscheduled consult/referral dispositioning;
    c. Consult Toolbox (CTB) COVID-19 Priority Options and Specialty Care Prioritization document utilization; and
    d. Use of Discontinue and Cancel consult/referral statuses in Computerized Patient Record System.

2. As per the VA MISSION Act, Access Standards apply in all circumstances to give Veterans choices about community care (CC) when they are eligible. Below is information that further clarifies the process.
    a. Veterans are wait time eligible for CC when any unscheduled consult/referral has a file entry date or patient indicated date that is more than 20 (for primary care or general mental health) or 28 (for specialty care) days in the past.
    b. Of note, if a Veteran is eligible for community care, the opportunities and benefits of receiving care within VHA can and should be provided as long as it does not restrict their ability to choose their preferred setting of care. Suggested scripting is included in an attachment to this document. Enhanced "ChooseVA" scripting for front-line staff can be found in Attachment A.

3. An updated PID on clinician review may guide prioritization of open consults/referrals but *may not* be used to impact wait time eligibility for community care. This guidance supersedes the following previously distributed:
    a. Memorandum Outpatient Appointment Scheduling Management Moving Forward Post COVID-19, Attachment C: COVID-19 Related Consults released on July 8, 2020
    b. Updated Attachment C: COVID-19 Related Consults and RTC Orders Management Including Community Care Requirements Around Wait Time Eligibility released on August 3, 2020

4. In March 2020, the Office of Veterans Access to Care (OVAC) issued guidance around management of consults/referrals that could not be scheduled due to the COVID-19 pandemic. Open and unscheduled consults/referrals should now be dispositioned according to guidance as outlined in Attachment B.

Subj: Changes to Consult/Referral Management during COVID-19

5. In May 2020, OVAC, the Office of Community Care and Specialty Care Services released the COVID-19 updates to the Consult Toolbox which included guidance to prioritize consult/referral review. To ensure that Veterans' care needs are met in a timely manner, the consult toolbox is now mandated to be used for all consults/referrals classified as Priority 1 or 2 for all services. See Attachment C for further details.

6. In order to better facilitate care delivery for Veterans and to enhance interprofessional communication, the consult/referral action ***cancel*** should replace ***discontinue*** in all instances. The status ***discontinue*** will no longer be utilized. See Attachment D for further details.

7. We are enhancing our capabilities to monitor the ability to schedule into our community care networks, particularly given the ongoing impacts of COVID-19. To align with OVAC's Cancelled Appointments and Consult Management Initiative (CACMI), Office of Community Care is mandating that facility community care staff utilize the Consult Toolbox Appointment Tracking tab, specifically the "Return from Community Care Provider" section to track scheduling challenges in the community. See Attachment E for further details.

8. When a Veteran is eligible for community care due to wait time and opts in, the VAMC staff member who forwards the internal consult/referral to community care should place the date of the next available internal VA appointment on the consult/referral when forwarding to community care. This will assist community care staff when discussing appointment availability options with the Veteran.

9. We seek to partner with Veterans to support them in decision making about care delivery whether in the VA or in community partners. For any questions please email at (b)(6) @va.gov.

(b)(6)

for
Renee Oshinski

TABLE OF CONTENTS

This Table of Contents is a guide to outline the various chapters and sections of the Office of Community Care Field Guidebook (FGB). The chapters and chapter titles as well as the sub-chapters information is below as a reference guide.

** Please Note: The sub-chapters are not hyperlinked to the chapters within the FGB.

CHAPTER

Decision Support Tool
Delegation of Authority Medical Services (DOAMS)
HSRM
Live and Work Well (LAWW) Optum Regions Only
Meet your CI Team
Operating Model
Options to Identify Community Providers
PPMS
Radiology Solution
REFDOC
Screening Triage Tool
Single Booking
Standardized Episodes of Care (SEOC) Database
VA Online Scheduling
VA Portal Changes

Note: The information in the Office of Community Care Field Guidebook (FGB) contains "live" documents that are consistently updated with new and updated information. Please ensure to access the FGB using the link below, when printing or saving a copy of the FGB to your local desktop. https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

VHA Office of Community Care (OCC)

Field Guidebook

Chapter 1: Introduction

Last Updated on: Tuesday, August 3, 2021

1.0 Introduction to the Community Care Network

The Department of Veterans Affairs (VA) is committed to providing Veterans access to timely, high-quality health care in the setting aligned with each Veteran's needs. In support of this objective, the Office of Community Care (OCC) aims to deliver a single, consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, their families, community providers, and VA staff. VA Medical Centers (VAMCs) may purchase care in the community under multiple programs and payment authorities, as outlined in the 10N Memorandum "Options for Providing Community Care (dated June 12, 2017).

A significant part of that single, consolidated program is the Community Care Network (CCN) services and healthcare resources contract, being awarded to as many as four contractors over the course of FY 2018. This set of contracts provides a network of licensed healthcare providers and practitioners to provide medical, surgical, Complimentary and Integrated Health Services (CIHS), Durable Medical Equipment (DME), pharmacy, and dental services to Veterans who are unable to receive care at a VAMC. The CCN contracts were developed with a focus on transparency, accountability, quality and increased communications between VA, providers, and Veterans. Ultimately, VA seeks a consolidated, streamlined community care program

that will provide Veterans with access to a high-quality integrated care network that provides the best of VA and the best of the community.

The new CCN is divided into four regional networks that provide local flexibility and increased access to care. Unlike previous network regions, the CCN regions are now aligned to state boundaries. It is important to note that the new CCN is not a new community care program. Rather it is a redesigned network and contract vehicle VA uses to buy care for Veterans in the community.

The Office of Community Care has developed a two-part CCN Transition Plan to support stakeholders in navigating the transition to this new network:

- The CCN National Transition Plan, intended for OCC National staff, provides national level guidance for the transition, providing the governance structure and high-level guidance for national staff on activities and requirements by functional area.
- The CCN Regional and Local Transition Plan, intended for OCC Regional and Facility staff, provides guidance for all stages of transition and is a living document, to be updated continuously throughout all phases of nationwide deployment, to ensure the most current information is made available as VAMCs implement CCN.

Both transition plan documents, along with supplemental information and training related to CCN, Fact sheet, etc. is located on the CCN Transition SharePoint.

The CCN Region listing is located on Community Care Network (CCN) Fact Sheet.

1.1 Field Guidebook: Purpose and Intended Audience

Building upon the Transition Plan, the Office of Community Care has designed the Field Guidebook to serve as a single guiding artifact for VA staff on how to purchase care in the community. The Field Guidebook includes guidance for VAMCs before, during, and after the transition to the new CCN. The Guidebook builds upon the foundation laid by the Operating Model and the CCN transition guidance provided in the CCN National and Regional Transition Plan and will cross-reference with other guidebooks on CCN - specific processes including site preparation and continuity of care maintenance. The Guidebook defines systematic business and clinical processes for VA staff as they coordinate Veteran care across the continuum. It has applications for multiple audiences:

- For members of the integrated teams, the Field Guidebook provides step-by-step guidance on how to perform the work purchasing and coordinating care for Veterans in the community and why these steps are performed.

- For medical center and facility community care leadership, the Field Guidebook provides repeatable processes to monitor and evaluate how care is delivered in the community.
- For oversight councils at the VAMC, VISN, and National levels, the standardized processes outlined in the Field Guidebook enable the Oversight Councils to monitor trends in community care and to ensure appropriate resources are allocated to deliver a quality experience to all community care stakeholders.
- For providers to understand the process of how to request community care for Veterans and to understand the process by which that care will be delivered and followed through to completion.

Importantly, as the transformation of community care continues, the Field Guidebook, as a living document, will be refined over time to incorporate newly implemented Information Technology (IT) solutions or business processes that change how care is purchased in the community.

1.2 Facility Community Care Office Competency Assessment Form

The Registered Nurse Competency Checklist is for use by facility community care offices.

- This checklist serves as a tool to help facility community care offices understand what is needed of the RN to understand the job. Additional resources can be found at Department of Veterans Affairs VHA Office of Community Care Questions and Answers Database and on YouTube at VHA Community Care.

1.3 Relationship to the Community Care Operating Model

The Field Guidebook builds upon the foundation set by the VHA Community Care Operating Model (Operating Model). The Operating Model is the foundational platform for each topic outlined in the Field Guidebook. The model describes how resources (people, process, technology, and data) should be organized within the VA Medical Centers (VAMCS) and provides the framework for how VHA will manage community care. The model is grounded in five foundational elements which are supported throughout the Field Guidebook:

- Clear roles and responsibilities across clinical and administrative functions
- Consistent processes to make serving Veterans more efficient
- Active partnerships to manage the care of each Veteran
- Standardized care coordination to align level of interventions with Veteran needs
- Responsive customer service to meet Veteran needs at the point of service
- Information on the Operating model can be found in the Operating Model Fact Sheet.

1.4 Organization

The Field Guidebook is organized into chapters that correspond with high-level steps for purchasing care in the community, from when an initial request for care is received to when medical documentation is sent by the community provider and care coordination follow-up is performed. A chapter specific table of contents is located at the beginning of each chapter to enable the reader to better understand how specific content relates to CCN. The legend below displays the various symbols that categorize content as applying to sites either in a pre-CCN transition state, post-CCN transition state or as applicable to both. Links to other resources are available in each chapter for VA staff to obtain further details on individual tools and processes.

- Community Care Hub - MISSION Act
- VA Insider - VA MISSION Act
- Webpage (Public) – Office of Community Care Landing page
- Fact Sheet: General Information
- Video: Veteran Community Care - Overview
- Information Sheet: Current vs. Future
- Article: Top Questions Answered
- Article: What is the latest on community care?
- Community Care Public Website
- Community Care YouTube Playlist

Last Modified on: Tuesday, August 3, 2021

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https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

VHA Office of Community Care Field Guidebook

Chapter 2: Eligibility, Referral, and Scheduling

Last Modified on: Tuesday, August 3, 2021

How to Refer to Community Care	2.13	One Consult Model Overview
	2.14	Scenarios When a New Community Care Consult is Required
	2.15	How to Create a Community Care Consult
	2.16	Ordering a Consult
	2.17	Guidance on Decision Support Tool Contingency Operations
	2.18	How to Forward an Existing In-House Consult to Community Care
	2.19	Enhancement to Expedite Community Care Appointing Process
	2.20	How to Schedule Under CCN When Veteran Requests Appointments via VA Online Scheduling (VAOS)
Routing, Clinical Review of Community Care Consults and Determining What Services to Authorize	2.21	Routing, Clinical Review of Community Care Consults and Determining What Services to Authorize
	2.22	Leveraging the Delegation of Authority for Routing Community Care Consults
	2.23	How to Perform Clinical Review for Services Requested
	2.24	How to Assess Clinical Appropriateness
	2.25	How to Determine and Document Veteran's Care Coordination Needs
	2.26	How to Determine Clinical Service Availability within VAMC or Sister Facility
	2.27	How to Assess which Services to Buy

Last Modified on: Tuesday, August 3, 2021

2.0 Eligibility

Training Slides and the Decision Support Tool (DST) Demo from the *Community Care Eligibility Training for Clinical Staff* Slides conducted on July 29th and July 30, 2020 are available for reviewing as follows:

- Reviewing and Capturing Community Care Eligibility for Clinical Staff – Training Slides
- DST Demo
- Community Care Eligibility Training for Clinical Staff – Recorded Session
- Community Care Eligibility Training for Clinic Staff Frequently Asked Questions (FAQs)

The Consult Toolbox 2.0 Training Demo is available on TMS: ID VA 4567333

Changes to Consult Referral Management during COVID-19

Training was held September 29, 2020 and October 1, 2020 during the Internal VHA and CC Appointment Open Office Hours regarding the expanded community care wait time eligibility due to COVID-19.

A recording of the training session has been included in this section:
https://vacctraining.adobeconnect.com/p5dxz3vhygx6/

Eligibility business solutions will allow VA providers to determine care choices collaboratively with their Veteran patients, by consolidating eligibility, enrollment, care site, and consult criteria review options. This will help determine, communicate, and track eligibility. IT Solutions include: VA Online Scheduling (VAOS), Decision Support Tool (DST), and Enrollment System (ES).

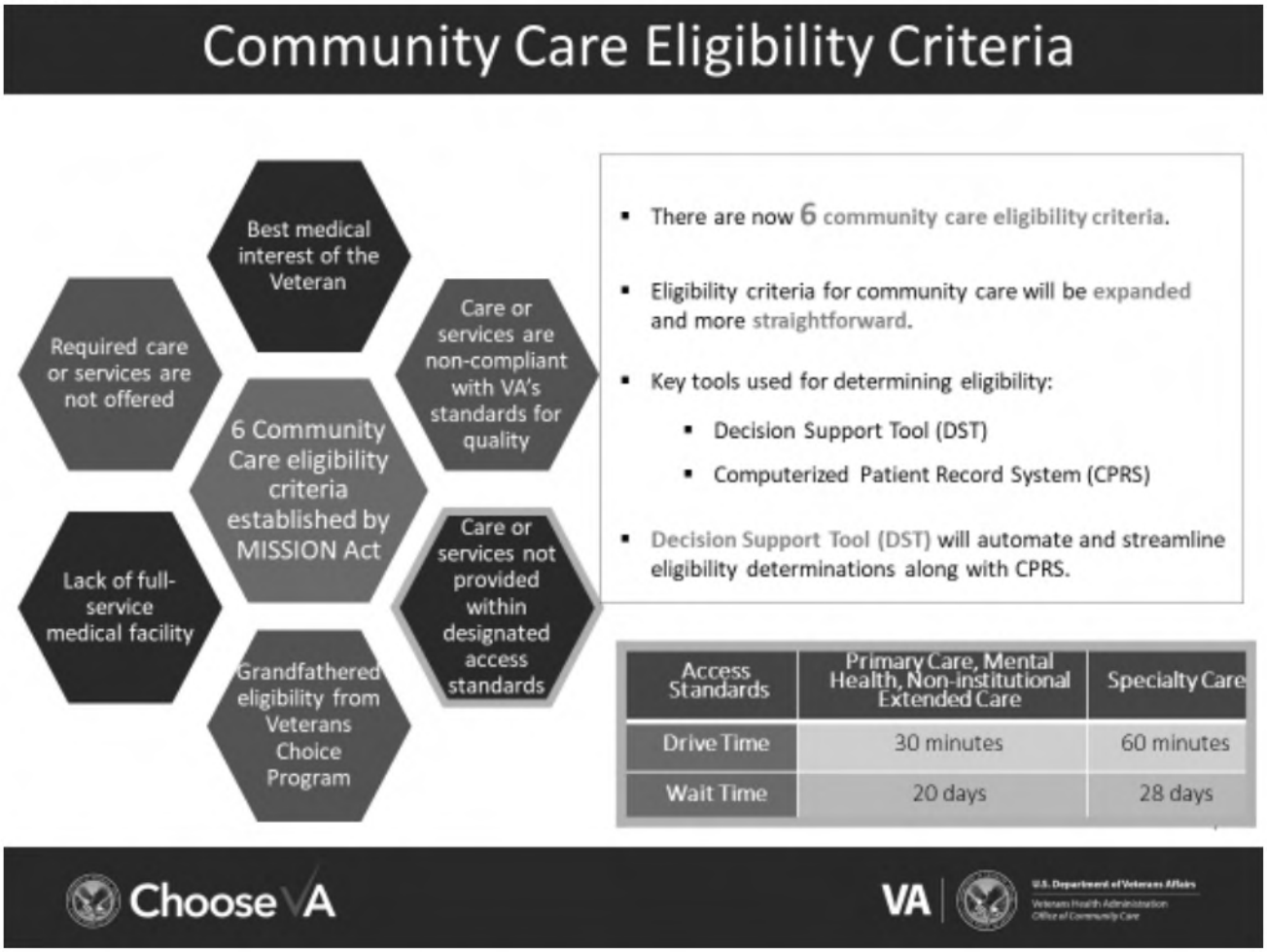
Community Care eligibility is based on the guidance set forth by the MISSION Act. Additional guidance on community care eligibility can be found throughout this chapter, in addition to the tools used to determine community care eligibility.

Additionally the MISSION ACT Fact Sheets provides detailed information on community care eligibility and the MISSION Act.

It is also important to note that in addition to being eligible for community care based on MISSION Act criteria the Veteran must also meet specific eligibility criteria to obtain care within the VA. When a community care consult is received in community care staff, the facility community care staff can proceed with scheduling the consult if the Category for enrollment is listed as Enrolled. If the Category lists anything other than Enrolled (e.g., Pending, Not Enrolled, etc.) or if their Primary Eligibility indicates non-Veteran eligibilities such as Humanitarian, Sharing Agreement, CHAMPVA, TRICARE, you cannot proceed and you must work with the enrollment/eligibility office within your VAMC.

Reference section 2.12 in this chapter for more detailed information on community care eligibility codes within the Veteran's record.

- The table below gives an overview of community care eligibility based on MISSION Act criteria:



Community Care Eligibility as Part of the Moving Forward Plan

As VA Medical Centers begin to remodel and schedule Veterans for VA appointments the processes for New Patients with Consults and Established patient must be followed in order to determine community care eligibility based on wait time standards as indicated **in Chapter 2, section 2.19.**

- **Offering all Options within the VA:**

  Regardless of community care eligibility be sure to offer the Veteran all options for care:

  - Discuss benefits of VA care /Known VA safety protocols
  - Offer virtual options including telephone, telehealth and VA Video Connect (VVC)
  - Offer to schedule appointment further into the future when clinically appropriate
  - Offer care at alternate VA locations (Inter Facility Consult)
  - E-Consult
  - Consider overbooking if possible.

Last Modified on: Tuesday, August 3, 2021

Telehealth Considerations

Per the MISSION Act, the below verbiage from the preamble applies when determining community care eligibility when the appointment being offered is considered Telehealth. "The proposed rule stated that if the VA is able to furnish a covered veteran with care or services through telehealth, and the veteran accepts the use of this modality for care, VA would determine that is was able to furnish such care or services in a manner that complies with designated access standards. We received one comment that urged VA to ensure that the option for the Veteran to have face-to-face care would be maintained if the Veteran did not choose the telehealth modality. We do not make changes based on this comment. As stated in the preamble of the proposed rule, VA will not require a veteran to accept the use of telehealth for the purpose of meeting VA's designated access standards." The specific guidance from the law can be found here: https://www.regulations.gov/docket?D=VA-2019-VHA-0008. Select the Final Rule document and search the word telehealth.

Determining Community Care Eligibility when Scheduling Surgical Procedures

For specialty care, including surgery, the appointment wait time requirement is 28 days. This standard applies to outpatient surgical consultation, pre-operative consultation and testing, and to surgical procedures, including those performed within an operating room. Veterans are eligible to receive community care for surgery services based on the wait time criterion when:

1) An appropriate surgical clinic appointment is not available within 28 days of consult request file entry date (or from Patient Indicated Date (PID), if specified); or
2) preoperative testing and consultation cannot be scheduled within 28 days of decision to obtain; or 3) an operation cannot be scheduled within 28 days from the day that both the surgeon and the patient determine that the specific surgical procedure is indicated.

Authorization for community care surgical services may include surgical consultation, preoperative testing, surgical procedures and associated care, or only a portion of these services.

Please see the *Guidance for Scheduling Surgery under MISSION Reference Sheet* for additional information, and reference Chapter 3 of the Office of Community Care Field Guidebook for additional scheduling and Request for Services (RFS) guidance.

Note that Veterans may also be eligible for surgical community care based upon other criteria as defined by the VA MISSION Act and explained here.

Review for Community Care Eligibility by Scheduling Staff

Recommendations on When to Run DST/CC Eligibility

Staff responsible for consult and appointment management, must ensure to review the Veteran's community care eligibility. 38 CFR 17.4010(a)(5) implements the eligibility determination requirements for community care for a Veteran. The process in place to conduct this review is outlined in the sections below.

As part of the updated process, DST/CC Eligibility should be used by the referring provider ONLY when he/she has a strong clinical reason for the Veteran to be made eligible to

receive community care under the best medical interest (BMI) provision in the MISSION Act. **It is important to note, BMI decisions are only to be made by clinical staff members, that are part of the patient's care team. Administrative staff are not to make BMI community care eligibility determinations.**

Referring Provider:

- In this scenario, the referring provider will capture the BMI eligibility determination by running the DST/CTB 2.0 upon consult entry and placing supporting clinical information on the consult.
- If the care is offered in-house, the consult will still be routed to the RCT/specialty clinic for review.
- BMI eligibility can be captured using DST/CTB 2.0 at the time of submitting the consult.
- When running DST if the Veteran's community care eligibility reflects a static eligibility (drive time, hardship, grandfather), the referring provider will not be able to capture BMI eligibility determination.
- In all other scenarios, the referring provider should consider if e-consult is appropriate and consider if the requested service can be provided via telehealth, telephone or IFC. The referring will be relieved from having to use DST and let the downstream colleagues utilize this tool when determining where the Veteran is eligible to seek the timeliest care. If the consult does not already have DST information entered by the referring provider (BMI determination- see recommended process above), the RCT/specialty clinic will be responsible for launching DST/CTB 2.0 to review the Veteran's community care eligibility information, review the appointment availability for wait time eligibility and then having the discussion with the Veteran about his/her options for care.

Referral Coordination Team (RCT)/Specialty Clinic

- The specialty clinic and/or RCT should run DST/CTB 2.0 in order to determine the Veteran's community care eligibility and guide the conversation with the Veteran about the VA and community care appointment options.

Note: Community care eligibility for Veteran's seeking primary care must still be determined by the primary care team; to include provider, nurse and scheduler.

It is highly recommended that a clinical member of the RCT or specialty clinic run the DST/CTB 2.0 to determine and review community care eligibilities (except wait time). Upon running eligibility the clinical staff member will select TBD/Deferred save the results, in order to allow the assigned scheduling staff to review the applicable community care eligibility as part of the discussion on available options for care with the Veteran. The assigned scheduling staff for the care being requested will review the consult comments to determine the DST/CTB 2.0 results.

If the Veteran reflects community care eligibilities, this information should be communicated to the Veteran for consideration. If DST or CTB 2.0 did not reflect community care eligibility the scheduler must review to determine if the wait time eligibility criteria is a factor for the care. If eligibility was not run prior to the scheduler receiving the appointment request for action, then at that time the scheduler should launch DST/CTB 2.0 and review for community care eligibilities (except wait time).

To consider wait time eligibility the scheduler must first determine if the appointment request is within the community care wait time standards (WTS). If the request is within the WTS, the scheduling staff must then determine if the appointment can be scheduled within the by looking at the specific clinic where the Veteran will be scheduled. At this time the staff member should also review the average community care wait time for the type of care being requested. This will assist with guiding the wait time conversation with the Veteran. Prior to contacting the Veteran ensure to review and consider the key factors outlined in section 1.4.1 in this guidebook.

<table>
<tr><th colspan="3">Community Care Wait Time Standards (WTS)</th></tr>
<tr><th colspan="2">Routine</th><th>Considerations</th></tr>
<tr><td>Primary Care/Mental Health/Non-Institutional Extended Care Services</td><td>Specialty Care</td><td rowspan="2">The WTS for community care must be considered if the following applies:

1. The PID on the consult is within 20 or 28 days (based on the type of care being requested) from the file entry date.
2. The appointment within the VA cannot be scheduled within the 20/28 days of the file entry date.</td></tr>
<tr><td>20 days</td><td>28 days</td></tr>
</table>

As of 10/01/2020 the following steps should take place once all possible community care eligibility option have been reviewed and discussed with both NEW and ESTABLISHED Veterans.

a. If Veteran opts into community care proceed with forwarding the internal consult to a community care consult title following the steps outlined in section 2.18 of the Office of Community Care Field Guidebook (FGB).
b. If the Veteran decides to opt-out of community care, the staff then should follow VA scheduling protocols and thereby schedules the appointment and document the opt out by capturing #COO# in the internal VA appointment comments.
c. If a VAMC can accommodate a Veteran by wait time standards, it is still required that that RCTs ask the Veteran if they would like to know about their other potential community care eligibilities.

Established patients: Also review for other eligibility if the Veteran requests

- If the Veteran requests to review for other community care eligibility, at that time a VCCPE consult can be used to determine community care eligibility.
- If the Veteran does not request to review for other community care eligibility proceed with scheduling the internal VA appointment

Average Community Care Wait Times in DST/CTB 2.0 CC Eligibility ab

The addition of the community care average wait time to DST/CTB 2.0 CC Eligibility tab will assist end users, to include the Referral Coordination Team (RCT) and specialty clinic schedulers, when having that thoughtful conversation with Veterans regarding their VA and community care options and the average wait times both in VA and community care. It is important to note DST/CC Eligibility is providing the average wait time for both calculations and not the exact wait time. The methodology of the calculations is similar, but a different date parameter is applied. In both situations, the exact wait time is determined at the time of scheduling into the specific clinic where the Veteran is to be seen, when knowledge of the next available appointment is accessible. More information on the average community care wait times added in DST can be found in section 2.9 of this chapter.

Key Factors to Consider when Discussing Care Options with the Veteran:

When having the conversation with the Veteran, after community care eligibility has been determined, the end user should be aware of the following:

- Available options within the VA to provide the care (i.e. face-to-face, Interfacility Consult (IFC), e-consult, Telehealth (TH) etc.)
- Review the average wait times in the community and within the VA for the care being requested in order to provide the patient with an overall idea on the appointment wait time, once the request is routed.
- Emphasize that the average community wait times are not reflective of the actual available appointments at any one community provider's office. DST/CTB 2.0 reflects an average of all community providers who offer the requested service to Veterans referred to the community by that VAMC's Healthcare system (CBOCs and off-site facilities).
- Consider the community care appointment availability and safety considerations, specific to the COVID-19 Pandemic.

Scenario 1:

Mr. Smith saw his primary care provider (PCP) on 7/2/20 and his PCP submitted a consult for Mr. Smith to be seen by the internal endocrinology clinic.

The endocrinology clinic within One Town VAMC is currently in phase 2 of their Moving Forward Plan and has started to schedule Veterans for face to face appointments. In Mr. Smith's case, the endocrinologist, working in conjunction with the Referral Coordination Team (RCT) has determined that the initial appointment can be done via VA Video Connect (VVC).

The RCT scheduler contacts Mr. Smith to schedule his VVC appointment and reviews the community care eligibility captured when DST was run, as the endocrinology clinic is in the Moving Forward Phase.

In this scenario Mr. Smith is eligible for community care due to drive time and must be offered the option to be seen in the community. Communicating the options within the VA is key in this process and clearly communicating to Mr. Smith that although he is eligible for community care for drive time there are options within the VA to provide the care and considering the current COVID-19 Pandemic we have a VVC appointment options in order to safely render the requested care.

Scenario 2:

Ms. Jones saw her primary care provider (PCP) on 6/30/20 and her PCP submitted a consult for her to be seen by the internal ortho clinic for an evaluation for her persistent shoulder pain.

Due to the COVID-19 pandemic the clinic is not scheduling any face to face (F2F) appointments at this time, unless upon clinical review it is determined that a F2F appointment is clinically necessary.

Upon review by the clinical member of the RCT it is determined that a Telehealth (TH) appointment is appropriate. In this scenario the clinical member of the RCT determined that it was not clinically necessary or safe for Ms. Jones to be seen within the VA during the COVID-19 Pandemic and therefore it is also not safe to refer Ms. Jones to the community as the facility is not in their Moving Forward Phase.

It is important to note the following possible changes in the outcome of this scenario:

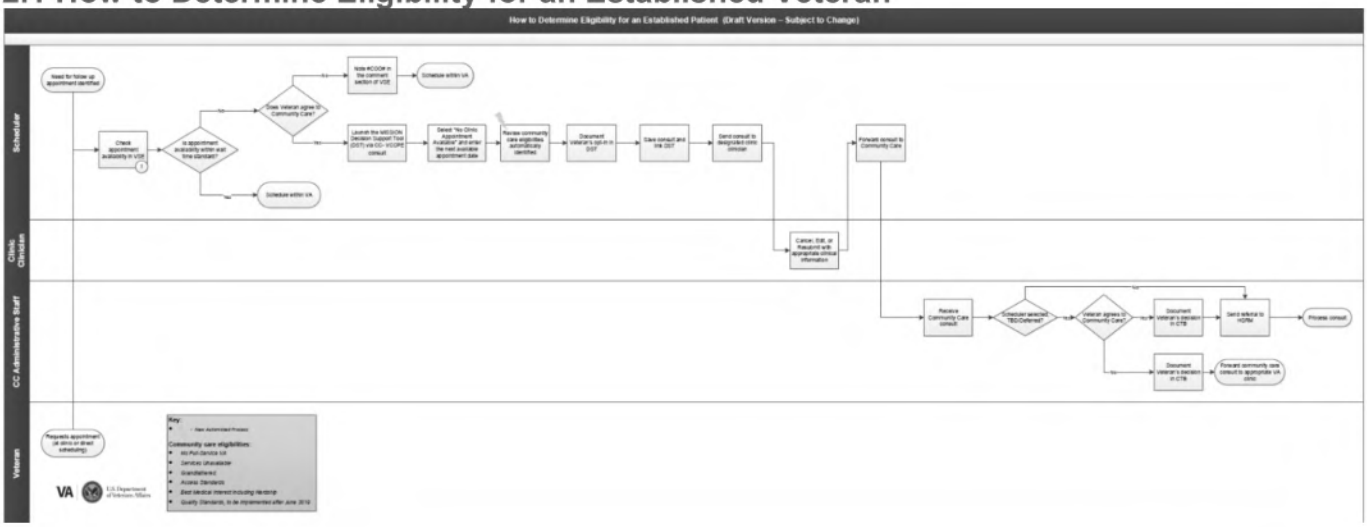
- If Ms. Jones turns down the TH appointment and a clinical member of the team determines that a F2F appointment is appropriate, at that time community care eligibility must be reviewed and discussed with Ms. Jones so that Ms. Jones has the opportunity to choose the best option for her on where to get her care.

- If Ms. Jones requests to know her community care eligibility or states that she is eligible for community care and would like to be seen in the community, then at that time we do have to honor her request. In this conversation it is important to discuss with Ms. Jones the safety considerations in the community, consideration of appointment availability in the community during the pandemic, options within the VA to obtain the care (i.e. TH, VVC etc.).

Ultimately, Ms. Jones does have the option if she would like to be seen in the community using her community care eligibility, but the discussion on safety, availability and appointment modality options within the VA is key in this conversation.

Last Modified on: Tuesday, August 3, 2021

2.1 How to Determine Eligibility for an Established Veteran



PROCEDURES

General Considerations:

- These steps outline how to determine eligibility for established veterans in a clinic using the MISSION Decision Support Tool (DST)/CTB 2.0 CC Eligibility tab, and a Veterans Community Care Eligibility (VCCPE) Consult.
- Primary Role: Scheduler or Clinic Administrative Staff.
- Secondary Roles: Facility community care office, Designated Clinical Staff.
- There is a report available in VSSC to track VCCPE consults.
    - This report is available in the Consult Cube under the Open Consults tab **and** the Special Purpose tab. **note:** this report is currently available in both locations. It will be removed from the Open Consults tab in the near future.

STEP	ACTIVITY
1	**Determine the Applicable Access Standard** Review Table 1 to determine which access standards apply to the care sought by the Veteran. Primary care, mental health, and extended care services have a 20 day wait time standard in 2019, whereas specialty care has a 28 day wait time standard.

Wait Time Standards			
Routine		**Stat**	**Special Instructions**
Primary Care/Mental Health	**Specialty Care**	**All Stat Consults**	**All Special Instructions Consults**
20 days	28 days	1 day	Access Standards are not applicable if CID is greater than the Wait Time Standard

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
2	**Determine if the Veteran is wait time eligible** Wait time access standards that differ by primary care/mental health and specialty care are only applicable for routine consults. Stat consults have a special wait time standard and wait time standards are not applicable to consults with special instructions. **Routine Urgency** If the consult urgency is routine, the wait time standards are measured based on the file entry date of the consult and by reviewing the CID/PID on the consult. If the CID/PID on the consult is within the 20 or 28 days, depending on the type of care being requested, then the Veteran could be eligible for community care if there are no available appointments in the specific clinic in which the Veteran is to be scheduled into for this care. For example, if the date of request for a specialty care appointment is 7/1/2019 and the CID/PID is 7/5/2019, and the first available appointment is 9/1/2019 (more than 28 days from 7/1/2019), then the Veteran is eligible for community care based on wait time. Another example, if the request for the specialty care appointment was created on 7/1/2019 and the CID/PID on the consult is 8/15/2019, then wait time eligibility for community care is no longer a consideration since the CID/PID is outside of the wait time standards. **Stat Urgency** STAT Care for PC3 In instances where community care is clinically required within 24 hours of treatment (both inpatient and outpatient) from a VA physician, an eligible Veteran can receive STAT care in the community under the PC3 contract. STAT community care is defined as VA Clinical to Community Care Clinician care that required immediate referral with resolution within 24 hours that is directly coordinated by the VA. PC3 CC consults can be initiated and coordinated for STAT care by the VA staff to support transfer to a TW provider at the ED, inpatient or outpatient care based on clinical need. When STAT care is requested from a VA physician, the VA will schedule the care with a CC provider that is in the TW network. The VA will submit a 10-0386sch through the TW portal within 1 business day of the referral for care. Failure to submit the referral timely could result in claim denial for the CC provider. TW will send a retroactive authorization letter to the Veteran and the provider once the VA referral is received and the TW authorization is created. Referrals originating from a referring VA facility to a CC provider in TW's network for ED, inpatient or outpatient service for STAT care will be considered preauthorized and must be accompanied by a VA referral. STAT care **does not include** referrals originating from a CC provider or Veteran self-referrals for community care (to include distance-eligible Veterans). **Key Items:** • Definition of STAT Care • Must be a referral from a VA physician to a TW network provider • VA will schedule the care and conduct any needed care coordination

PROCEDURES	
	• VA must submit a 10-0386sch to TW within 1 business day for TW to send a retroactive authorization letter to the Veteran and CC provider **Special Instructions Urgency** If the consult urgency is special instructions, then access standards do not apply if the CID is greater than the Wait Time Standard (WTS). If the No Later Than Date (NLTD) is beyond the date of request plus the wait time standard, then the Veteran is deemed to have waived their community care eligibility and no eligibility is determined.
3	**Check appointment availability in VistA Scheduling Enhancements (VSE)** • If there is an appointment available within the applicable wait time standard, schedule a VA appointment. • If there is no appointment available within the applicable wait time standard, continue to step 4. For Veterans requesting a follow-up appointment, wait time is calculated from the date of request. For Veterans with a Return to Clinic order with a CID less than 20/28 days, wait time is calculated from the date the order was signed. If the scheduler cannot schedule within the wait time standard, the scheduler should contact the provider immediately so that options can be discussed, including overbooking or RN communication. For Veterans with a Return to Clinic order with a CID greater than 20/28 days, the wait time standard is considered waived.
4	**Document the Veteran's opt-in decision** • If the Veteran opts into community care, continue to step 5. • If the Veteran opts out of community care, note #COO# in the comments section of VSE and continue to Step 17.
5	**Navigate to CPRS** Navigate to CPRS and begin entering a CC Admin VCCPE consult. The appropriate consult name for the VCCPE consult will vary based on the facility VCCPE consult naming conventions.
6	**Launch the MISSION Decision Support Tool (DST)** **(CTB Version 1.9.0078)**  Click "Launch DST" when prompted.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
	(CTB Version 2.0) Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.
7	**Enter the clinical consult service** **(CTB Version 1.9.0078)** Enter the clinical service in the text field below the Veteran's demographic information (please see figure 1 below). **Clinical Service Dropdown Menu:** All inactive stop codes have been removed from the Clinical Service dropdown menu. A full list of Clinical Services available for selection is available in the "DST – Clinic Service Mapping" table on the DST CI Solutions SharePoint site

Last Modified on: Tuesday, August 3, 2021

PROCEDURES

ChooseVA

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

Decision Support Tool - VHA and Community Care Wait Times

What are average wait times in Decision Support Tool (DST)?

- VHA and community care average wait times are based on each selected clinical service mapped to the consult request.
- The times are based on the time between when an appointment is made and the actual appointment date.
- These times should only be used for general reference during the conversation with the Veteran because they are based on historical data that is collected across many different VA and community provider locations.
- It is important to remember that "average wait time" is different from the "next available appointment time," which could be quite different.

Why are average wait times important?

Having both average VHA and community care appointment wait times in DST will allow Referral Coordination Team (RCT) members, clinic schedulers and providers to easily review the average wait times for a selected clinical service to help make the best-informed decisions for the Veteran's care.

How are average wait times calculated?

- VA average wait time is calculated based on the time between the date an appointment is created to the date of the internal VA appointment.

How are average wait times calculated (cont.)?

- Community care average wait time is calculated based on the time between the date an appointment is created to the date of the community appointment, as recorded in HSRM.

Important Points to Share with Veterans:

- Community care wait time is based on the information captured in HSRM, across all community provider locations.
- Average wait times are not used to establish community care eligibility.
- Community care wait time eligibility is determined at the time of scheduling the internal VA appointment, and is based on the clinic availability for the exact clinic where the Veteran is to be scheduled.
- If the Veteran chooses to be seen in the community, make sure to capture the Veteran's community care scheduling preferences.

Disclaimer: The data for facility community care offices currently using Patient-Centered Community Care (PC3) that have the contractor schedule Veteran community care on their behalf will not be all inclusive because these sites do not use HealthShare Referral Manager (HSRM) to process community care referrals. The data for these sites will reflect the most recent average community care wait time once they begin to use HSRM for referral management.

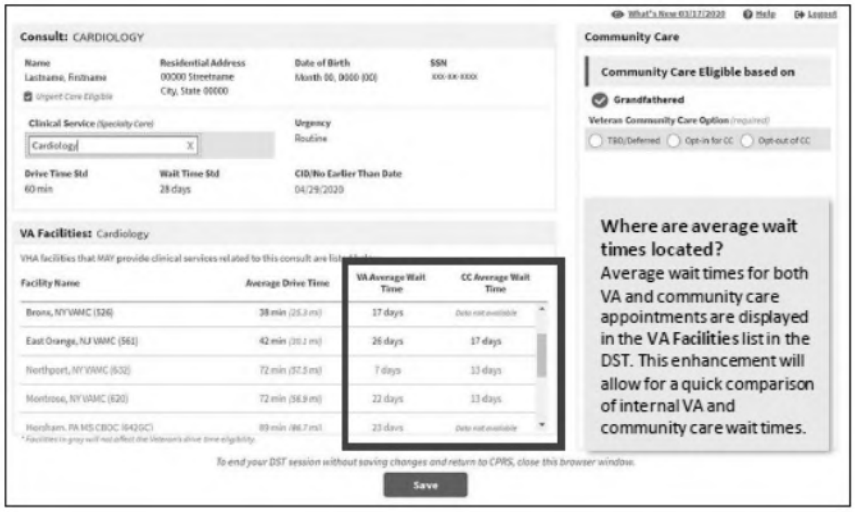
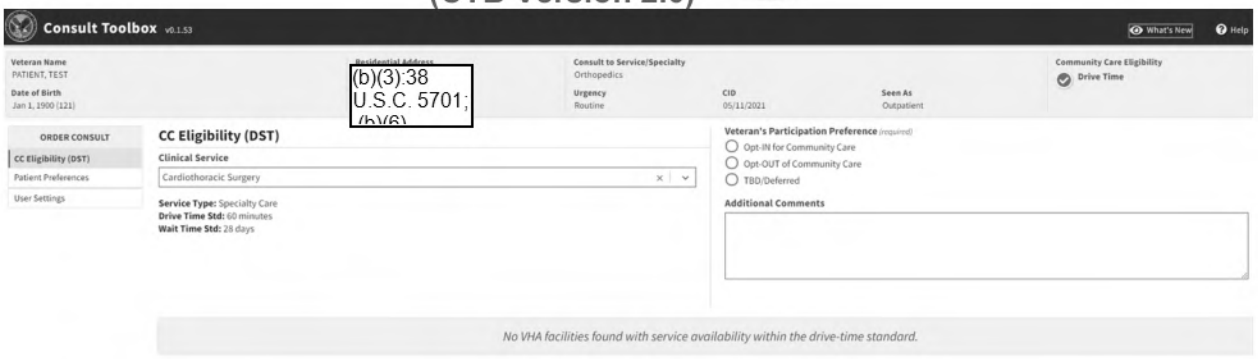


Figure 1. Established Patient DST Dashboard

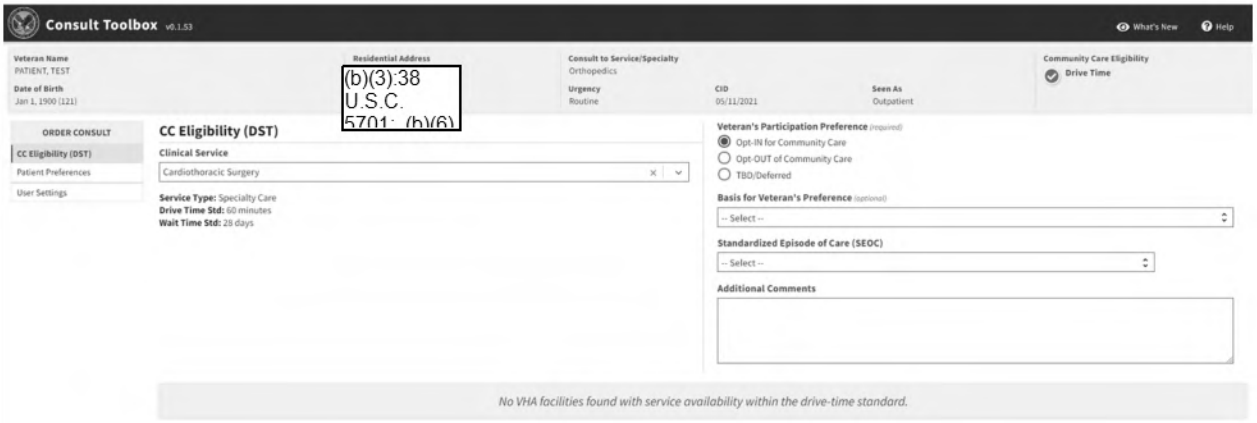
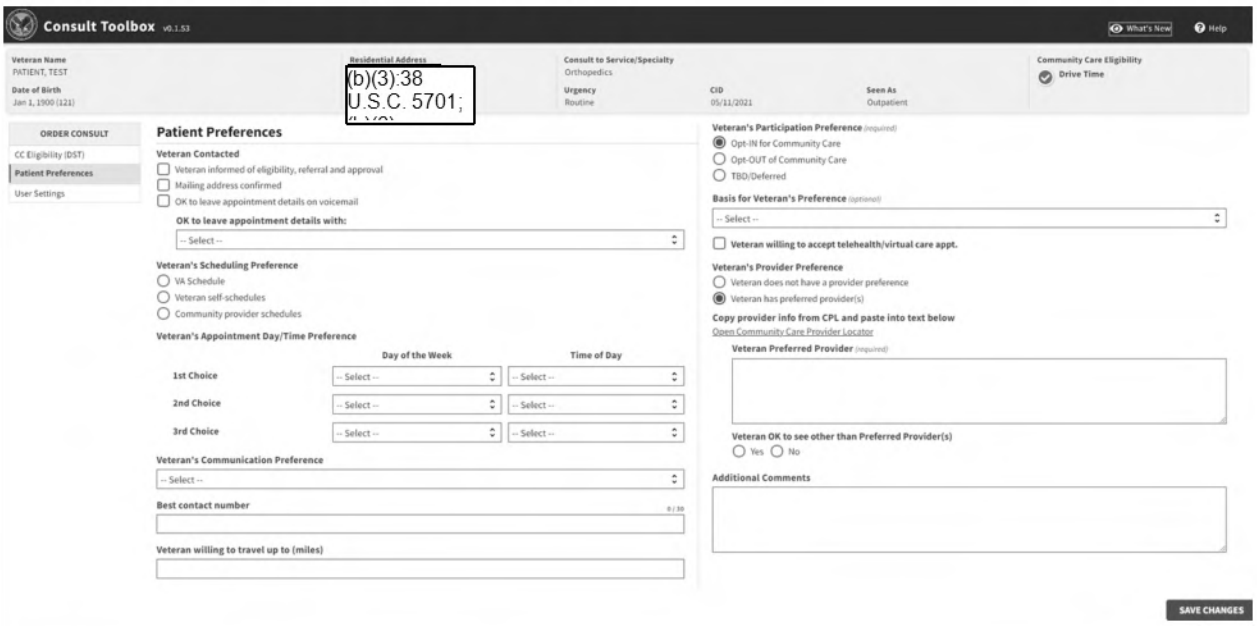
Last Modified on: Tuesday, August 3, 2021

PROCEDURES

	(CTB Version 2.0) 
8	**Enter the Next Available Appointment date** Enter the next available appointment date. The next available appointment date can be found in VSE.
9	**Review automatically identified community care eligibilities** The automatically identified community care eligibilities will populate in DST/CTB 2.0.
10	**Document the Veteran's opt-in decision in DST** (CTB Version 1.9.0078) Document the Veteran's prior opt-in decision to community care, selecting the radio button "Opt-in."

Last Modified on: Tuesday, August 3, 2021

PROCEDURES

	(CTB Version 2.0) Document Veteran's Participation Preference, Basis for Veteran's Preference, and Standardized Episode of Care.  Document Patient Preferences for scheduling. 
11	**Save consult** Save the consult by selecting the save/save changes button.
12	**Finish entering community care consult** Finish entering the community care consult following normal consult entry processes.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
13	**Add Significant Finding Alert** Use the Action menu within Consult Toolbox to add a Significant Finding alert. *Note: the use of significant findings in this process is not mandatory, but the facility should have a process to ensure that these consults are addressed timely within the consult timeliness standards.
14	**Enter Comment** Enter the comment "Please review for community care eligibility"
15	**Send consult to designated clinic clinician** Send the consult to the designated clinic clinician for review.
16	**Clinician reviews community care consult** The clinician may overbook the Veteran or cancel/edit/resubmit consult with the appropriate clinical information. The clinical will send the consult back to the scheduler.
17	**Forward consult to community care** The scheduler will forward the consult to community care utilizing the consult toolbox for documentation.

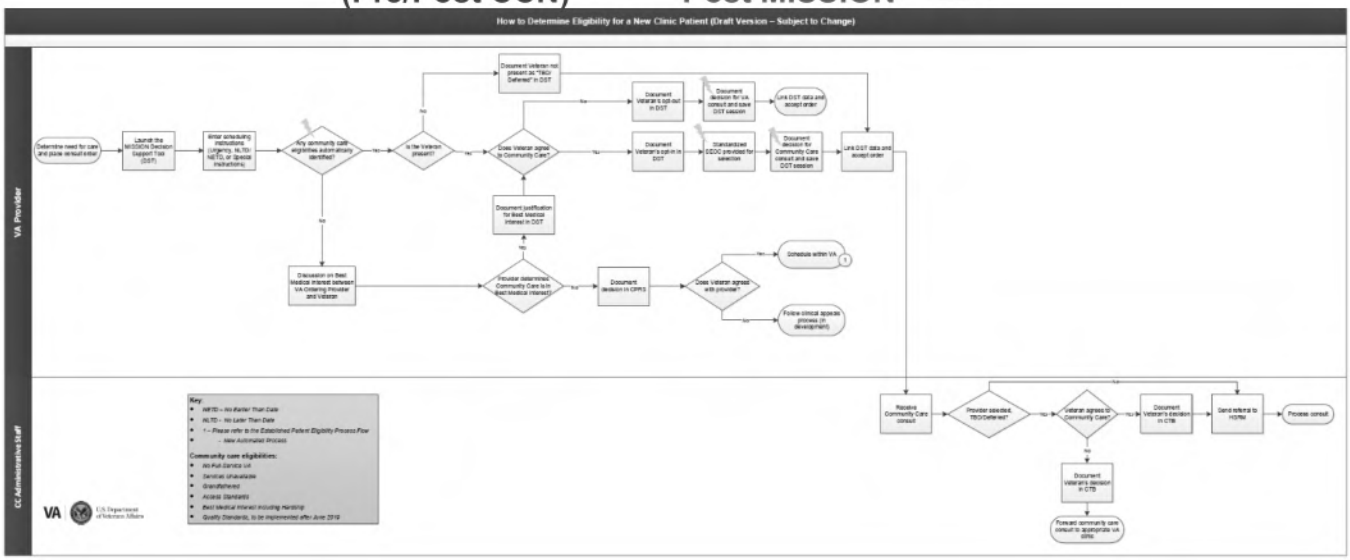
18	**Facility community care office receives community care consult**
	
	• If the Veteran's opt-in decision was documented, continue to step 19.
	• If the Veteran was not present, contact the Veteran to document their opt-in to community care.
	  ○ If Veteran opts in, document in Consult Toolbox and continue to step 19.
	  ○ If Veterans opts out, document in Consult Toolbox and forward to the appropriate VA clinic for scheduling.

19	**Facility community care office sends referral to HSRM** Select the "Send to HSRM for Referral" button at the bottom of the Authorization tab in Consult Toolbox.
20	**If the Veteran opts out of community care (continued from step 4)** **Schedule care within the VA** Schedule an appointment within the VA using VSE. For additional information on using VSE, please VSE Pulse Page

Last Modified on: Tuesday, August 3, 2021

2.2 How to Determine Eligibility for a New Clinic Veteran

(Pre/Post CCN) Post MISSION



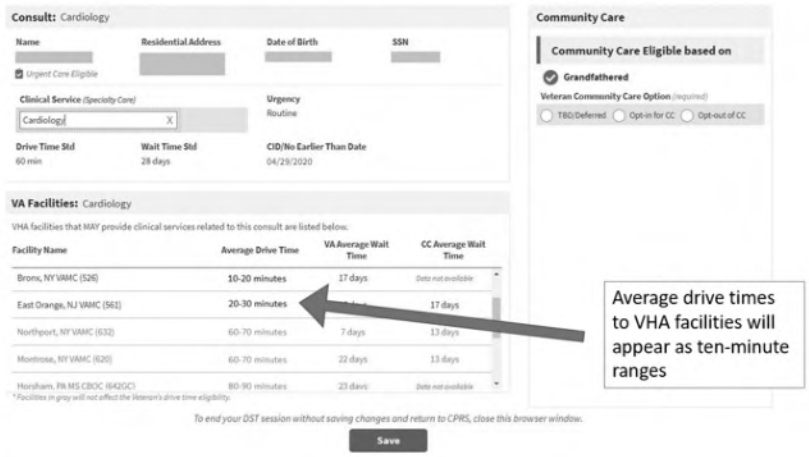
PROCEDURES

General Considerations: The purpose of this process is to determine community care eligibility as a new Veteran in a clinic. The new Veteran should be reviewed for community care eligibility when a provider identifies the need for particular care requiring a consult to be placed by a provider.

- Primary Role: VA Provider.
- Secondary Roles: Facility community care office, Scheduler.

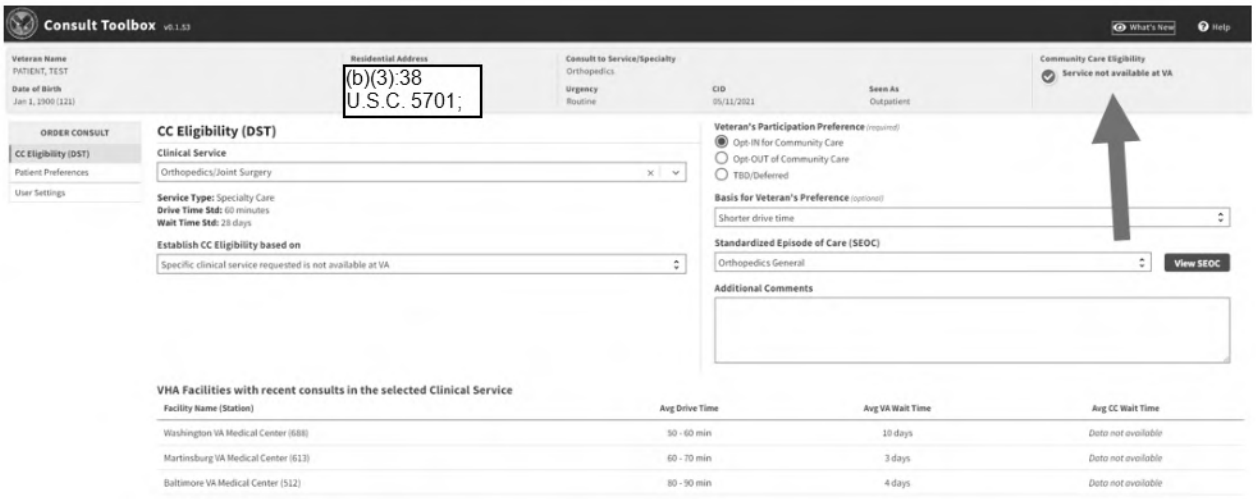
STEP	ACTIVITY
1	**Determine need for care and start the consult order in CPRS** **(CTB Version 1.9.0078)** If use of DST is required, a launch button will appear. **(CTB Version 2.0)** Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
2	**Launch the MISSION Decision Support Tool (DST)** **(CTB Version 1.9.0078)** Click "Launch DST" when prompted. **(CTB Version 2.0)** Select the Open Consult Toolbox button.
3.	**View automatically identified community care eligibilities** **(CTB Version 1.9.0078)** The automatically identified community care eligibilities will populate in DST. The Veteran's overall eligibility will be listed in the Community Care section of the screen as either "Community Care Eligible" or "Not Community Care Eligible." Please note services unavailable eligibility will display as drive time eligibility in the DST MVP.  Figure 2. New Patient DST Dashboard **(CTB Version 2.0)**

Last Modified on: Tuesday, August 3, 2021

PROCEDURES

	 • If the Veteran is "Community Care Eligible," continue to Step **5**. • If the Veteran is "Not Community Care Eligible," continue to Step **11.**
4	**Document the Veteran's opt-in decision** • If the Veteran opts into community care, select the radio button "Opt-in" and continue to Step 6. • If the Veteran is not present, select the radio button "TBD/Deferred" and continue to Step 6. • If the Veteran opts out of community care, select the radio button "Opt-out" and continue to Step 13.
5	**Document Decision for Community Care Consult** The standard consult and SEOC are provided for selection. Document the decision for community care in DST.
6	**Finish entering community care consult and accept order**
7	**Facility community care office receives Community Care consult** • If the Veteran's opt-in was documented, continue to step 10. • If the Veteran was not present, contact the Veteran to document their opt-in to community care. • If Veteran opts in, document in Consult Toolbox and continue to step 10. If Veterans opts out, document in Consult Toolbox and forward to the appropriate VA clinic for scheduling.
9	**Facility community care office sends referral to HSRM**

PROCEDURES	
	• Select the "Send to HSRM for Referral" button at the bottom of the Authorization tab in Consult Toolbox.
10	**If Veteran is "Not Community Care Eligible" (continued from step 4):** **Determine Best Medical Interest** The provider may determine, after discussion with the Veteran, that receiving care in the community is in the best medical interest of the Veteran. If the provider determines that community care is in the Veteran's Best Medical Interest, document justification in DST/CTB 2.0 CC Eligibility and continue with Step 5. If provider determines that community care is not in the Veteran's Best Medical Interest, continue to Step 12.
11	**Document VA care outcome for best medical interest discussion** Save eligibility data, then document the decision in CPRS. If the Veteran disagrees with the determination, refer to the clinical appeals process.
12	**If Veteran opts out of community care (continued from step 5):** **Document decision for VA consult** Document the decision for a VA consult in DST/CTB.
13	**Accept order** Accept the order.

Last Modified on: Tuesday, August 3, 2021

2.3 How to Determine Eligibility for a New Enrollee Appointment Request

(Pre/Post CCN)  (Post MISSION) 

PROCEDURES

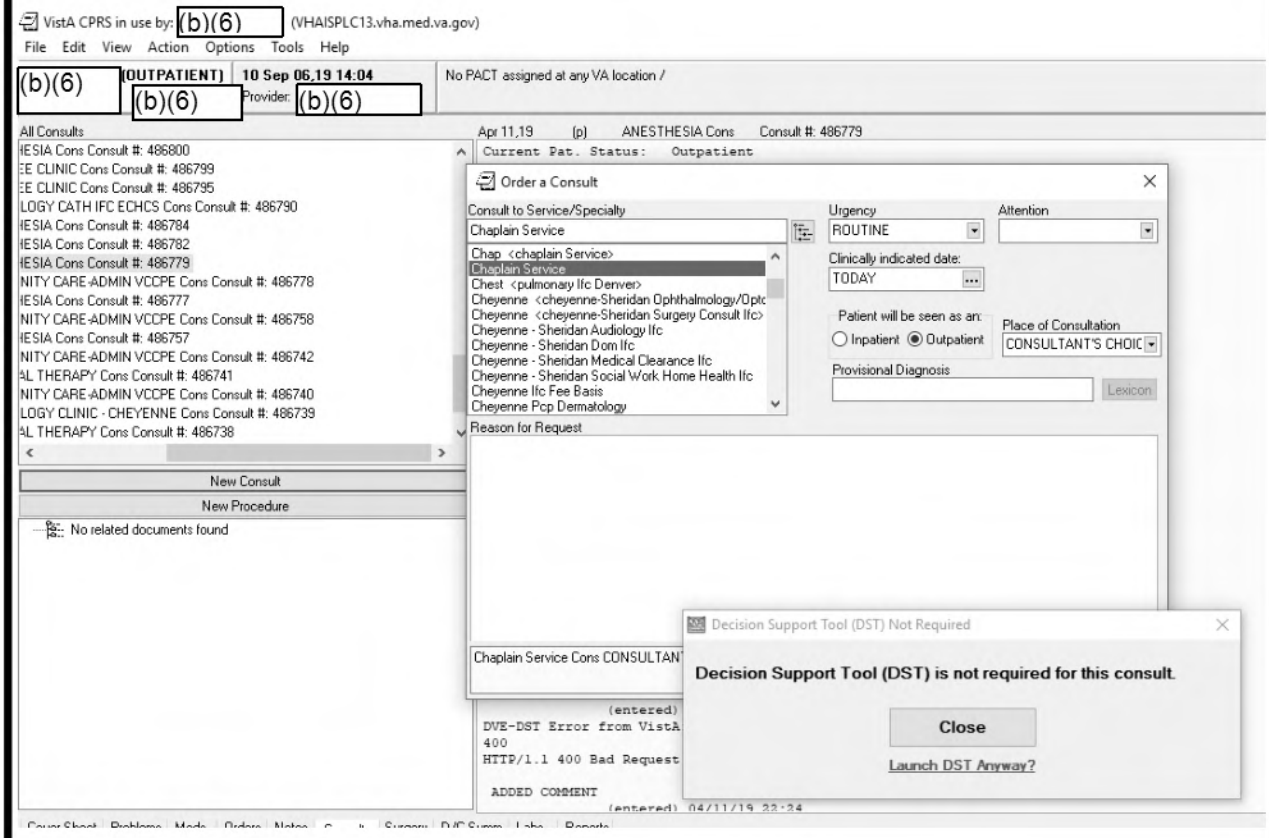
General Considerations:

- The purpose of this process is to check a Veteran's eligibility for community care when a Veteran calls or walks in requesting a primary care appointment.
- Primary Role: Primary Care Clerk or Eligibility Clerk
- Secondary Roles: Facility community care office, C6.

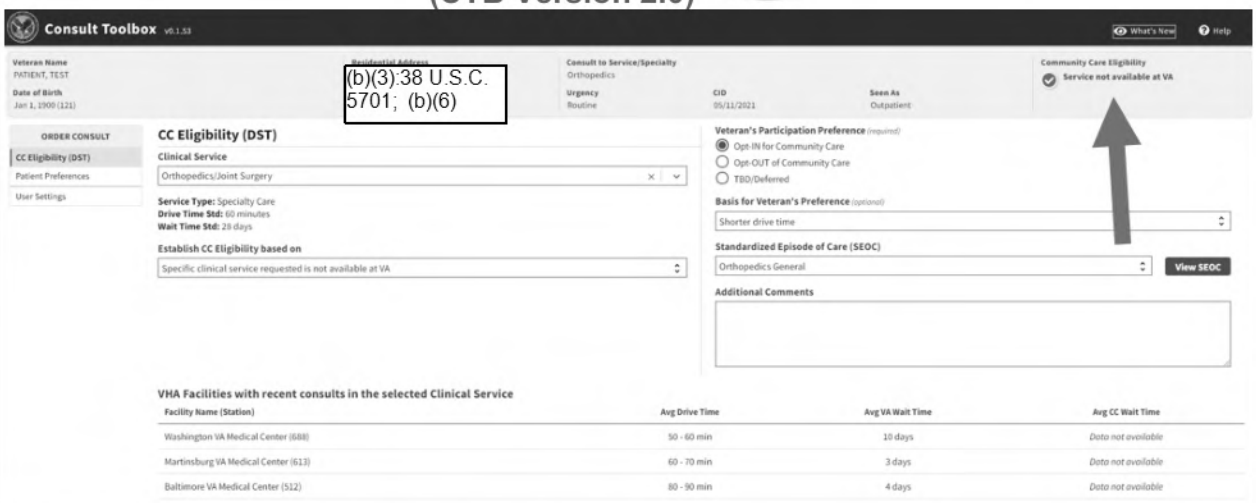
For more information regarding VHA Primary Care Administrative Consults, please refer to:

Primary Care Administrative Consult Training and Primary Care Administrative Consult SOP

STEP	ACTIVITY
1	**Receive request and NEAR list** Primary Care Clerk or Eligibility Clerk receives the Veteran's request for a primary care appointment, as well as the NEAR list.
2	**Check appointment availability in VistA Scheduling Enhancements (VSE)** • If there is an appointment available within 20 days (the applicable wait time standard), schedule a VA appointment. • If there is no appointment available within 20 days, continue to step 3. **Wait time is calculated from the date of request.**
3	**Document the Veteran's opt-in decision** • If the Veteran opts into community care, continue to step 4. If the Veteran opts out of community care, note #COO# in the comments section of VSE and schedule the Veteran for next available VA appointment.
4	**Navigate to CPRS** Navigate to CPRS and begin entering a CC Admin Primary Care consult using the Admin Key. The consult will default the PID to the current date and populate a generic diagnosis. The primary care 6-month SEOC will be embedded.
5	**Select SEOC Duration**

PROCEDURES	
	Select a 6- or 12-month Primary Care SEOC Duration in CTB.
6	**(CTB Version 1.9.0078)** **Launch the MISSION Decision Support Tool (DST)** Click "Launch DST" when prompted. • This pop-up window will now display for any consult that is mapped to a Clinical Service set to DST Required= False. If users do not want to open the DST, they should select close. If they would like to launch DST, they should click on the Launch DST Anyway link. 
7	**(CTB Version 1.9.0078)** **View automatically identified community care eligibilities in DST** The automatically identified community care eligibilities will populate in DST.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
	Please note: Services unavailable eligibility will display as drive time eligibility in the DST MVP. **(CTB Version 2.0)** 
8	**Document the Veteran's opt-in decision.** Document the Veteran's prior opt-in decision to community care, selecting the radio button "Opt-in." In CTB Version 2.0, also select basis for Veteran's Preference and SEOC.
9	**Save consult** Save the consult by selecting the save button.
10	**Finish entering community care consult** Finish entering the community care consult following normal consult entry processes.
11	**Facility community care office receives community care consult** Facility community care office receives consult and reviews eligibility in the comments section.
12	***Facility community care office contacts Veteran to obtain preferences** *Facility community care office contacts the Veteran to obtain their scheduling preferences. * **NOTE: This should be the exception. Every effort will be made to document community care scheduling preferences in all instances prior to check-out or before the consult is forwarded to community care**

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
13	**Facility community care office sends referral to HSRM** Facility community care office sends referral to HSRM.
14	**Facility community care office schedules Veteran or allows Veteran to self-schedule** Facility community care office schedules the Veteran or allows the Veteran to self-schedule.
15	**Facility community care office alerts PACT or C6** • If the Veteran is eligible due to wait time, drive time, or services unavailable, facility community care office staff alert PACT (continue to step 16). • If the Veteran has grandfathered, no full-service VA medical facility in the Veteran's state, or hardship eligibility displayed, the facility community care office staff alert C6 (continue to step 17).
16	**Patient Aligned Care Team (PACT) coordinates Veteran's care** PACT receives an alert, assigns the Veteran to the community primary care provider, and to PACT Team for care coordination. PACT will coordinate the Veteran's care throughout the episode of care.
17	**C6 coordinates Veteran's care (C6 is not in place yet, future state)** C6 receives an alert, assigns the Veteran to the community primary care provider, and to C6 for care coordination. C6 will coordinate the Veteran's care throughout the episode of care, as well as contact the Veteran and provider to define the C6 role verbally and in writing.

2.4 How to Determine and Manage Best Medical Interest (Hardship)

(Pre/Post CCN) **Post MISSION**

Best Medical Interest:

- Medical best interest is NOT to be selected based on convenience or preference
- When using the best medical interest community care eligibility criteria, the ordering provider must enter medical justification for the eligibility determinations listed below:
  - Considerations to include:
  - Nature or simplicity of Service
  - Frequency of Service
  - Need for an attendant
  - Potential for Improved Continuity of Care
  - Difficulty in traveling
- It is important to note, BMI decisions are only to be made by clinical staff members, that are part of the patient's care team. Administrative staff are not to make BMI community care eligibility determinations.

Best Medical Interest (BMI) Definitions:

- **BMI: Nature or simplicity of service:** To be considered if the requested medical services can more easily and safely be provided in the community and would be medically burdensome for the Veteran to receive the care in the nearest VA. Traveling difficulties for the Veteran should be considered in this determination. Examples include routine optometry exam, hearing evaluation or chiropractic care

- **BMI Frequency of Service:** To be considered if the frequency of the requested care is often enough to be a medical or clinical burden to the Veteran to have to travel to the nearest VA to receive. Examples include physical therapy, chemotherapy, radiation therapy etc.

- **BMI: Need for an Attendant:** To be considered when an attendant is required for a specific episode of care. An attendant is any person who provides required aid and/or physical assistance to the Veteran, for a Veteran to travel to a VA medical facility for hospital care or medical services. The provider must consider the care/procedure being requested and/or the Veteran's medical condition when determining the need for an attendant.

  Note: This definition is consistent with the definition of this term in VA's beneficiary travel regulation (see 38 CFR 70.2.), but that definition at § 70.2 is dependent on separate eligibility under the Beneficiary Travel program

- **BMI: Potential for Improved Continuity of Care:** To be considered if the requested service were to occur in VA it would disrupt an established treatment plan with a community provider who delivers stable, consistent care to the Veteran during a specific episode of care. Examples could be: Recent surgery, active chemotherapy. Not for someone who had a knee replacement 2 years ago and wants follow-up, this would require a new consult with a new determination of eligibility for a new episode of care.

- **BMI: Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 minutes for Primary Care and Mental Health and 60 minutes for Specialty Care) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (Social Work consult, etc.) when making this determination

Recommended Process for Capturing BMI using DST:

(CTB Version 1.9.0078)

The Office of Veterans Access to Care (OVAC), and the Office of Community Care (OCC) have developed additional clarification and guidance regarding assessment of community care eligibility, use of the Decision Support Tool (DST), and Best Medical Interest (BMI) criteria based upon field input. All VA Medical Centers (VAMCs) are required to follow the guidance below for new patients to a service.

a. This supersedes the Guidance on Discussion of Veteran Eligibility for Community Care memorandum released June 5, 2019.
b. Primary Care (PC) should only run the DST when documenting BMI, when the provider deems there is a strong clinical reason to use medical hardship for the Veteran to become eligible to receive community care.
    i. PC may also document BMI clinical hardship concerns without completing the DST within the referral request to flag the potential for BMI to the Referral Coordination Team (RCT).
    ii. The RCT will triage referrals, even those with BMI eligibility determinations, to review and discuss with the Veteran available modalities of care within the VA and community and the Veteran's preference for that referral.
    iii. VAMCs should follow the process outlined in Chapter 2 "Eligibility" of the Office of Community Care Field Guidebook (FGB) to document "opt-in" or "opt-out" of community care (https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx).

(CTB Version 2.0)

Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

- VAMCs should follow the Enhancement to Expedite Community Care Appointment Scheduling (VIEWS 02313272) released on February 27, 2020 to capture Veteran's community care scheduling preferences. Note: This process is being re-released by the Office of Community Care in the upcoming weeks.

- PC should have initial, high-level conversations with Veterans about the value of choosing VA for their health care. These discussions should include benefits of continuity of care and understanding of Veterans concerns.
- The RCT must review all possible appointment modalities while triaging the consult to ensure the Veteran understands all options for care within VA. The RCT (including the scheduler on the team) must relay the benefits of choosing VA and indicate medically appropriate in-house care options (VVC, Telephone, and E-consult) for Veterans that reduces risk of COVID-19 transmissions to Veterans and staff.
- A consult *entered directly to community care* must have the BMI eligibility reason captured by the ordering provider. The nurse would not be responsible for capturing the BMI eligibility determination, if not captured by the ordering provider. In this scenario the team would need to work with the ordering provider to capture the recommendation using CTB.
- If the consult is *forwarded from an internal consult service*, the nurse can only indicate BMI if the ordering provider has this documented in the consult.
- The RCT or any person that is scheduling the patient appointment must ask every Veteran if they would like to review their eligibility options for Community Care. The guidance on the process and sequence on how to review community care eligibility reference chapter 2, section 2.0 of the Office of Community Care Field Guidebook.
- While a Veteran who is eligible for community care can always choose whether to receive community care, employees are encouraged to invite Veterans to receive their care through VA's direct system, highlight the benefits of VA care and empower Veterans to be active participants of their care.

There are two types of Best Medical Interest (BMI) eligibility: episodic and hardship/general.

The first is Episodic: Based on the specific episode of care being referred to the community for the duration of that episode of care.

Episodic Best Medical Interest will be captured by the VA provider using the Decision Support Tool (DST) or the CC Eligibility tab in the CTB 2.0.

Example Episodic BMI: Specific Episode of Care- A Veteran is recovering from shoulder surgery and should not be driving long distances. There is a physical therapy location near the Veteran's home and the provider sees that the veteran has no other community eligibilities. If the referring provider and Veteran agree that physical therapy should be furnished in the community, the Veteran would be eligible for an episodic authorization.

It is important to note that, BMI is intended to be entered by the ordering provider at the time of the request for care. Because quality of care and timeliness of care in the VA and the community are not available to the ordering provider, these options have been removed from the CC Eligibility/DST BMI determination. Additionally, non-providers had been using the best medical interest determination in the DST on previously signed consults. To be consistent and compliant with the regulation, as of November 12, 2019, the ability for BMI to be determined using the DST on a consult previously signed by the ordering provider has been removed.

Below are DST scenarios that that have been brought to our attention with recommended mitigation strategies:

- There are providers who ask other team members (i.e., PACT staff) to run the DST and select BMI as the eligibility criteria on a consult that they have already signed. Again,

we have taken away the option to identify BMI on a signed consult and therefore a comment should be placed on the consult and the consult forwarded/routed to community care for them to use the above-mentioned process to document that provider's request. In this scenario, providers should be instructed to please use the DST to document their BMI determination.

- Some providers create community care consults and launch the DST when they're requesting services that they know are not offered at their VA facility (this often happens to providers at CBOCs) but the DST does not show the veteran to be drive time eligible and the provider uses the BMI determination. This is not an appropriate use of BMI and the provider should simply document in the community care consult template the justification of "the service is not available". The community care staff will then use the CTB to document that eligibility criteria. The other option is if an in-house consult was created, the DST should not be launched. The Provider should forward the consult to community care by utilizing the Consult Toolbox (CTB).

Hardship Determination

There are two types of hardship eligibility under the Mission Act.

- Best Medical Interest: An episodic hardship that allows the Veteran to obtain their care in the community for a specific episode of care. This is recommended by either the referring provider or the Referral Coordination Team. Best Medical Interest is discussed in chapter 2, section 2.9 of this guidebook.
- General Hardship: It allows a Veteran to obtain some or all of their care in the community as opposed to Best Medical Interest which is for a specific episode of care.

General Hardship Determination Process:

- The Community Care-Hardship Determination consult can be entered by a referring provider. This consult is reviewed by the Chief of Staff (COS) of a facility, or their delegate, to determine if the Veteran's clinical circumstance or situation is adequate to meet a medical hardship which prevents the Veteran from obtaining their medical care at the VA. **Please note, just because a Veteran is deemed hardship-eligible, that does not mean all their care must be in the community.**
- A consult for each specific episode of care would need to be entered and the Veteran must be given the opportunity to Opt-In or Opt-Out of individual episodes of care as they are requested. The duration of the requested hardship can be either 6 or 12 months. **Please note, some of the listed examples may apply to both the 6- and 12-month options depending on the Veteran's clinical needs.**
- Final determination of approval or disapproval should be made by the COS, or their delegate, based on the Veteran's unique clinical picture and available clinical documentation. Examples are listed below:

6 Months:

- Veteran with recent extended hospitalization with resulting debilitation and delayed recovery necessitating close follow up with multiple community providers/specialists. **Condition is expected to improve.**

- Veteran with a new diagnosis requiring multi-specialist involvement who needs to remain close to home for the duration of treatment **(treatment < 6 months)**
- Veteran with a mental health exacerbation creating a safety risk for the patient or others but the condition is expected to resolve/improve. **Condition is expected to resolve/improve**

12 Months:

- Veteran with chronic debilitating disease which makes it prohibitively difficult to travel to the VA.
- Veteran with a new diagnosis requiring multi-specialist involvement who needs to remain close to home. **For the duration of treatment (treatment > 6 months)**
- Veteran with a cognitive impairment leaving them incompetent to make decisions or provide consent for care. **The Veteran's caregiver needs to remain in their local area.**
- Veteran with mental health issues creating a safety risk for the patient or others. **Condition is not expected to resolve/improve.**
- Veteran requiring continuous assistive equipment, such as a ventilator, that would make travel unsafe
- Veteran is unable to perform the activities of daily living (ADLs) independently and they require a caretaker for basic ADLs.

Hardship Eligibility or General Best Medical Interest is a consult-driven process.

Example General BMI (Hardship): A Veteran was just diagnosed with a malignancy. The treatment plan includes surgery, chemotherapy and radiation therapy L which makes the veteran ill and weak. The duration of this treatment plan will possibly be 9-12 months. The veteran lives near a major university Medical Center that offers not only comprehensive oncologic care but also general and specialty care. The veteran has no other community care eligibilities identified (Drive time or fixed eligibilities like grandfathered in). If the VA provider and the Veteran agree that there is a hardship determination, the Veteran would be eligible to receive community care for one year.

- Potential reasons for general best medical interest (hardship) include geographical challenges, environmental factors, a medical condition that impacts the ability to travel, or if a Veteran needs to travel to their nearest VA medical facility by air, boat, or ferry.

Examples include the presence of a body of water (including moving water and still water), a geologic formation that cannot be crossed by road, roads that are not accessible to the general public (such as a road through a military base or restricted area), traffic, or hazardous weather.

- In the future, VA providers will select a consult duration of either 6 months or 12 months by selecting the appropriate radio button. In June 2019, all hardship consults will have a one-year duration.
- Primary Role: VA providers determine and manage General Best Medical Interest (Hardship) eligibility unless otherwise noted.
- Secondary Roles: Chief of Staff, Facility community care office
- A hardship determination means that the Veteran is eligible to receive community care, but a review for clinical appropriateness is still required by the designated Delegation of Authority.

Last Modified on: Tuesday, August 3, 2021

How General Best Medical Interest (Hardship) is Displayed

The Enrollment System (ES) executes a daily query to extract approved Hardship Determination consults from the Corporate Data Warehouse. The extraction is based on the consult factor HAR-Hardship request approved by COS or by his or her designee paired with the COMMUNITY CARE-HARDSHIP DETERMINATION consult. ES will automatically calculate the 6 months to 12 months expiration date from the date that ES extracts the data (typically the day after the consult is approved). A new future approval would reset the one-year period from the new date ES extracts the new approved consult. Hardship is displayed using the Health Benefit Plan "Veteran Plan - CCP Hardship Determination" in CPRS and VistA, and the eligibility outcome "Hardship" in the Enrollment System.

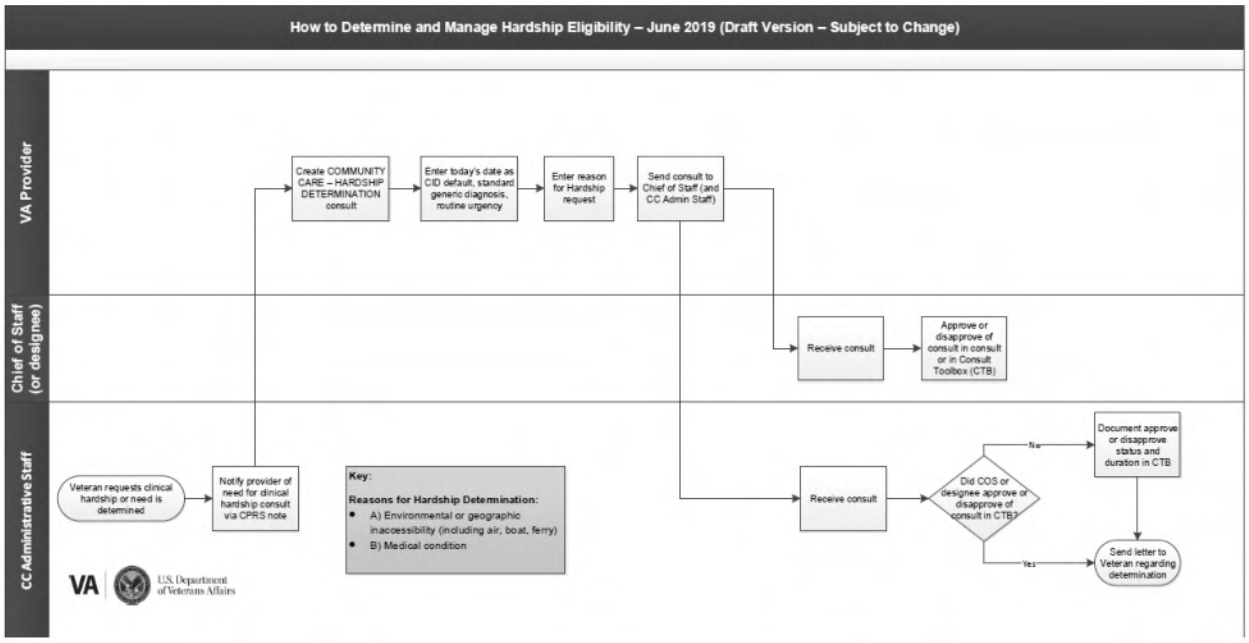
How to View Hardship Eligibility Expiration Dates

Hardship eligibility expiration dates can be found in the Enrollment System on the Eligibility tab in the Community Care Determination page. Within the Hardship panel, the date the hardship was granted and the date the hardship expires are listed. For example, if the consult was approved by the Chief of Staff on 6/13/19, then the "Date Hardship Granted" would be listed as 6/14/19, with the "Date Hardship Expires" listed as 6/14/20.

Historical Hardship Data

Veterans who had unusual or excessive burden eligibility or air, boat, and ferry eligibility under the Veterans Choice Program will also display the hardship determination in ES. Veterans with a hardship determination extending from the Veterans Choice Program will age off two years after the original hardship determination date, unless a new Hardship Determination consult is approved for the Veteran. For example, if a Veteran was assigned a hardship designation on 10/1/2018, this will continue to be assigned until 10/1/2020. If a new hardship consult was approved on 9/1/2020, then hardship would continue to be assigned until 9/1/2021.

Last Modified on: Tuesday, August 3, 2021



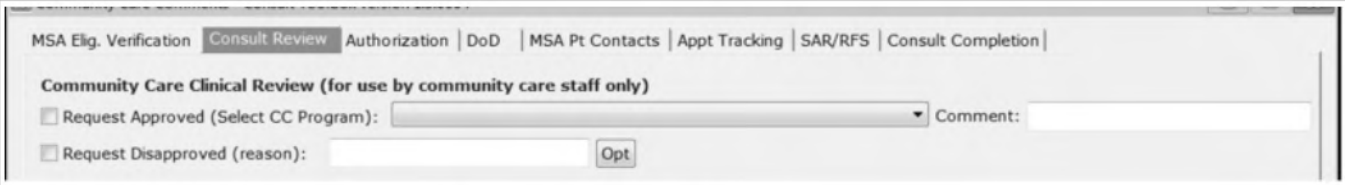
PROCEDURES

STEP	ACTIVITY
1	**Determine need for General Best Medical Interest (Hardship) Consult** If a Veteran requests hardship or if the need for hardship is determined, OCC staff will inform the provider by adding a note to CPRS
2	**Determine if appeal is related to address or clinical need** • If the appeal is related to an address, continue to step **3.** • If the appeal is related to a clinical need, continue to step **4.** **Add a note to CPRS** Facility community care staff will add a note to CPRS to inform the provider of the need for a hardship consult.
3	**Create "COMMUNITY CARE – HARDSHIP DETERMINATION" consult in CPRS** For detailed instructions on how to create a consult in CPRS, please refer to Chapter 2 of the Field Guidebook

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
	
4	**Enter clinical information** Enter today's date as the CID default, the standard generic diagnosis, and the urgency as routine into the ADMIN HARDSHIP consult.
5	**Enter reasons for General Best Medical Interest (Hardship) request** The reason for a Hardship request includes: Environmental or geographic inaccessibility (including air, boat, ferry) Medical condition with a required text field for its description
6	**Enter the duration** Enter 6 months or 12 months duration in reason for request field.
7	**Send consult to Chief of Staff and facility community care office administrative staff**
8	**Receive consult** Chief of Staff and facility community care office admin staff receive the consult.
9	**Approve or disapprove of consult in Consult Toolbox (CTB)** This step is performed by the VA medical facility Chief of Staff.
10	**Administratively close the consult and comment on whether the consult was approved or disapproved by the Chief of Staff** This step is performed by the facility office of community care staff.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
	
11	**Send letter to Veteran regarding determination** • If the Chief of Staff approved or disapproved of the General Best Medical Interest (Hardship) eligibility, send the Veteran a letter regarding the determination. • If the Chief of Staff did not approve or disapprove of the General Best Medical Interest (Hardship) eligibility, document the status and the duration in Consult Toolbox and then send the Veteran a letter regarding the determination. • COS or designee should send the decision letter • The Hardship Determination Letter Template is available here Approved Community Care-Best Medical Interest (Hardship) Determination Approval & Disapproval Letter **Note:** These letters are also available to the facility Clinical Application Coordinators to create a letter template in CPRS.

Monitoring BMI Usage using Available Reports:

The BMI Usage Reports presentation and the BMI Usage Report Training Video are available for review.

The Office of Community Care (OCC) has collaborated with VSSC and created reports to monitor the usage of BMI at the facility level. These reports allow facilities to determine usage of BMI recommendations within the medical center. The reports will allow for analysis and trending to answer questions such as:

1. What providers in my facility are referring care to the community using BMI as an eligibility reason?
2. What are the referral trends for BMI at my facility or VISN level?
3. Are providers entering consults directly to community care for care that is offered within my facility, with BMI as an eligibility reason?

In order to answer these questions, in addition to other questions facilities should use the following reports:

Last Modified on: Tuesday, August 3, 2021

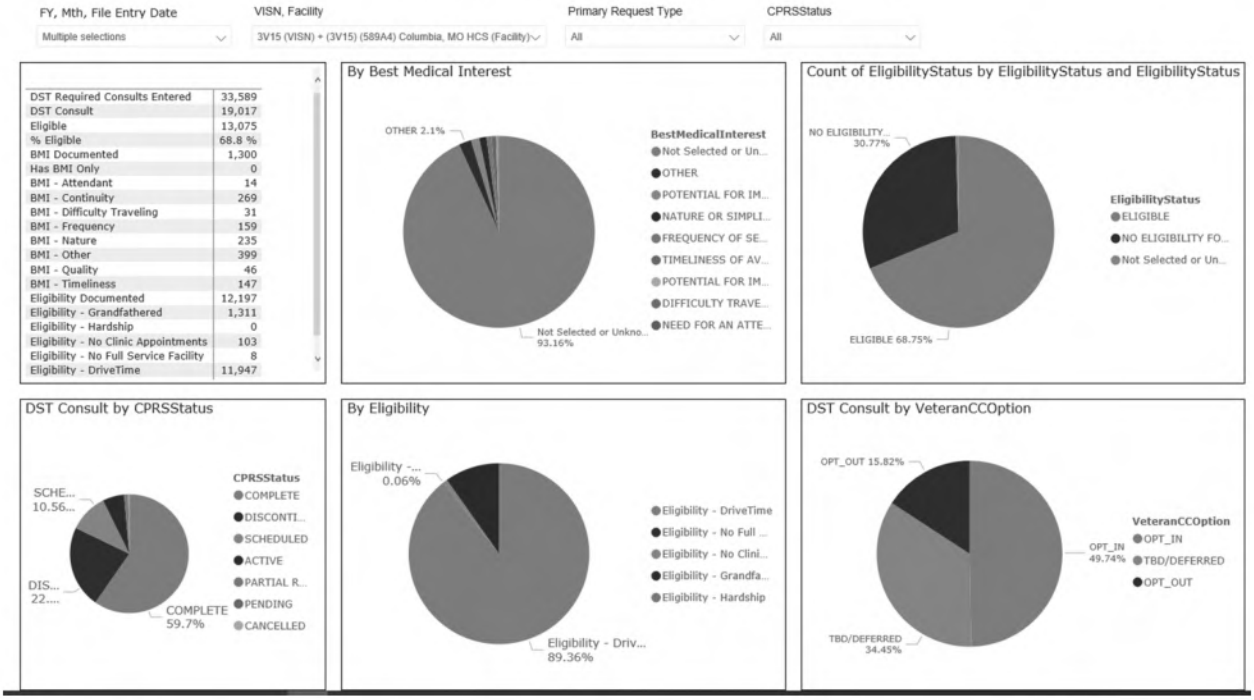
(CTB Version 1.9.0078)

DST Usage Report:

The DST Usage Report allows end users to review consults where the Decision Support Tool (DST) has been used to capture the community care eligibility reason. The report has many tabs to assist with analyzing community care referral patters and DST usage patterns. There are a few specific tabs that are the most beneficial when analyzing DST BMI data captured.

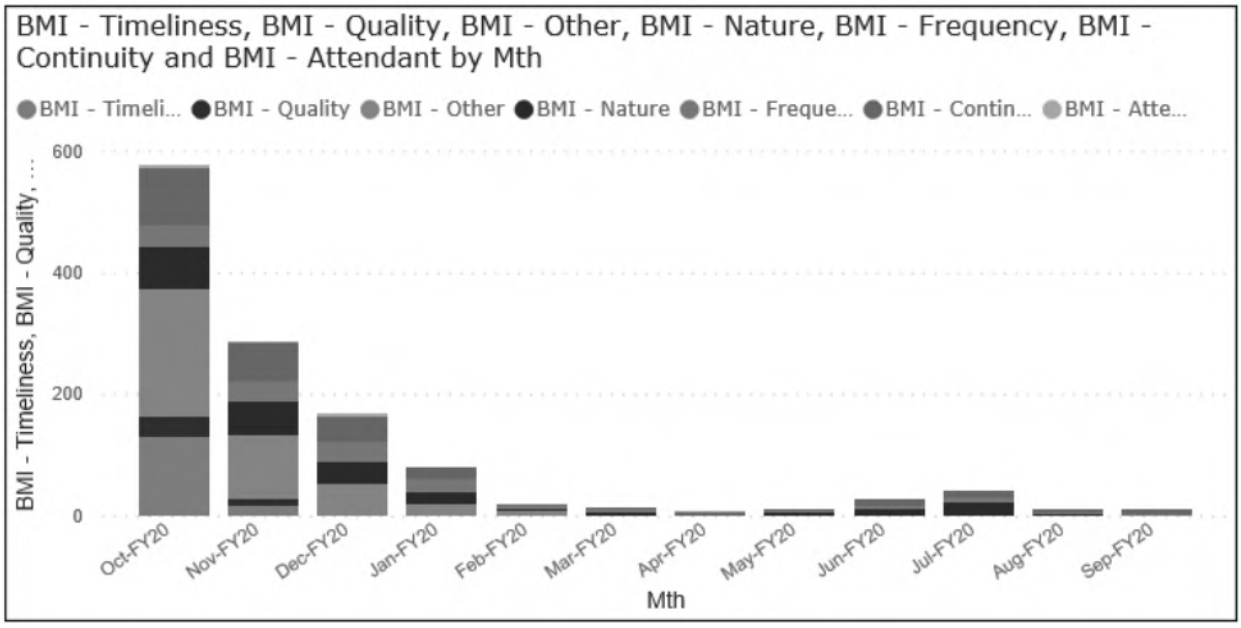
***It is important to note that the DST Usage Report only captures community care eligibility information when DST is used.**

1. **Summary Tab-** This tab captures information at the national, VISN or facility level for overall DST usage and eligibility reasons captured using DST. Sites can drill down to the Primary Request type in order to see community care consults specifically had DST ran and the specific eligibility reasons captured with DST.

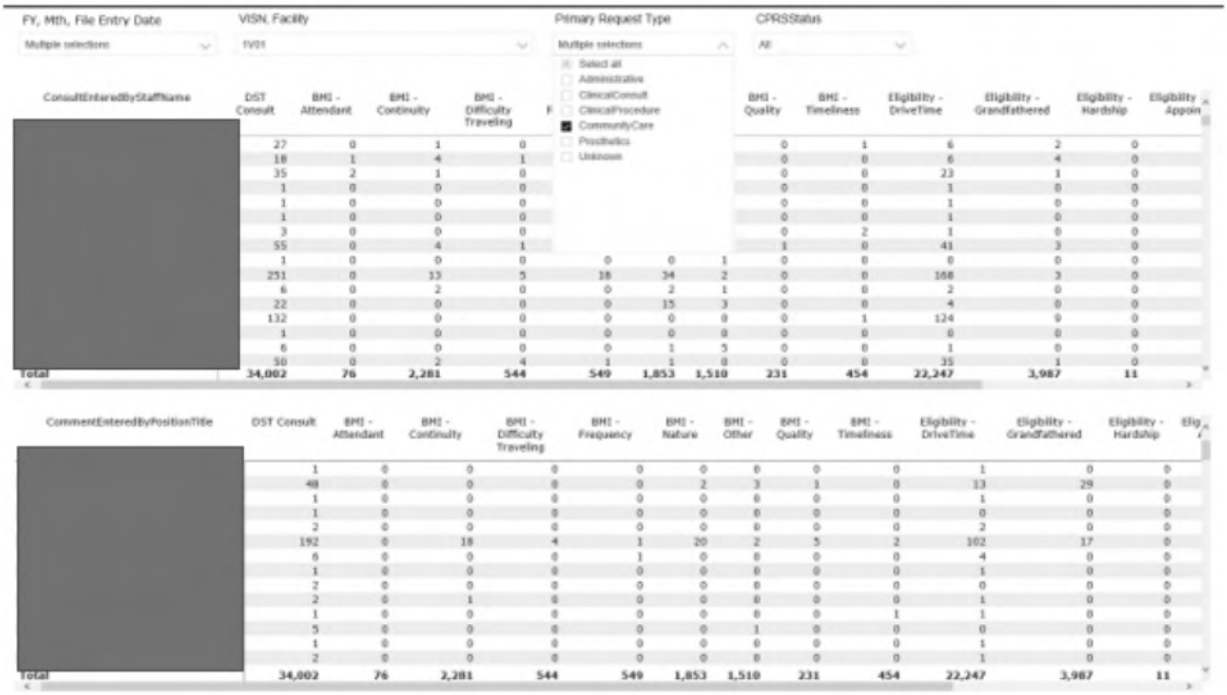


2. **Usage Trend Tab:** This tab captures monthly trends in BMI usage at the National, VISN or facility level. The trend report captures monthly overall usage and also breakdown by the specific BMI option selected within DST.

Last Modified on: Tuesday, August 3, 2021



3. **Usage by Ordering Provider Tab:** This tab captures DST usage by staff and position title. End users can review the type of community care eligibility selections made by these staff using DST. In order to drill down to community care consults, end users can select “community care” under the Primary Request Type drop down.



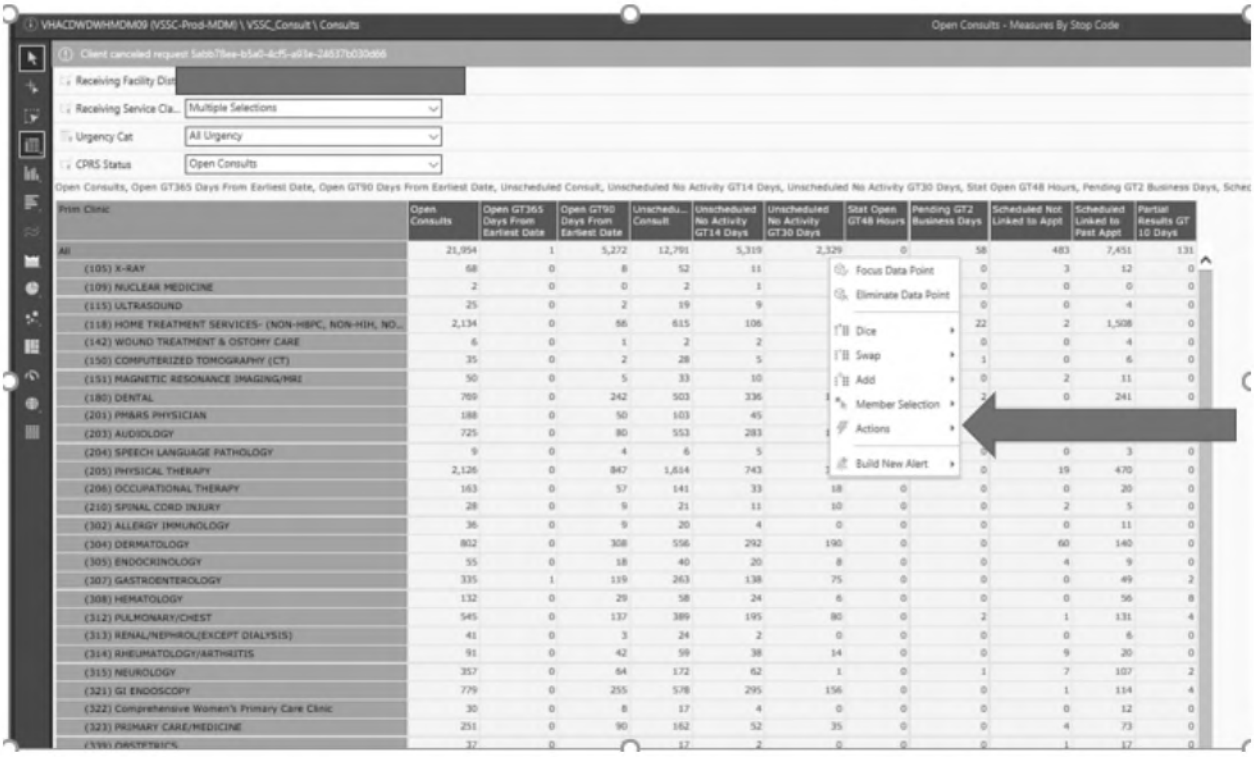
Last Modified on: Tuesday, August 3, 2021

(CTB Version 1.9.0078) **(CTB Version 2.0)**

Consult Cube:

The consult cube allows VISNs and facilities to capture consult level information in order to monitor and track consult actions. Once in the Consult cube end users can select “Open in Pyramid Analytics. Once on the page, end users can drill down to National, VISN or facility level data. Additionally, within the consult cube, when extracting the SSN level data end users can drill down to community care consults and review the consult justification reasons used for consults that were entered directly to community care.

In order to drill down to the SSN level access end users must have the correct level of access. Please reference the PHI/SSN Access FAQ for assistance with this process.

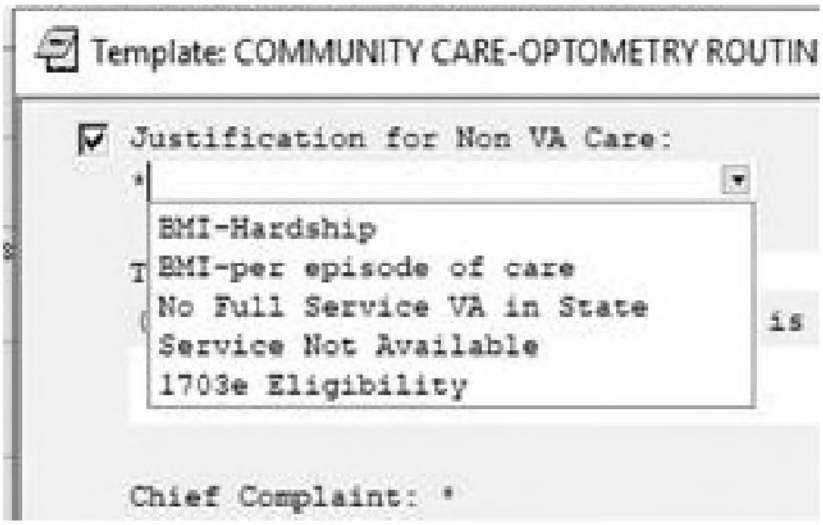


Once an end user drills down to the SSN level information a separate page will open, that can be exported to CSV or Excel. Once exported end users can review the “Consult Reason” tab for consults that were entered directly to community care in order to determine the consult justification reasons used.

Last Modified on: Tuesday, August 3, 2021

The end user will need to analyze the data in order to capture justification reason trends.

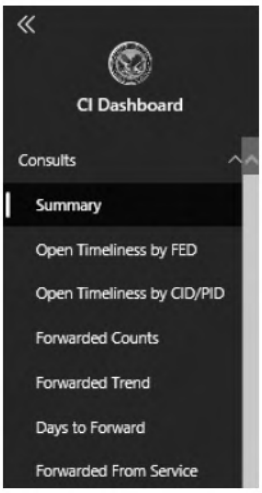
The Office of Community Care is working with VSSC to try to develop a report that captures this data in a format that is easier to manipulate.



CI Power Bi Dashboard:

This report is only available to the VISN Business Implementation Managers (BIMs) at this time. The Office of Community Care is actively working with VSSC to make this information available to all end users.

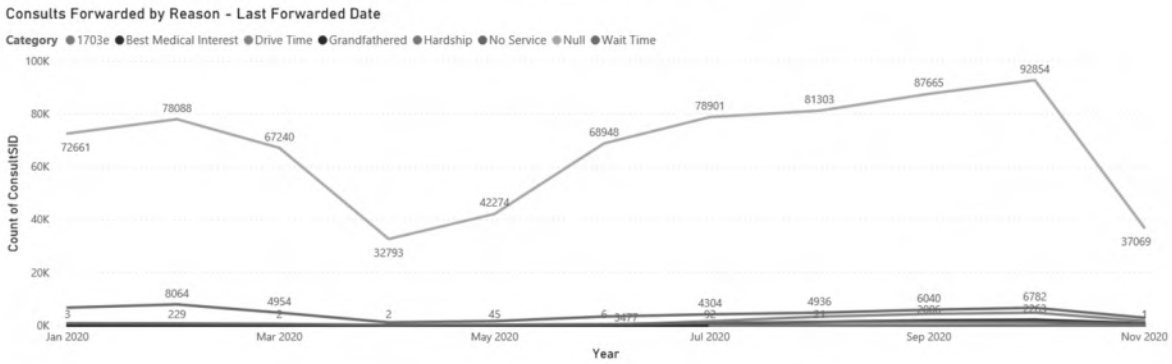
In the CI dashboard there are multiple reports to monitor forwarding trends. Sites can monitor number of consults forwarded to community care over a specific timeframe. Additionally, sites can review forward community care eligibility reason trends, when end users use the Consult Toolbox to forward a consult to community care



Last Modified on: Tuesday, August 3, 2021

Consults Forwarded by Reason - Last Forwarded Date

Year	1703e	Best Medical Interest	Drive Time	Grandfathered	Hardship	No Service	Null	Wait Time	Total
2020	**114**	**7,185**	**17,323**	**381**	**336**	**9,717**	**739,796**	**51,420**	**826,268**
January		3	218	12		917	72,661	6,850	**80,661**
February			229	15		812	78,088	8,064	**87,208**
March		2	219	22		642	67,240	4,954	**73,079**
April		2	38	5		266	32,793	1,265	**34,369**
May			45	4		355	42,274	1,729	**44,407**
June		6	187	5		554	68,948	3,477	**73,177**
July	92	539	1,700	45	30	1,041	78,901	4,304	**86,652**
August	21	1,436	3,448	45	62	1,444	81,303	4,936	**92,695**
September		2,006	4,486	92	127	1,557	87,665	6,040	**101,971**
October		2,263	4,947	96	82	1,464	92,854	6,782	**108,486**
November	1	928	1,806	40	35	665	37,069	3,019	**43,563**
Total	**114**	**7,185**	**17,323**	**381**	**336**	**9,717**	**739,796**	**51,420**	**826,268**



2.5 Best Medical Interest vs. Delegation of Authority

Best Medical Interest is one criterion used to determine eligibility for community care under the MISSION Act.

Delegation of Authority is used in the consult review process for determining clinical appropriateness of a requested service prior to approval.

Best Medical Interest (BMI)	Delegation of Authority (DOA)
• One of six eligibility criteria that can qualify a Veteran to receive community care • Potential reasons for general **BMI** include geographical challenges, environmental factors, and clinical needs based on medical condition • **Example**: If a Veteran has a certain type of ovarian cancer which their VA oncologist is not experienced in treating, and the Veteran lives close to a community medical facility where there is a specialist for that type of cancer, the Veteran could be eligible for community care if the clinician and Veteran agree it is in the **best medical interest** of the Veteran to receive treatment from the community medical facility	• After eligibility has been confirmed, clinical review is performed to determine if the requested services are clinically appropriate to be authorized for delivery in the community • Clinical review should be completed by staff who have been given **DOA** by the facility's Chief of Staff • If the provider entering the consult is also listed as the delegated authority, the clinical review requirement is met and subsequent review is not needed to authorize a referral into the community • **Example**: If the VA oncologist enters the community care consult for cancer treatment and has **DOA** for this service, additional clinical review is not required. If the VA oncologist is not the delegated authority, the consult should be routed to the appropriate clinical reviewer(s)

BMI and DOA are key components of the community care process flow when facility OCC staff receive a request for services (RFS)

Last Modified on: Tuesday, August 3, 2021

2.6 Mileage Eligible Veteran Requesting an Appointment

PROCEDURES

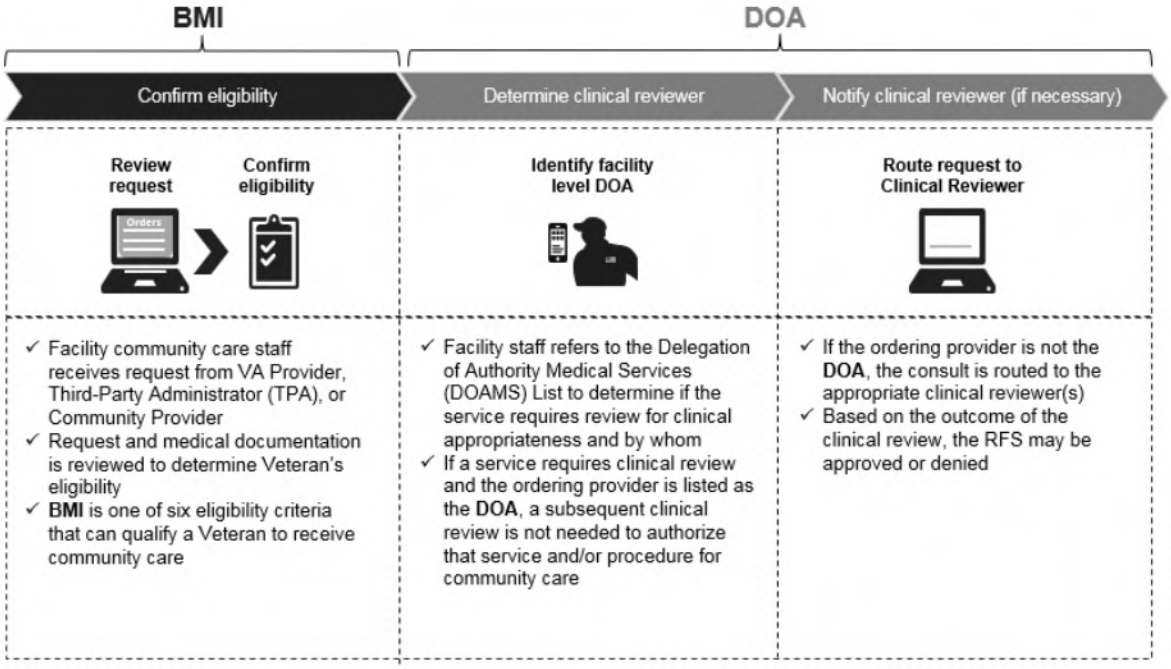
General Considerations: On 5/1/2019, VAMCs began care coordination for Mileage Eligible Veterans. TriWest will refer all Mileage Eligible Veteran calls to the local VAMC for resolution. Facility community care staff should follow the process below when a DEV calls to request an appointment.

STEP	ACTIVITY
1	Call is answered by VAMC.
1a	Veteran's record is in CPRS. Proceed to Step 2.
1b	Veteran's record is not in CPRS. Proceed to Step 3.
2	Confirm Veteran is mileage eligible in Enrollment System, Vista or CPRS. The eligibility process is detailed in Chapter 2 of the Field Guidebook.
2a	If Veteran is not eligible and feels the information is incorrect, provide Veteran with the phone number and POC for the Eligibility Office at the VAMC.
2b	If Veteran is eligible, proceed to step 4.
3	If Veteran is not in CPRS, confirm Veteran is mileage eligible via Enrollment System.
3a	Send encrypted email to the facility VAMC eligibility POCs.
3b	Include the facility office of community care staff scheduling personnel on email to the Eligibility Office.
3c	Facility office of community care staff will determine a method to track these Veterans so that they can appoint when the record has been entered into CPRS.
4	Inquire what type of care the Veteran is requesting.
4a	If the request is for a primary care (PC) appointment with a VA provider, call the Primary Care Provider Office.

4b	If the request is for a PC appointment with a community provider:
	• A consult would be placed using the COMMUNITY CARE-ADMIN PRIMARY CARE consult.
	• Chief of Staff or designee must identify the PCP POC in the VAMC who will place all PCP Consults and any Community Care Provider Orders.
	• Input authorization using the steps provided in Chapter 5 of the Field Guidebook:
	  • CCN
	  • PC3
	  • VCA (when available)

4c	If the request is for care covered under Direct Scheduling, refer to Chapter 2.14 of the Field Guidebook for Direct Scheduling guidance.
4d	If the request is for specialty care, refer Veteran to PCP who can evaluate and make a referral for the service. Create a Community Care coordination note to document this call.

PROCEDURES	
4e	If the request is from a Community Primary Care Provider for Specialty Care, forward the request to the Provider designated by the Chief of Staff or designee who will place Community Care Provider Orders.



2.7 Special Notes for Former Distance-Eligible Veterans (Grandfathered Veterans)

(Pre/Post CCN) **(Post MISSION)**

Former distance-eligible/grandfathered Veterans who receive care exclusively in the community will be managed by at the facility level.

Per the **Veteran Community Care Eligibility Factsheet**, a Veteran qualifies under the "Grandfather" provision by two different ways. Initially there are two requirements that must be met in every care:

- Veteran was eligible under the 40-mile criterion under the Veterans Choice Program on the day before the VA MISSION Act was enacted into law (June 2018), and
- Veteran continues to reside in a location that would qualify them under that criterion.

If both requirements have been met, a Veteran may be eligible if one of the following is also true:

- Veteran lives in one of the five States with the lowest population density from the 2010 Census: North Dakota, South Dakota, Montana, Alaska and Wyoming.

Last Modified on: Tuesday, August 3, 2021

Note: Any changes to the Veterans Community Care Eligibility codes will be reflected in the Enrollment System (ES). Those systems like the Decision Support Tool (DST), HealthShare Referral Manager (HSRM) that subscribe to the E&E web service will still ingest the required data.

Only the Veterans who are Grandfathered eligible (those who received care under the title 38 rule during June 6, 2017 through June 6, 2020) based on care data are impacted. Beginning June 7, 2020, for those Veterans whose Grandfather eligibility is based on care date, the ES will recalculate the Community Care static eligibility based on the information on in the Veterans record.

The Grandfathered eligible Veterans based on the five (5) low-density states will not be affected and the Veterans Community Care Eligibility Codes of G (Grandfathered) will remain in the ES. Also, those Veterans that relocate to the low-density states will be calculated as G=Grandfathered.

2.8. Routing, Clinical Review of Community Care Consults and Determining What Services to Authorize

(Pre/Post CCN)

After services have been requested and eligibility has been confirmed, clinical review is performed to determine if the requested services are clinically appropriate to be authorized for delivery in the community, or if any service can be delivered at the local VA Medical Center (VAMC). Clinical review is completed by using industry standard tools, evidence-based medicine, and/or local guidance (as defined by the VA facility's Chief of Staff) to determine if a service is needed based on the Veteran's diagnosis and clinical acuity.

Last Modified on: Tuesday, August 3, 2021

2.9 How to Determine Eligibility for Community Care

The process for determining a Veteran's eligibility uses the Decision Support Tool (DST). The Veterans Health Administration (VHA) Office of Community Care has created a real-time decision support tool to help VA Providers and Veterans quickly review the criteria prescribed in the VA Mission Act of 2018, determine whether a given Veteran is eligible and would be best served utilizing the Veterans Community Care Program, and document the decision rationale in the Veteran's health record. The Decision Support Tool (DST) is a software tool that helps standardize how VA providers & staff decide the appropriate location for a Veteran to receive care. DST provides the availability of services within the VA & about the Veteran's eligibility for Community Care. Additionally, the DST documents the outcome of the decision process by adding a standardized comment to the consult. DST is designed for analyzing internal VA consults.

The DST software will:

- Allow the care provider to view relevant data within the existing CPRS consult order workflow, that helps the guide the conversation with the Veteran to decide if a consult service should be referred to the local VA facility, a near-by VA facility via Inter-Facility Consults (IFC), or to a community provider by providing information about the following:
    - Veteran's static community care eligibility for accessing care in the community
    - Drive time standards associated with the requested consult service.
    - Average wait times for the requested clinical service at VA facilities near the Veteran's place of residence and average wait times for community care appointments. Note that average wait times may not be used to determine wait time eligibility.
    - Capture the Veteran's stated preferences (opt-in/out) or To Be Determined (TBD)/Deferred.
- Document the rationale for the referral decision in the consult record.
- Generate structured text based on the displayed results that can be used for downstream report generation.

Separate processes exist for determining eligibility for an established clinic Veteran, a new clinic veteran, making a general inquiry, determining eligibility based on a new enrollee appointment request, and special notes are also included regarding the process for former distance-eligible Veterans (grandfathered Veterans). Reference the Office of Community Care Decision Support Tool Contingency SOP for the step by step guidance on the process to follow in the event that DST is unavailable.

Information for users regarding updates to the Decision Support Tool

DST Mapping changes and technical updates can be tracked in the What's New pop-up that appears when users access DST. To ensure the DST is most optimal for end

user, the tool is being continuously updated and improved. The What's New content details the changes of past builds and gets updated to do the same for future builds.

DST Mapping File can be viewed on the DST- Clinical Service Mapping spreadsheet
This spreadsheet details the specific DST stop code, clinical service and SEOC mapping.

- **Best Medical Interest of the Veteran**
  In order to better align DST with national guidance on establishing community care eligibility based on the Veteran's best medical interest, the following updates will be made to DST:
  - The Best Medical Interest control will become read-only when DST is launched from a signed consult.
  - The Best Medical Interest control will only be available when DST is launched from an unsigned order and will only appear if DST does not identify any other community care eligibility criteria for the Veteran.
  - The dropdown list of Best Medical Interest justifications will be shortened. The justifications below will remain available:
    - Nature or simplicity of service
    - Frequency of service
    - Need for an attendant
    - Potential for improved continuity of care
    - Difficulty in traveling

Released in March 2020

Best Medical Interest of the Veteran

The preferred process for capturing the Best Medical Interest (BMI) community care eligibility determination is for the referring provider to use DST at the time of submitting the consult, to communicate the BMI eligibility reason recommendation. Once BMI is documented, the Referral Coordination Team (RCT) or specialty clinic should review the consult to determine if other appointment modalities are available within the VA or if a referral to community care is the best option for the Veteran after he/she opts-in to community care.

Providers can also document considerations in the body of the consult for the RCT to consider when reviewing the consult with the Veteran, but this is not considered a true BMI eligibility determination by the ordering provider.

At the time of using DST, the referring provider will experience the following updates:

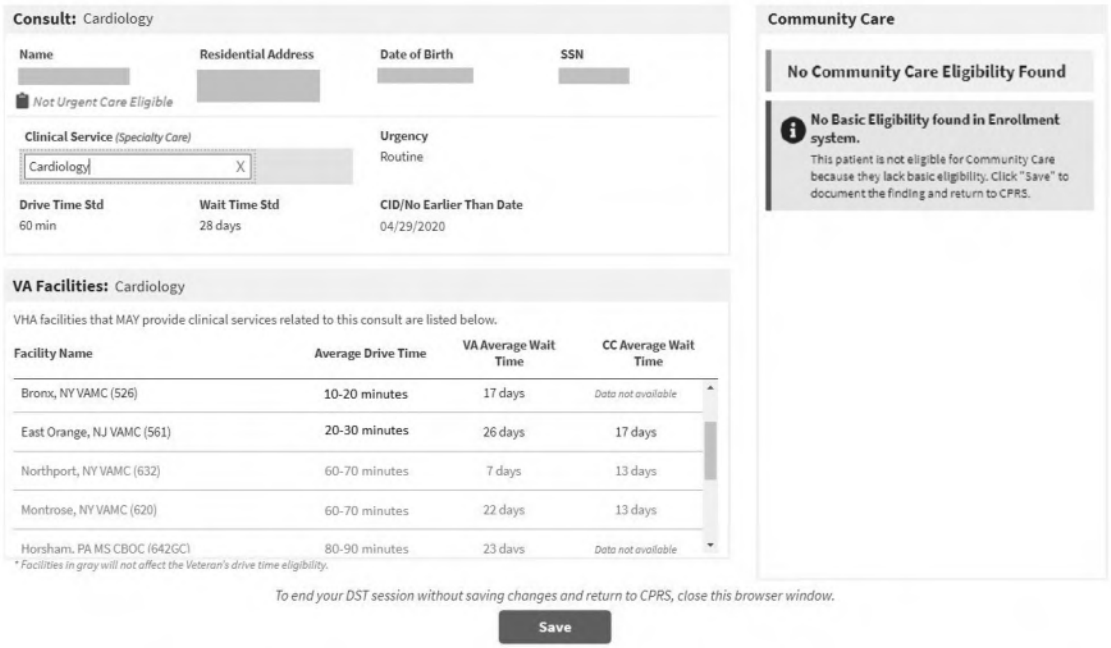
- The 'Other' option will be removed from the dropdown list of Best Medical Interest justifications.
- An additional option 'Difficulty in traveling' will be added to the dropdown list of Best Medical Interest justifications. The list will become:
  - Nature or simplicity of service
  - Frequency of service
  - Need for an attendant
  - Potential for improved continuity of care
  - Difficulty in traveling

Definition **BMI: Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 minutes for Primary Care and Mental Health and 60 minutes for Specialty Care) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (Social Work consult, etc.) when making this determination.

- Referring providers using DST to establish Community Care eligibility based on any Best Medical Interest justification must enter a brief rationale explaining the medical need in the free-text field that appears below the justification selection.

Other DST Changes

- If a patient is designated in the Enrollment System (ES) as ineligible for community care, DST will now display a message indicating that a patient is ineligible for Community Care because they lack Basic eligibility.
    - This affects patients eligible for VA care but not otherwise eligible for community care, such as CHAMPVA patients being seen at the VAMC under the CITI program.



- To ensure that DST is used as an eligibility tool rather than as a scheduling tool, the following enhancements will be made:
    - Clinically Indicated Date and consult urgency will be become read-only in DST. The CID and urgency from CPRS will display in DST.
    - Providers who have used the 'Special Instructions' feature of DST will no longer be able to do so. Instead, providers may indicate additional scheduling instructions via an added comment on the body of the consult.
    - DST will no longer calculate or display a "No Later Than Date" on consults except for the following: Veterans Community Care Program Eligibility (VCCPE), community care direct scheduling and community care admin primary care consults.
    - DST will no longer add text to the consult reporting "No Earlier than" or "No Later Than" dates.

- To better support community care wait time eligibility determinations on VCCPE, community care direct scheduling and community care admin primary care consults, the field 'No Later Than Date' has been renamed to 'Wait Time Eligibility Date.'

- Wait Time Eligibility Date is calculated as Today (i.e. the date DST information is linked to the consult) plus the Wait Time Standard (20 days for Primary Care/Mental Health; 28 days for Specialty Care; 1 day for Stat consults).
- If the CID is greater than Today plus the Wait Time Standard, the consult is not applicable for wait time eligibility and the following message will be displayed: *'Wait time eligibility for community care is not applicable for this consult due to the CID not being within the wait time standard.'*
- See additional wait time eligibility details in the OCC Field Guidebook in Chapter 2, section 2.19
- Addition of Community Care Average Wait Time- June 22, 2020
- Adjustment to VHA Average Wait Time- June 22, 2020
- Support of Clinical Service Synonyms- May 19, 2020
- Updates to the Clinical Service Mapping

Community Care Average Wait Time

Community care wait time is calculated by determining the average time from the date a community care appointment is made to the date of the appointment itself, as recorded in Health Share Referral Manager (HSRM). DST displays the average wait times of all appointments booked or completed under Standard Episodes of Care (SEOCs) related to the requested clinical service, based on a rolling 90-day assessment. The Community Care data displayed is for community care appointments associated with the facility and SEOCs associated with the selected clinical service. This information is provided to inform providers, schedulers and Veterans of the comparable wait time in the community so they can make an informed decision when considering community care.

The average wait times reflected for community care appointments are based on the community care appointment being captured in HSRM. This specific calculation is based on the following:

- Days between the appointment made date and the appointment date based on HSRM calculations
- HSRM referrals with an appointment in booked or completed status and an appointment date time within the past 90 days
- Exclusions
  - Appointments with a null made date or appointment date
  - Appointments with a made date greater than the appointment date
- No minimum referral number required in order to capture the community care wait time average

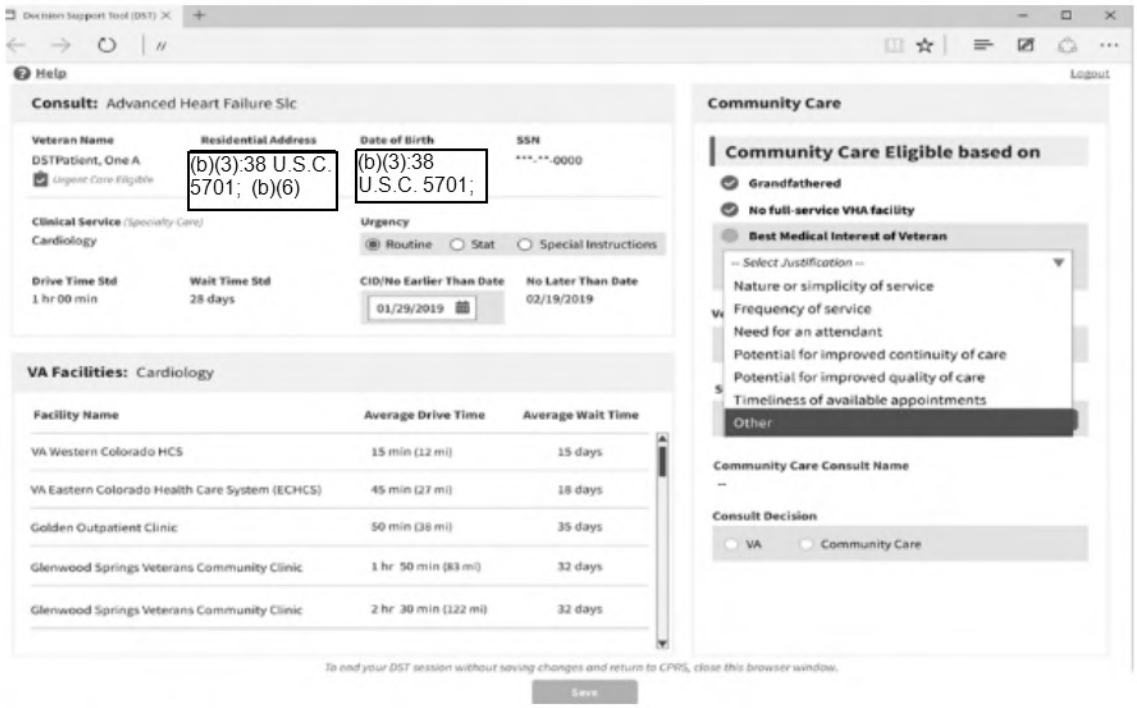
The addition of the community care average wait time to DST will assist end users; to include the Referral Coordination Team and specialty clinic schedulers, when having that thoughtful conversation with Veterans regarding their VA and community care options and the average wait times both in VA and community care. It is important to note, DST is providing the average wait time for both calculations and not the exact wait time. The methodology of the calculations is the same and, in both situations, the exact wait time is determined at the time of scheduling when knowledge of the next available appointment is accessible.

When having the conversation with the Veteran, after community care eligibility has been determined, the end user should note the following:

1. Available options within the VA to provide the care (i.e. IFC, e-consult, TH etc.)
2. Review the average wait times in the community and within the VA for the care being requested in order to provide the patient with an overall idea on the appointment wait time, once the request is routed.
3. Emphasize that the DST derived average community wait times are not reflective of the actual available appointments at any one community provider's office but an average of all community providers who offer the service to Veterans seen at this VAMC's Healthcare system (CBOCs and off-site facilities).
4. If the Veteran opts into community care, at that time capture the Community Care Scheduling Preferences (for additional guidance see chapter 2, section 2.19) prior to forwarding the consult to a community care consult title.

Adjustment to VHA Average Wait Time- The internal appointment data logic in DST will temporarily be adjusted to capture pending or completed appointments back to January 1, 2020 and forward as a result of the COVID-19 impact on VHA appointments.

Last Modified on: Tuesday, August 3, 2021



DST COVID-19 Impact Updates:

- During the COVID-19 Pandemic, many VA facilities have seen a reduction in the number of face to face VHA appointments scheduled or have been offering telehealth alternatives for more than 60 days. For this reason, some VA facilities that do offer specific services are no longer seeing this information reflected in the DST facilities list.
- To resolve this issue, the algorithm used to capture VHA Average Wait Time data in DST will be temporarily updated to identify VA facilities within the search radius that report pending or completed appointments back to January 1, 2020 linked to consults associated with the stop code of the selected clinical service. Facilities that only offer the service via telehealth are excluded.
- The search radius logic in DST includes VA facilities within a 90-minute drive time radius of the Veteran's residential address that may offer the requested service.

Clinical Service Synonyms

DST now supports Clinical Service Synonyms. When you are selecting the Clinical service, you can start typing the value you are looking for. Common synonyms are searchable and will appear in the drop down along with the official clinical service name. When you select a Clinical service synonym from the drop-down list, the official clinical service name will be displayed. Only official clinical service names will be saved with the DST information and written to the consult when signed.

Example:

Value typed in the clinical service field: acupuncture

Clinical service drop-down option displays: Acupuncture <Complementary and Integrative Health Treatment>

When selected, Clinical Service field displays: Complementary and Integrative Health Treatment

Clinical Service Mapping Updates

The following Clinical Services have been added and are available for selection in DST, per the MCAO FY20 Mid-Year Active Stop Codes list (http://vaww.dss.med.va.gov/programdocs/pd_oident.asp):

391 Cardiac ECHO

392 Ambulatory ECG Monitoring

The following Clinical Services have been renamed, per the MCAO FY20 Mid-Year Active Stop Codes list (http://vaww.dss.med.va.gov/programdocs/pd_oident.asp):

311 Cardiac Implantable Electronic Devices (CIED) (previously Pacemaker)

372 Weight Management and MOVE! Program- Individual (previously MOVE! Program-Individual)

Released 12/19/19

Improved Data on VHA Facilities Displayed in DST

In order to improve the accuracy of the list of VHA facilities and average wait times shown in DST, DST will update its data sources. The updated data's methodology is described below:

- **VHA facilities** being displayed have pending or completed appointments within the last 60 days that are linked to consults associated with the stop code of the selected clinical service and will be sorted by drive time from the Veteran's residential address. Facilities that only offer the service via telehealth will be excluded.
- **Average wait time** is calculated as the rolling average of wait times (time between create date and appointment date) for new patient completed appointments with the stop code of the selected clinical service, within the last 30 days.

Average wait time is displayed in DST for reference only. Eligibility for community care based on wait time should be determined at the time of scheduling, not in the DST.

Released 10/16/2019

- **Consults to Launch Administrative Dashboard:** Administrative Primary Care consults and Community Care Direct Scheduling consults will now launch the Administrative DST dashboard, the same dashboard that launches from VCCPE consults. Within the Administrative DST Dashboard, you will no longer be given the opportunity to select SEOCs via DST. You must use the Consult Toolbox Authorization tab to select the SEOCs. View the DST- Clinical Service Mapping spreadsheet, and navigate to the Admin list tab for the full list of consult titles that launch the Administrative DST dashboard.

Released on 9/18/19

- **Radiology/Nuclear Medicine Services in DST:** Following an update to DST's data sources, Radiology/Nuclear Medicine clinical services have been reenabled in the DST. The following Radiology/Nuclear stop codes will both prompt the launch of DST and will be available in the clinical service dropdown menu within the tool:

  - 105 X-ray
  - 109 Nuclear Medicine
  - 110 Interventional Radiology Pre-/Post-Procedure Consult
  - 115 Ultrasound
  - 145 Myocardial Perfusion Studies
  - 150 Computerized Tomography (CT)
  - 151 Magnetic Resonance Imaging (MRI)
  - 153 Interventional Radiography

  Staff should resume using the DST for Radiology/Nuclear Medicine consults to assist with determining community care eligibility, based on MISSION Act criteria.

Veteran Eligibility Status Workflow

- As of Release 11.0 of HSRM (11/23/2020), HSRM will check the eligibility status in Enrollment System
  - If a veteran is eligible for Community Care, the normal referral workflow will be followed
  - If a veteran is not eligible for Community Care, the system will prevent addition of Program Authority and further action on a referral. Users will need to contact their Eligibility department and/or refresh Eligibility data.

- Workflow Details:
  - (1) On the Referrals Details screen, if a VCE code of X is received, the Program Authority field will be greyed out with a message alert "Veteran is not eligible for Community Care, contact your local Eligibility Department and try refreshing the Eligibility Screen".

  - (2) When a user navigates to the 'Eligibility' screen from the 'Referral Detail Screen', in the 'Eligibility Status' section, the description reads 'Not Eligible' reflecting a VCE code of X in the background. The X code is not displayed
  - (3) The 'Refresh Eligibility Data' button is available only when a veteran is 'Not Eligible.' When an 'Eligible' VCE status code is received, the 'Refresh Eligibility Data' button is greyed out

- *Note: A user may select 'Refresh Eligibility Data' multiple times if expecting an updated eligibility status*
- *Note: Eligibility is referral specific, not veteran specific*
- *Note: In CTB v2.0 (Tentative: Feb 2021) a user will only be able to send a consult to HSRM if the patient is eligible for CC*

(CTB Version 2.0)

Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0 tool to help VA Providers and Veterans quickly review the criteria prescribed in the VA Mission Act of 2018, determine whether a given Veteran is eligible and would be best served utilizing the Veterans Community Care Program, and document the decision rationale in the Veteran's health record.

The Decision Support Tool (DST) Community Care Eligibility Software built into the CTB 2.0 helps standardize how VA providers & staff decide the appropriate location for a Veteran to receive care by providing the availability of services within the VA & about the Veteran's eligibility for Community Care. Additionally, the CTB 2.0 documents the outcome of the decision process by adding a standardized comment to the consult.

The DST software within the CTB 2.0 will:

- Allow the care provider to view relevant data within the existing CPRS consult order workflow, that helps the guide the conversation with the Veteran to decide if a consult service should be referred to the local VA facility, a near-by VA facility via Inter-Facility Consults (IFC), or to a community provider by providing information about the following:
  - Veteran's static community care eligibility for accessing care in the community
  - Drive time standards associated with the requested consult service.
  - Average wait times for the requested clinical service at VA facilities near the Veteran's place of residence and average wait times for community care appointments. Note that average wait times may not be used to determine wait time eligibility.

- Capture the Veteran's stated preferences (opt-in/out). Or To Be Determined (TBD)/Deferred.

- Document the rationale for the referral decision in the consult record.
- Generate structured text based on the displayed results that can be used for downstream report generation.

Separate processes exist for determining eligibility for an established clinic Veteran, a new clinic veteran, making a general inquiry, determining eligibility based on a new enrollee appointment request, and special notes are also included regarding the process for former distance-eligible Veterans (grandfathered Veterans). Reference the Office of Community Care Decision Support Tool Contingency SOP for the step by step guidance on the process to follow in the event that DST is unavailable.

Mapping changes and technical updates can be tracked in the What's New pop-up that appears when users access the Consult Toolbox 2.0. To ensure the tool is most optimal for end user, the tool is being continuously updated and improved. The What's New content details the changes of past builds and gets updated to do the same for future builds.

DST Mapping File can be viewed on the DST- Clinical Service Mapping spreadsheet This spreadsheet details the specific DST stop code, clinical service and SEOC mapping.

- **Best Medical Interest of the Veteran**
  In order to better align the CC Eligibility (DST) tab with national guidance on establishing community care eligibility based on the Veteran's best medical interest, the following updates will be made to the CC Eligibility (DST) tab:
  - The Best Medical Interest control will become read-only when the CC Eligibility (DST) tab is launched in the CTB 2.0 from a signed consult by a non-clinician.
  - The Best Medical Interest control will only be available when the CC Eligibility (DST) tab is launched from an unsigned order in the CTB 2.0 and will only appear if the CC Eligibility (DST) tab does not identify any other community care eligibility criteria for the Veteran.
  - The dropdown list of Best Medical Interest justifications will be shortened. The justifications below will remain available:
    - Nature or simplicity of service
    - Frequency of service
    - Need for an attendant
    - Potential for improved continuity of care
    - Difficulty in traveling

Best Medical Interest of the Veteran

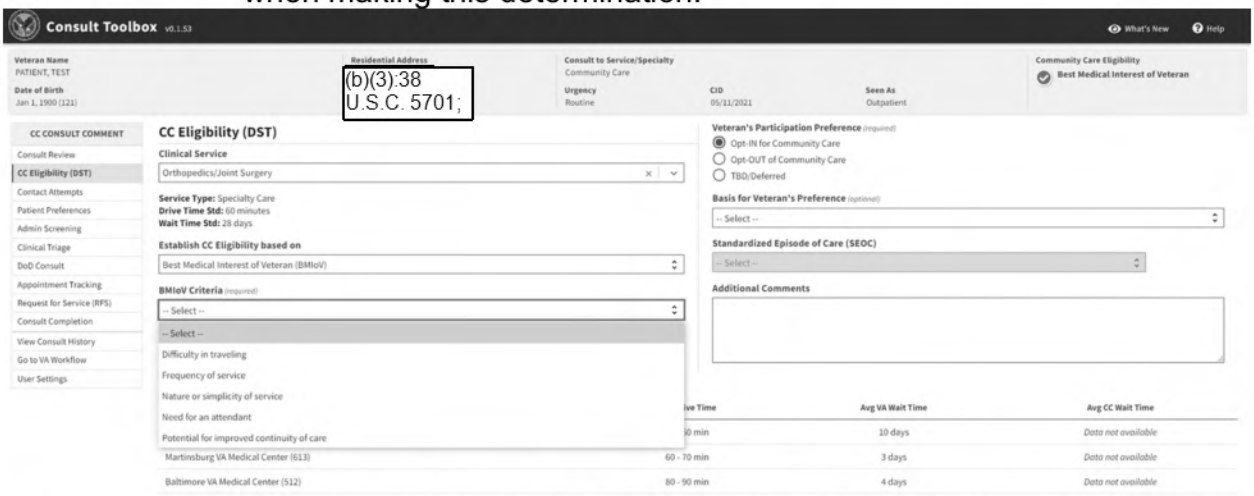
The preferred process for capturing the Best Medical Interest (BMI) community care eligibility determination is for the referring provider to use the CC Eligibility (DST) tab at the time of submitting the consult, to communicate the BMI eligibility reason recommendation. Once BMI is documented, the Referral Coordination Team (RCT) or specialty clinic should review the consult to determine if other appointment modalities are available within the VA or if a referral to community care is the best option for the Veteran after he/she opts-in to community care.

Providers can also document considerations in the body of the consult for the RCT to consider when reviewing the consult with the Veteran, but this is not considered a true BMI eligibility determination by the ordering provider.

At the time of using the CC Eligibility (DST) tab in the CTB 2.0, the referring provider will experience the following updates:

- The 'Other' option has been removed from the dropdown list of Best Medical Interest justifications.
- An additional option 'Difficulty in traveling' will be added to the dropdown list of Best Medical Interest justifications. The list will become:
    - Nature or simplicity of service
    - Frequency of service
    - Need for an attendant
    - Potential for improved continuity of care
    - Difficulty in traveling

        Definition **BMI: Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 minutes for Primary Care and Mental Health and 60 minutes for Specialty Care) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (Social Work consult, etc.) when making this determination.



- Referring providers using DST to establish Community Care eligibility based on any Best Medical Interest justification must enter a brief rationale explaining the medical need in the free-text field that appears below the justification selection.
  Example:

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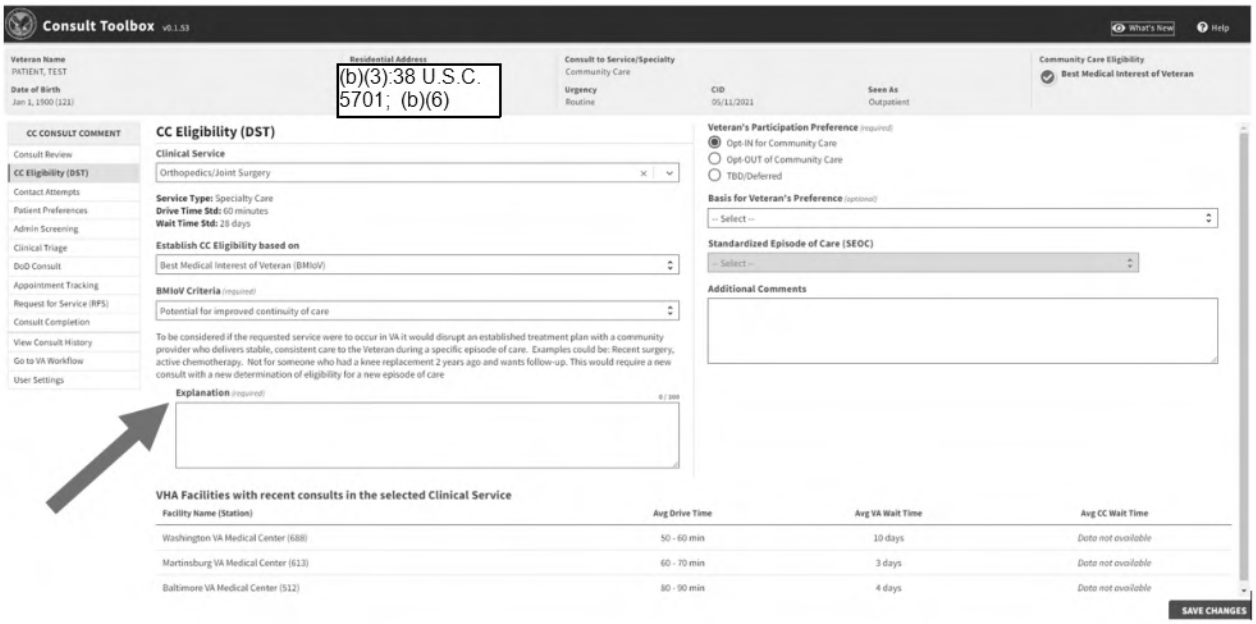
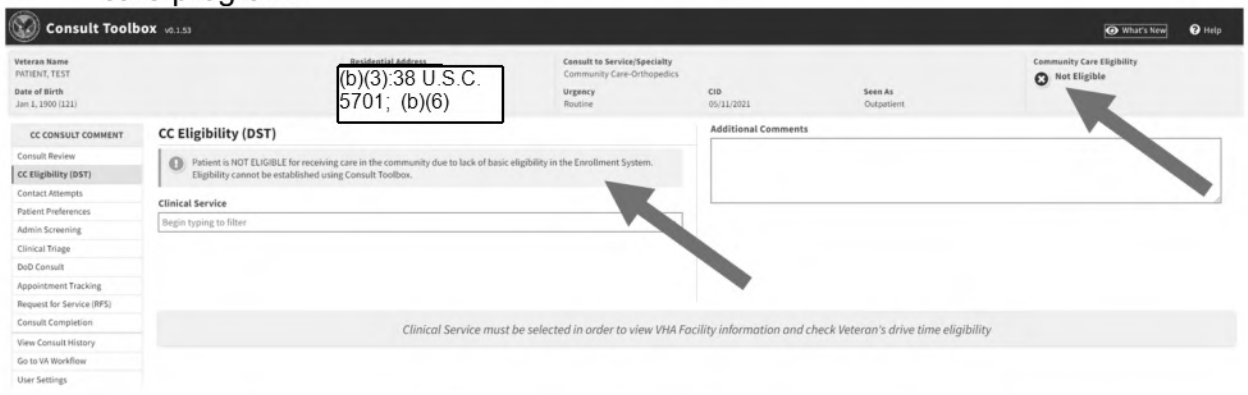


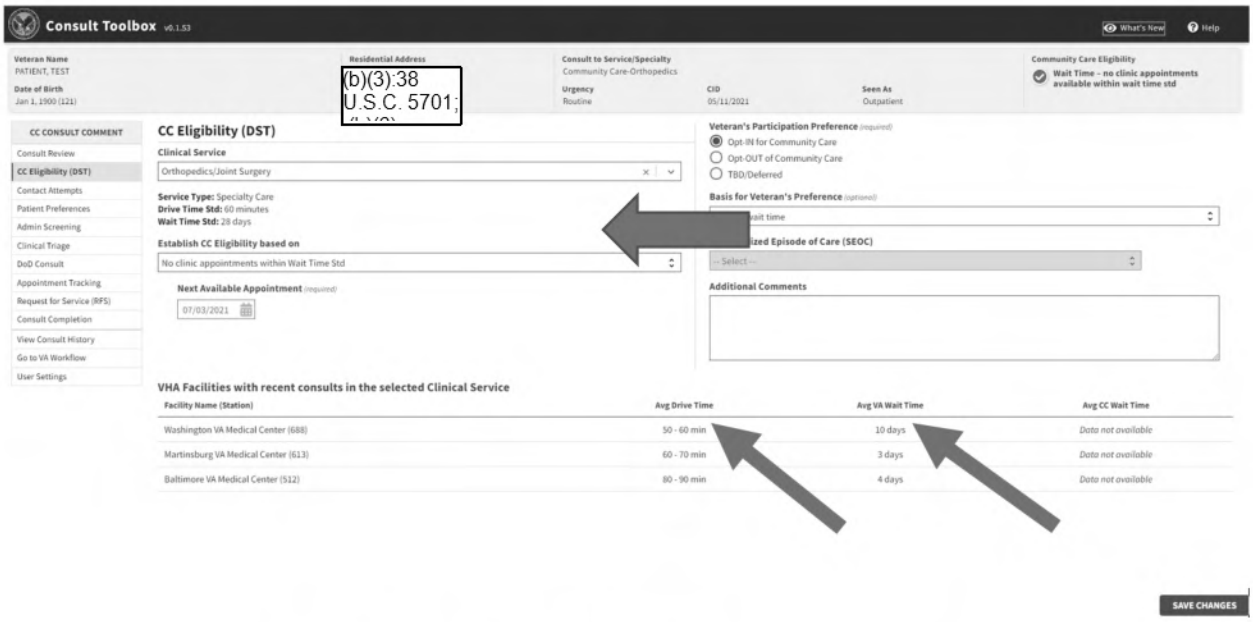
Other CTB 2.0 CC Eligibility (DST) Tab Notes

- If a patient is designated in the Enrollment System (ES) as ineligible for community care, Consult Toolbox will display a message indicating that a patient is ineligible for Community Care because they lack Basic eligibility.
    - This affects patients eligible for VA care but not otherwise eligible for community care, such as CHAMPVA patients being seen at the VAMC under the community care program.



- To better support community care wait time eligibility determinations on VCCPE, community care direct scheduling and community care admin primary care consults, the field ‘No Later Than Date’ has been renamed to ‘Wait Time Eligibility Date.’

Last Modified on: Tuesday, August 3, 2021



- Wait Time Eligibility Date is calculated as Today (i.e. the date information is linked to the consult) plus the Wait Time Standard (20 days for Primary Care/Mental Health; 28 days for Specialty Care; 1 day for Stat consults).
- If the CID is greater than Today plus the Wait Time Standard, the consult is not applicable for wait time eligibility and the following message will be displayed: *'Wait time eligibility for community care is not applicable for this consult due to the CID not being within the wait time standard.'*
- See additional wait time eligibility details in the OCC Field Guidebook in Chapter 2, section 2.19
- Addition of Community Care Average Wait Time- June 22, 2020
- Adjustment to VHA Average Wait Time- June 22, 2020
- Support of Clinical Service Synonyms- May 19, 2020
- Updates to the Clinical Service Mapping

VHA Facilities Displayed

- **VHA facilities** being displayed have pending or completed appointments within the last 60 days that are linked to consults associated with the stop code of the selected clinical service and will be sorted by drive time from the Veteran's residential address. Facilities that only offer the service via telehealth will be excluded.
- **Average wait time** is calculated as the rolling average of wait times (time between create date and appointment date) for new patient completed appointments with the stop code of the selected clinical service, within the last 30 days.

Average wait time is displayed is for reference only. Eligibility for community care based on wait time should be determined at the time of scheduling, not in the DST.

Community Care Average Wait Time

Community care wait time is calculated by determining the average time from the date a community care appointment is made to the date of the appointment itself, as recorded in Health Share Referral Manager (HSRM). the CC Eligibility (DST) tab in the CTB 2.0 displays the average wait times of all appointments booked or completed under Standard Episodes of Care (SEOCs) related to the requested clinical service, based on a rolling 90-day assessment. The Community Care data displayed is for community care appointments associated with the facility and SEOCs associated with the selected clinical service. This information is provided to inform providers, schedulers, and Veterans of the comparable wait time in the community so they can make an informed decision when considering community care.

The average wait times reflected for community care appointments are based on the community care appointment being captured in HSRM. This specific calculation is based on the following:

- Days between the appointment made date and the appointment date based on HSRM calculations
- HSRM referrals with an appointment in booked or completed status and an appointment date time within the past 90 days
- Exclusions
  - Appointments with a null made date or appointment date
  - Appointments with a made date greater than the appointment date
- No minimum referral number required in order to capture the community care wait time average

The addition of the community care average wait time to the CC Eligibility (DST) tab in the CTB 2.0 will assist end users; to include the Referral Coordination Team and specialty clinic schedulers, when having that thoughtful conversation with Veterans regarding their VA and community care options and the average wait times both in VA and community care. It is important to note, DST is providing the average wait time for both calculations and not the exact wait time. The methodology of the calculations is the same and, in both situations, the exact wait time is determined at the time of scheduling when knowledge of the next available appointment is accessible.

When having the conversation with the Veteran, after community care eligibility has been determined, the end user should note the following:

- Available options within the VA to provide the care (i.e. IFC, e-consult, TH etc.)
- Review the average wait times in the community and within the VA for the care being requested in order to provide the patient with an overall idea on the appointment wait time, once the request is routed.
- Emphasize that the CTB 2.0 derived average community wait times are not reflective of the actual available appointments at any one community provider's office but an average of all community providers who offer the service to Veterans seen at this VAMC's Healthcare system (CBOCs and off-site facilities).
- If the Veteran opts into community care, at that time capture the Community Care Scheduling Preferences (for additional guidance see chapter 2, section 2.19) prior to forwarding the consult to a community care consult title.

Adjustment to VHA Average Wait Time- The internal appointment data logic in the CTB 2.0 will temporarily be adjusted to capture pending or completed appointments back to January 1, 2020 and forward as a result of the COVID-19 impact on VHA appointments.

CC Eligibility (DST) COVID-19 Impact Updates:

- During the COVID-19 Pandemic, many VA facilities have seen a reduction in the number of face-to-face VHA appointments scheduled or have been offering telehealth alternatives for more than 60 days. For this reason, some VA facilities that do offer specific services are no longer seeing this information reflected in the facilities list.
- To resolve this issue, the algorithm used to capture VHA Average Wait Time data in CC Eligibility (DST) tab of the Consult Toolbox 2.0 will be temporarily updated to identify VA facilities within the search radius that report pending or completed appointments back to January 1, 2020 linked to consults associated with the stop code of the selected clinical service. Facilities that only offer the service via telehealth are excluded.
- The search radius logic in the CTB 2.0 includes VA facilities within a 90-minute drive time radius of the Veteran's residential address that may offer the requested service.

Clinical Service Synonyms

CTB 2.0 supports Clinical Service Synonyms. When you are selecting the Clinical service, you can start typing the value you are looking for. Common synonyms are searchable and will appear in the drop down along with the official clinical service name. When you select a Clinical service synonym from the drop-down list, the official clinical service name will be displayed. Only official clinical service names will be saved with the DST information and written to the consult when signed.

Example:

Value typed in the clinical service field: acupuncture

Clinical service drop-down option displays: Acupuncture <Complementary and Integrative Health Treatment>

When selected, Clinical Service field displays: Complementary and Integrative Health Treatment

Veteran Eligibility Status Workflow

- As of Release 11.0 of HSRM (11/23/2020), HSRM will check the eligibility status in Enrollment System
    - If a veteran is eligible for Community Care, the normal referral workflow will be followed

- If a veteran is not eligible for Community Care, the system will prevent addition of Program Authority and further action on a referral. Users will need to contact their Eligibility department and/or refresh Eligibility data.

- Workflow Details:
  - (1) On the Referrals Details screen, if a VCE code of X is received, the Program Authority field will be greyed out with a message alert “Veteran is not eligible for Community Care, contact your local Eligibility Department and try refreshing the Eligibility Screen”.

  - (2) When a user navigates to the ‘Eligibility’ screen from the ‘Referral Detail Screen’, in the ‘Eligibility Status’ section, the description reads ‘Not Eligible’ reflecting a VCE code of X in the background. The X code is not displayed
  - (3) The ‘Refresh Eligibility Data’ button is available only when a veteran is ‘Not Eligible.’ When an ‘Eligible’ VCE status code is received, the ‘Refresh Eligibility Data’ button is greyed out
    - *Note: A user may select ‘Refresh Eligibility Data’ multiple times if expecting an updated eligibility status*
    - *Note: Eligibility is referral specific, not veteran specific*
    - *Note: In CTB v2.0 (Tentative: Feb 2021) a user will only be able to send a consult to HSRM if the patient is eligible for CC*

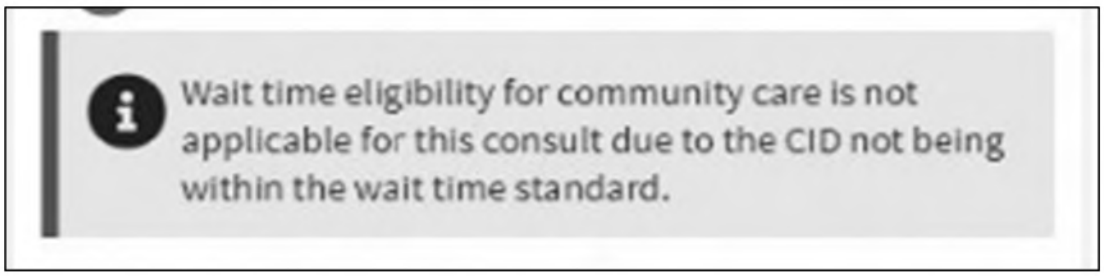
Last Modified on: Tuesday, August 3, 2021

2.10 Types of Consults Available where DST is used:

(CTB Version 1.9.0078)

The DST is accessible through the consult tracking feature in CPRS. A consult for the patient must be initiated and open in order for the DST to appear. There are three types of consults that MSAs will work with the most:

- Local in-house consult for specialty care
  - The local in-house consult is normally initiated from a provider in one service and sent to another service to request care for the patient. An example of a consult request would be a Primary Care provider requesting dermatology services for a patient with a rash.
- The Veterans Community Care Program Eligibility (VCCPE) consult
  - An administrative consult used to check eligibility for community care for established clinic patients. This administrative consult is routed to a provider in the clinic to review and modify as needed.
  - MSAs will need to be assigned an administrative key (or admin RBP to CC) in CPRS to have access to use the VCCPE consult.
  - The purpose of the VCCPE consult is to assist an administrative staff member (scheduler) with determining a Veteran's possible community care eligibility. However, VHA leadership has made the determination that VA staff should offer an opportunity to review full community care eligibility when an established Veteran requests the review. There is no requirement to automatically or proactively offer this review for all established Veterans; therefore, there is no longer the need for the use of #CDE# in the appointment comments. The VCCPE consult can be used when a Veteran has a return to clinic order, is eligible for community care due to wait time, or asks about his or her community care eligibility.
  - **Note:** VA Medical centers do not need to use the VCCPE consult process for Primary Care or community care direct scheduling services. For primary care, the facility can use the community care administrative primary care consult when appropriate. Direct scheduling services can be ordered directly to community care, if the patient is eligible and a discussion regarding the option to receive the care within the VA has taken place.
  - When launching DST from a VCCPE, community care direct scheduling, or community care admin primary care consult:
  - If the CID is greater than the Wait Time Standard, DST will display a message indicating that the wait time eligibility calculation is not applicable to the consult.
  - To assist schedulers and to facilitate national reporting, DST will now add text to the VCCPE or other administrative consult when wait time eligibility is not applicable



  - When you save the DST session, DST will write the following to the consult comments:
  - NWE-Wait Time eligibility is not applicable
- Community Care Consult
  - A consult specifically used to refer patients to the community for treatment.
  - A patient must be eligible to receive care in the community based on one of the 6 MISSION eligibility requirements.

The provider and the patient discuss treatment options for the patient as well as what additional care may be needed. When it has been determined that additional care is needed, the provider enters a consult in CPRS. When the consult is initiated, the provider reviews potential community care eligibility with the patient by launching the Decision Support Tool (DST). This is an informed conversation between the patient and the provider.

(CTB Version 2.0)

Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

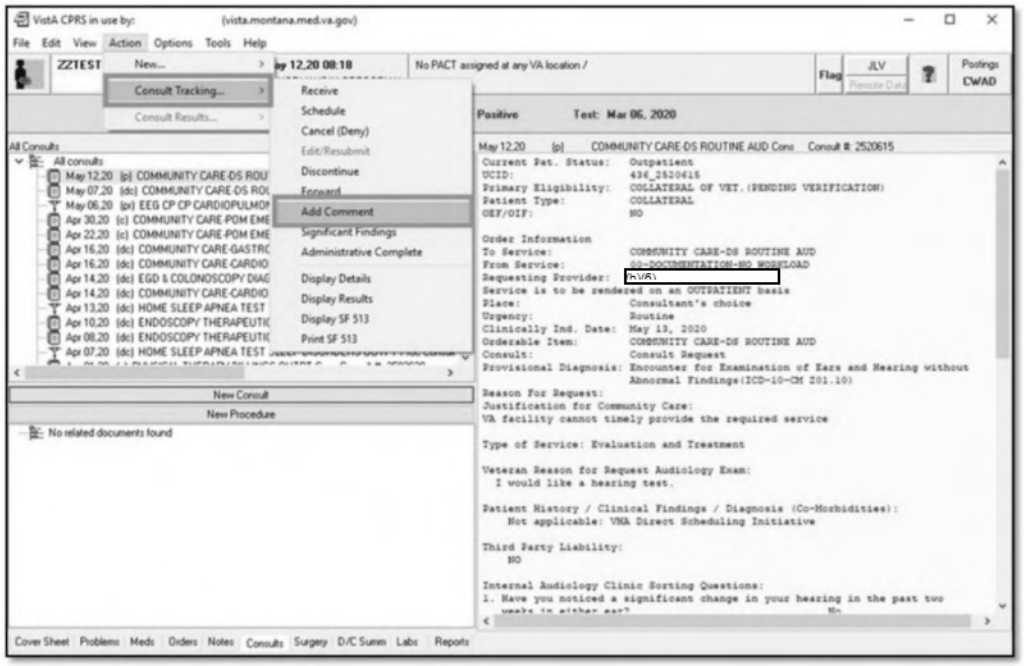
More information regarding this can be found in the Office of Community Care Field Guidebook Chapter 2, Section 2.15-2.19

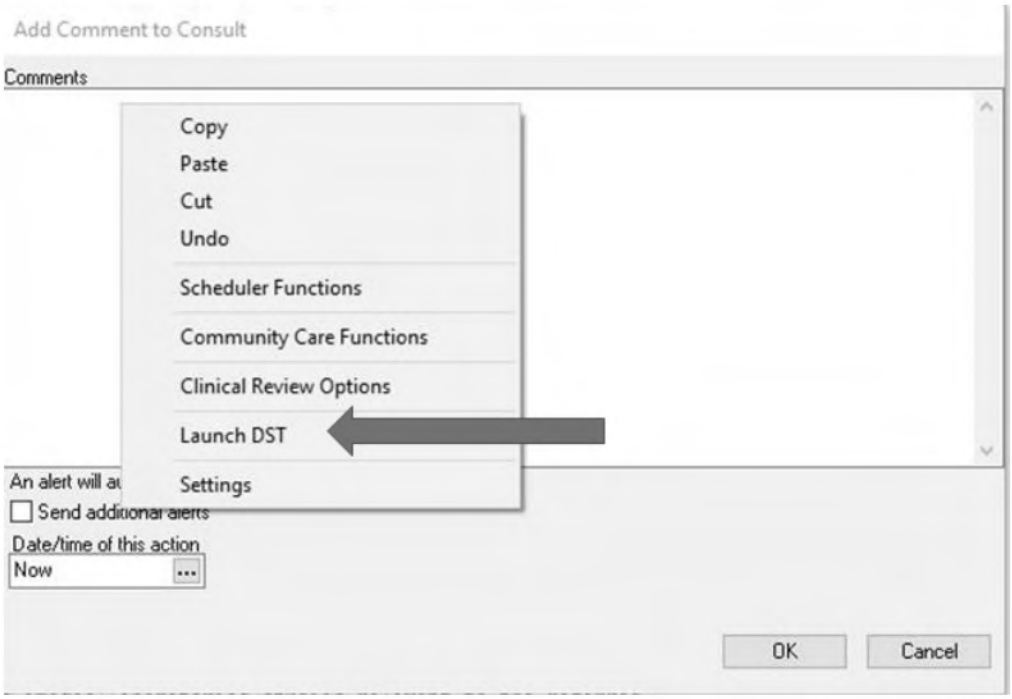
2.11 Navigating the DST

(CTB Version 1.9.0078)

When the provider orders a consult and launches the DST, it will list any community care eligibilities the Veteran has for the requested service, except for wait time eligibility. If access to the DST is not launched at the time of ordering the consult, follow these steps to launch the DST. The way to access DST is by going to Action in the top Task Bar and selecting Consult Tracking. The user can select any of the options (Note: Only add comment is highlighted in the below example). Once the appropriate consult action is selected the user will either see the CTB options come up or they can right click to see the options.

Last Modified on: Tuesday, August 3, 2021





If the patient is eligible due to specific criteria, a green check mark will be visible next to that criteria. Only one of the community care eligibility criteria must be met to be eligible for community care; the patient does NOT have to meet all criteria to be eligible. If the patient meets any of the criteria listed in DST, the patient is eligible for care in the community and can decide to receive care in the VA or in the community. The provider will:

- Ask the patient to choose where care will be received.
- Order consult

The Launch DST pop-up window will only display for outpatient consults mapped to a stop code that prompts DST. Providers may open DST to document BMI or may X out to close the window.

- If a consult is mapped to prompt DST, a window will appear that reads “MISSION Act allows the use of DST to determine and document Community Care Eligibility”. Providers may choose to Launch DST to document BMI or to select the X to close the pop-up.

- If a consult is not mapped to prompt DST, users will not see a window with the option to launch DST

Document the consult decision in DST.

If the patient states they would like to have care in the Community, the provider will:

- Select "Opt-In" in the DST.
- Select SEOC from drop-down.
- Select the Consult Decision: Community Care. Click Save.
- Complete Consult Information Required (Diagnosis, Reason for Request).
- Sign the consult.
- Forward the in-house consult to community care or to specialty service, to be received by the appropriate team. Any one on the team can forward the in-house consult to a

community care consult. This will start the process to have treatment in the community arranged for the patient.

If the patient decides to receive care within the VA, the provider will:

- Select "Opt-Out" in the DST.
- Select the Consult Decision: VA. Click Save.
- Complete Consult Information Required (Diagnosis, Reason for Request)
- Sign the consult.
- The consult will be sent to the specialty care individual or team to review and schedule an appointment for the patient.

Please review DST SharePoint for DST Tricks and Tips, FAQs, and additional information on navigating DST.

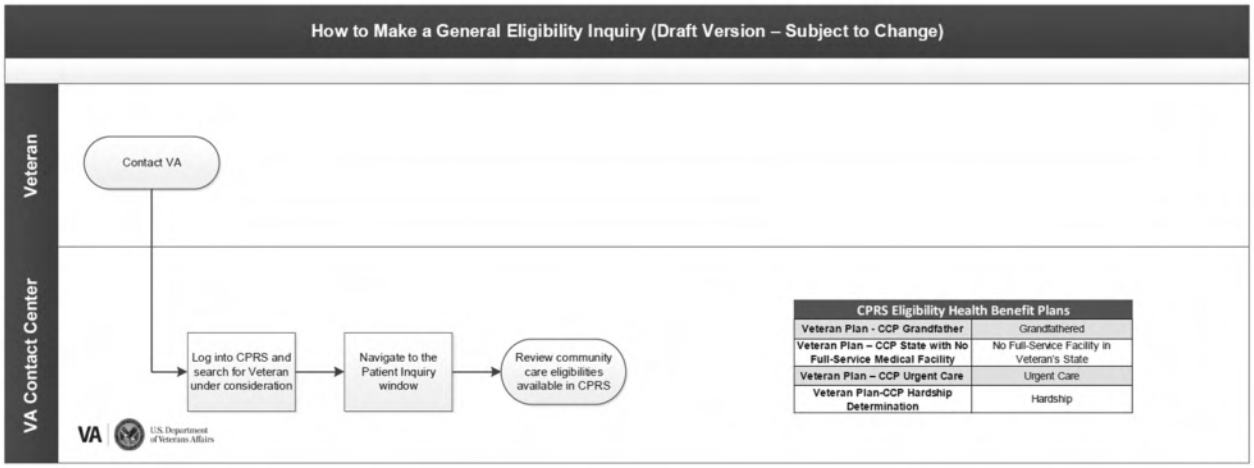
(CTB Version 2.0)

Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

Last Modified on: Tuesday, August 3, 2021

2.12 How to Make a General Eligibility Inquiry

(Pre/Post CCN) Post MISSION



When a Veteran contacts the local VA facility to request information on their eligibility for care the staff should log into CPRS and search for the Veteran.

The staff should navigate to the patient inquiry window located at the top left corner of the CPRS screen.

From there the staff can review the community care eligibility that is available in CPRS.

VHA Profiles Currently Assigned to Veteran:

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VHA Profiles Currently Assigned to Veteran:

VETERAN PLAN CCP URGENT CARE
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The above flow chart and screenshot of the CPRS Eligibility Health Benefit Plans are included as a reference to show various CCP eligibilities.

VIEWING AND CONFIRMING COMMUNITY CARE STATIC ELIGIBILITY USING VHA PROFILES IN VISTA & CPRS

The Enrollment System (ES) is the authoritative source for Community Care static eligibility only. The static eligibilities are: Basic, Entitled Care, Grandfathered, Hardship (General Best Medical Interest (BMI)), Restricted Care, State No Full-Service VA, and Urgent Care. The Enrollment System displays the Community Care Outcomes and the VHA Profiles. VHA Profiles (VHAPs) removes the subjectivity associated with the interpretation of benefits. They also reduce the need to have VA staff continually interpret benefits for Veterans and their families.

In the event staff is not able to access the Enrollment System to view and confirm a Veteran's Community Care Static eligibility they can access this information in Veterans Health Information Systems and Technology Architecture (VistA) Legacy or VistA Computerized Patient Record System (CPRS) in the form of VHA Profiles. The VHAPs are displayed in VistA's DG Patient Inquiry option (refer to Figure 2) and also displayed in CPRS Patient Inquiry Screen, refer to Figure 3.

VHAPs IN VISTA DG PATIENT INQUIRY

Crosswalk: Enrollment System Community Care static eligibility Outcome to VHAPs displayed in VistA DG Patient Inquiry and CPRS Patient Inquiry

Enrollment System Community Care Outcomes	VistA & CPRS Corresponding Community Care Program (CCP) VHAP Names	CCP VHAP Descriptions
Basic	Veteran Plan CCP Basic	Enrolled Veterans in the Veterans Affairs (VA) health care system meet the primary criteria for the new Community Care Program. These Veterans do not qualify for other static eligibilities for example: Grandfathered, Hardship (General Best Medical Interest), State No Full-Service VA, or Urgent Care. These Veterans however can be considered for Service Not Available, Access Standards, or Best Medical Interest (BMI).
Entitled Care	Veteran Plan CCP Entitled Care	Not enrolled covered Veterans who are 50 to 100% rated service connected and otherwise entitled to hospital care, medical services, extended care services and community care services. These Veterans are eligible for episodic care and flu shots.
Grandfathered	Veteran Plan CCP Grandfather	Enrolled Veterans who were driving distance-eligible under Veterans Choice Program. Require that the Veteran (1) be distance-eligible on the day before the MISSION Act was signed (June 5, 2018), and (2) is distance-eligible under Veterans Choice rules as of the start of the MISSION Act on June 6, 2019 and lives in in one of the five states with the lowest population density from the 2010 Census: North Dakota, South Dakota, Montana, Alaska, and Wyoming.
Hardship	Veteran Plan CCP Hardship Determination	Enrolled Veterans in a VA health care system. This eligibility is considered General Best Medical Interest. Veterans who meet MISSION Act access standards (wait time and drive time) may still face unusual or excessive burdens in accessing care at the VA based

Last Modified on: Tuesday, August 3, 2021

Enrollment System Community Care Outcomes	VistA & CPRS Corresponding Community Care Program (CCP) VHAP Names	CCP VHAP Descriptions
		on Environmental or geographic inaccessibility (including air, boat, ferry) or Medical condition and Veteran has received a consult. This eligibility has an expiration of 6 months or 12 months.
Restricted Care	Veteran Plan CCP Restricted Care	Not enrolled covered Veterans who are otherwise entitled to hospital care, medical services, extended care services and community care services, however they are only eligible for care related to their service connected conditions, Military Sexual Trauma (MST), or Mental Health Other Than Honorable (OTH) as documented in their record. This population includes Veterans and non-Veterans if they meet the following eligibility: 0% to 40%; SC 0% (non-compensable); or Veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty for that disability for the 12-month period following discharge or release; MST Non-Veteran (Active Duty); Emergent Mental Health (MH) Other-Than-Honorable (OTH) or Extended MH OTH.
State No Full-Service VA	Veteran Plan CCP State with no Full-Service Medical Facility	Enrolled Veterans who reside in a state with no full-service VA medical facility.
Urgent Care	Veteran Plan CCP Urgent Care	Enrolled Veterans who have received care through VA from either a VA or community provider within the past 24 months. Note: These Veterans can be considered for Service Not Available, Access Standards, or Best Medical Interest (BMI).
Ineligible*		Veterans who do not meet the criteria for enrollment in VA health care nor the criteria for not enrolled covered Veterans and non Veterans. This also includes Veterans and non Veterans who were eligible and subsequently became ineligible for VA health care and/or Community Care.
No Data Available **		Community Care Static eligibility has not been determined (temporary state).

Last Modified on: Tuesday, August 3, 2021

*Ineligible: No CCP VHAPs will display for these records; only the core VHAP and non CCP carveout VHAP(s) will display.

**No Data Available: No CCP VHAPs will display for these records; only the core VHAP and non CCP carveout VHAP(s) will display.

Last Modified on: Tuesday, August 3, 2021

VHAPs IN VISTA DG PATIENT INQUIRY

Users who need to view VHA Profiles (VHAPs) must have access to the Registration DG Patient Inquiry option. Staff requiring access to Patient Inquiry option, please follow your local VA Medical Center (VAMC) guidance for requesting Menu options.

Information for Patient Inquiry option information is below:

NAME: DG PATIENT INQUIRY MENU TEXT: Patient Inquiry

DESCRIPTION: This option is used to view basic demographic data concerning a specific patient including their inpatient status (or last admission if applicable), pending appointments and means test status.

STEPS TO VIEW VHAPs

- Step 1: Log in VistA with your credentials
- Step 2: To access the DG Patient Inquiry Option, type ^Patient Inquiry
- Step 3: Enter the identity traits (for example SSN, Member ID, or First Letter of Last Name and last four of SSN, etc.) to search for record

  Depending on the identity traits used, the record will present, or you must select the appropriate patient, see Figure 1

Figure 1: Patient Search

```
Select PATIENT NAME: 000000000  TESTPATIENT,VIEWVHAP        1-1-1900
000000000
 NO     NSC VETERAN
```

- Step 4: Press the <Enter> key until you get to the page that displays VHA Profiles Currently Assigned to Veteran: see Figure 2

Figure 2: VHAPs Displayed in VistA

```
TESTPATIENT,VIEWVHAP;    000-00-0000                    JAN 1,1900
================================================================

VHA Profiles Currently Assigned to Veteran:  <--
  VETERAN FULL MED BENEFITS TX COPAY EXMT AND RX COPAY REQ
  VETERAN PLAN CCP BASIC
```

Note: If a Veteran has no assigned VHAPs, “None” will be displayed.

VIEW VHAPs IN CPRS

Staff must have access to CPRS, please follow the guidance of your local VAMC leadership for access.

STEPS FOR VIEWING VHAPs in CPRS

- Step 1: Log in CPRS with your credentials
- Step 2: Enter the identity traits and select appropriate patient

- Step 3: Select the Patient Inquiry button

The Patient Inquiry button is located on the left side of the chart directly below the menu bar. The Patient Inquiry button displays the following information: Patient name, Social Security number, Date of birth, Age

- Step 4: Scroll down until you see the VHA Profiles Currently Assigned to Veteran, see Figure 3.

Figure 3 VHAP, CPRS Patient Inquiry

For more information on eligibility, and a listing of Enrollment Coordinators by station, please visit the Enrollment Eligibility Division SharePoint.

Last Modified on: Tuesday, August 3, 2021

2.13 One Consult Model Overview

(Pre/Post CCN)

On November 22nd, 2017, the VHA Office of Community Care established the ONE CONSULT Model as the standard consult management process for all requests for services obtained in the community. 10N Memorandum - National Deployment of One Consult Model, requires use of a new standardized naming convention: COMMUNITY CARE-Specialty name consult and retirement of the prior NON-VA CARE consult naming convention.

One Consult Model Overview

The Department of Veterans Affairs (VA) is committed to providing Veterans access to timely, high quality health care by developing programs and processes that are easy to understand, simple to administer, and meet the needs of Veterans and their families, community providers, As such, a One Consult Model has been developed to standardize essential aspects of consultation to improve transparency and timeliness of consult completion.

There are two acceptable consults that would be processed by the Office of Community Care:

- VA providers can directly enter or create a new COMMUNITY CARE-Specialty name consult if services are unavailable within VA, drive time or wait time exceed Mission Act standards, or the Primary Care Provider (PCP) has determined that the Veteran is eligible for a Hardship Designation.

- VA schedulers forward an existing VA In-House Consult with a required Provisional Diagnosis (ICD-10) Code based on One Consult Model Initiative and VA Ordering Provider agrees Veteran is appropriate for Community Care. At this time Internal Clinical Procedure Consults cannot be forwarded to community care, as all of the necessary information is not captured when forwarding and leads to errors. Appropriate staff will need to cancel the internal Clinical Procedure consult and submit a new community care consult requesting the care. At the time of entering the consult a comment must be added to the consult capturing the community care eligibility information and the original Patient Indicated Date (PID) from the internal consult.

2.14 Scenarios When a New Community Care Consult is Required

There are four scenarios in which a VA Staff would enter a new community care consult:

- Scenario 1: Ordering provider or administrative staff enters a Direct Scheduling-Routine services consult for services allowed by VA policy (Audiology, Optometry, Podiatry, Nutrition, Primary Care)
- Scenario 2: Ordering provider enters community care consult for a Return to Clinic (RTC) order or a Veteran Community Care Program Eligibility (VCCPE)
    - **VCCPE may also be entered by an administrative staff**
- Scenario 3: Ordering provider enters Radiology community care consult from an order
- Scenario 4: Ordering provider enters community care consult for Services Not Available

Note: The purpose of the VCCPE consult is to assist an administrative staff member (scheduler) with determining a Veteran's possible community care eligibility. However, VHA leadership has made the determination that VA staff should offer an opportunity to review full community care eligibility when an established Veteran requests the review. There is no requirement to automatically or proactively offer this review for all established Veterans; therefore, there is no longer the need for the use of #CDE# in the appointment comments. The VCCPE consult can be used when a Veteran has a return to clinic order, is eligible for community care due to wait time, or asks about his or her community care eligibility.

General Considerations:

The Admin Key patch is a technology solution that provides Department of Veterans Affairs (VA) community care staff the authority to release Direct Scheduling and Admin consults without requiring a signature of the clinical provider for 5 types of consult services: Optometry, Audiology, Nutrition, Podiatry and Primary Care. For steps on how to use the Admin Key please follow training Link.

There are four scenarios in which a VA provider (or when allowed by policy, authorized administrative staff) would create a new community care consult. Below are some key activities that are specific to these scenarios. Common steps across each of these scenarios begin with Step 1 in Procedure Table 1.1.2.

Note: Direct Scheduling Community Care Consults do not need to be triaged by a clinician and can be used for the entire episode of care. A Veteran can request these services, without needing a clinician to enter the consult, as Direct Scheduling consults are patient directed.

Last Modified on: Tuesday, August 3, 2021

For Direct Scheduling- Routine Exam (Audiology & Optometry)

(Pre/Post CCN)

Per 10N Memorandum - Audiology and Optometry Direct Scheduling Implementation, Internal VA facilities were required to implement Audiology and Optometry Direct Scheduling Implementation per both10N memos and complete implementation by December 31st, 2016. With the ability of a new or established Veteran to bypass Primary Care to request routine Audiology or Optometry exams, this enhances the Veteran experience, improve access in primary care and reduce wait times in these specialty clinics. Patient Self-Referral Direct Scheduling for Routine Exams is defined as the ability for Veterans to schedule an internal VA Audiology or Optometry routine appointment without a consult. Veterans must be able to schedule a routine appointment without a consult within the VA Clinics. Veterans must be able to call their VA facility (Call Center), or directly contact the clinic; or contact a VA clinic scheduler to make the routine appointment.

Standardized Sorting Questions are required for Audiology and Optometry to determine that the request is clearly routine. Consults may still be used in these clinics but not required for VA in-house routine exam requests. A consult for Community Care is required when services are not available or within 28 day timeframe and are the standardized administrative Community Care-DS Routine AUD or OPT Consult (pre-filled with all approved services: requirement to place name of Audiology or Optometry VA Provider who will be responsible for all communication and oversight of the consult, pre-established EOC timeframe and pre-filled Provisional Diagnosis (ICD-10 code).

Criteria for Audiology and Optometry Direct Scheduling:

What it is:	What it is not:
Any new or established Veteran patient can obtain routine appointments directly thru the Optometry, Audiology Clinics or a scheduling call center, without a consult.	Veterans will not be required to see a primary care provider to secure a routine appointment with Audiology or Optometry, before or after the appointment, for vesting purposes.
As of FY2019, Veterans receiving audiology and optometry services must be enrolled in a PACT to be placed into VERA Patient Classification Price group 2 (Audiology is approved (stop code 203), Optometry (stop code 408), Optometry is in process). Patients that are not enrolled in a PACT will be placed in the Non-PACT class which was funded at $780 in FY19. There are no planned changes to this process for the VERA 2020 Model.	No Veterans will be required to obtain a Primary Care consult for routine Optometry or Audiology care.
Consults from a medical provider to Audiology and Optometry may still be required if clinically indicated but not for routine care.	Direct access to Optometry or Audiology will not be contingent on service-connected status.

For all Internal VA Staff responsible to create or participate in your VA Facility Direct Scheduling – Routine Audiology/Optometry Project:

- Any new or established Veteran can bypass Primary Care and obtain routine appointments directly thru the Optometry and Audiology Clinics or a scheduling call center, without a consult for internal VA Aud/Opt routine exam appointments. This change negates the need for a Veteran to be scheduled with Primary Care for the sole purpose of a vesting

exam to utilize audiology and Optometry services and was implemented within VA facilities as of December 31st, 2016.

INTERNAL VA MSA Staff SORTING QUESTIONS for Audiology & Optometry

In order to ensure the quality and safety of the Veterans seeking Routine Audiology (ear) and Optometry (eye) care appointments, Standard Sorting Questions at several VA facilities have been vetted with the National Program Directors for Audiology and Optometry. These questions should be provided to the Veteran during their request for a routine scheduled VA clinic appointment to ensure their request for Routine Exams are clearly routine and Veterans are not seeking care for things other than routine exam purposes. It will be up to VA facility leadership (COS or designee, Audiology Chief or Optometry Chief or Chief of Medicine for Primary Care) to decide the VA staff who will review the Sorting Questions with the Veteran. Staff will be responsible to report any YES answers to the Sorting Questions that would indicate something other than routine and would need immediate evaluation. If immediate evaluation is needed, the MSA or VA Staff within the VA facility would not continue forward with scheduling and follow the established communication to the appropriate clinician within their VA facility for evaluation and plan

AUDIOLOGY SORTING QUESTIONS:

If the patient answers YES to any of the following two questions, a nurse or audiologist will need to triage the Veteran to determine urgency of an audiology evaluation:

- Have you noticed a significant change in your hearing in the past two weeks in either ear? (Y/N)
- Do you have pain/pressure/drainage in or from your ear(s)? (Y/N)
- Question on Hearing Aids:
  Do you have VA issued hearing aids that need repair? (Y/N)
  If Yes, follow established protocol used at your clinic.

OPTOMETRY SORTING QUESTIONS:

If the patient answers YES to any of the following questions, a nurse or the Optometry Clinic will need to triage the Veteran to determine urgency of an eye evaluation:

- Have you experienced a sudden, new onset of eye pain or increased light sensitivity?
- Have you experienced a sudden, new onset of floaters, flashing lights, or loss of side (peripheral) vision?
- Have you recently had any sudden, new changes in the outward appearance of your eye?
- Have you had a recent (in the last 30 days) eye surgery or trauma to the eye?
- Have you experienced sudden, new vision loss or double vision?

If patient answers NO to all questions, schedule a routine appointment in Optometry

For all Internal VA Staff and Facility Community Care Office Staff responsible for creating or coordinating a VA Facility Direct Scheduling - Routine process:

- If internal VA routine audiology or optometry exam clinic appointments are not available due to: service not offered within VA; or not available within 28 Days; or not available and/or timely at nearby IFC / VA facility; or not available at Department of Defense (DoD) facility as applicable, or exceeds drive time standards, it will be dependent on your local policy (per the Chief of Staff or designee) who at the VA facility (Audiology/Optometry clinic staff, Call Center staff or other VA Clinic staff) will place the required Standardized Administrative **Community Care-DS Routine AUD/OPT consult** using the nationally standardized Community Care Direct Scheduling Administrative consult templates. Please see the Clinical Pathways Table in Chapter 4. This is a required standardized administrative consult accompanied with a Standard Episode of Care (SEOC) with pre-filled information pertaining to authorized AUD/OPT approved routine exam services, requirement to place name of Audiology or Optometry VA Provider who will be responsible for communication and oversight of the consult, and pre-established Episode of Care (EOC) timeframe with the required pre-filled/hard-coded Lexicon (Provisional Diagnosis – ICD-10 code). Access the Program Management Office SharePoint Site to see all SEOC listings.
- Although internal VA Directive for Direct Scheduling Routine Exam Implementation does not require a VA In-house consult/referral, the Office of Community Care requires creation of the standardized administrative community care consult per 10N Memorandum - National Deployment of One Consult Model initiative implemented November 22, 2017.
- REQUIRED Use of AUD/OPT Standardized Sorting Questions: There is clear guidance built within the standardized administrative Community Care-DS Routine AUD or OPT consult PRIOR to creating the required Community Care-DS Routine Aud or Opt consult that if ANY Sorting Questions were answered as YES by the VETERAN, the VA Clinic MSA or VA Clinic Staff attempting to enter the standardized Community Care consult does NOT continue entering the consult and seek immediate guidance from the identified Clinical Staff per your local policy to evaluate the Veterans YES response to the Sorting Questions for further clinical evaluation and plan.
- MSA - IF a Consult for Community Care is placed and received in the Facility Community Care Office and there are ANY YES responses from the Sorting Question section of the consult, the Facility Community Care Office Clinical Review staff must be made aware immediately and contact the Veteran to review the Sorting Questions again and evaluate their current status surrounding their request for ROUTINE services for audiology or optometry. Any non-routine conditions would require contacting the local point of contact (POC) per your local policy directly for Clinical guidance on need for immediate Veteran evaluation and plan.
- The Community Care-DS Routine AUD or OPT consult is discontinued with the comment per current process to notify the ordering clinic and provider whose name was placed on the Administrative consult and use of the Consult Toolbox as indicated.
- ROUTINE OPTOMETRY Approved Community Care Consult Language: VA Authorizes one routine comprehensive eye exam annually per the pre-filled authorized optometry exam services contained in the required community care consult. If a new eye glass prescription is indicated, a community care provider will write a prescription and give the prescription to the Veteran. The Veteran will bring the prescription to their local VA facility in person and obtain the eyeglass per local policy at their Durable Medical Equipment (DME)/Prosthetics department. An EOC for a routine comprehensive eye exam must be

completed in a three-month timeframe. Note: The DS scheduling eye exam consult will require the corresponding Routine Optometry/Eye exam SEOC.

- ROUTINE AUDIOLOGY Approved Community Care Consult Language: VA authorizes one comprehensive diagnostic audiology evaluation a year. If hearing aids are indicated, the community provider is required to send a hearing aid order form and a copy of the Veteran's audiogram to VA Audiologist for approval and ordering. There is an Audiology Toolkit that the Facility Community Care Office staff must send to all community providers who are authorized to perform a routine audiology exam which contains standardized audiogram forms, templates, and guidance if hearing aids are required. Hearing aids will be mailed to the community care provider for one fitting and one follow up visit for an eight-month timeframe from first attended visit.
- Additional detail for this scenario is described in the "Direct Scheduling" section of the One Consult Standard Operating Procedure
- Additional Resources:
- Access to Care (AtC) Hub tour (video)
- Direct Scheduling Library

Last Modified on: Tuesday, August 3, 2021

For Direct Scheduling- Routine Exam (Podiatry & Nutrition)

(Pre/Post CCN)

On July 10th, 2017, a 10N Memo was released for Patient Self-Referral for Direct Scheduling Routine Podiatry and Nutrition clinic exams. As Audiology and Optometry, these services follow the same process for a Veteran accessing internal VA In-house routine Podiatry and Nutrition exams. The 10N Directive required the internal VA Clinics to begin Direct Scheduling for Routine Podiatry and Nutrition Clinic Exams to commence on December 31, 2017.

- As noted in Audiology & Optometry DS Routine Exam guidance, the Office of Community Care adopted the ONE CONSULT Model as of November 22nd, 2017 for all requests for services obtained in the community to have a required Community Care-Specialty Name Consult. There are standardized administrative Community Care-DS Routine POD and NUT Consults with the same pre-filled criteria for approved services, requirement to place name of the internal VA Podiatrist or Nutritionist who will be responsible for communication of the consult, EOC timeframe and Lexicon/Provisional Diagnosis (ICD-10 code).
- In the interim and until the release of the standardized administrative DS Routine POD/NUT consults, all VA facilities will place a required Community Care-Podiatry or Nutrition Consult if routine services are required in the community. It will be up to each VA facility local policy to determine who will place the required consult.
- Although internal VA Directive for Direct Scheduling Routine Exam Implementation does not require a VA In-house consult/referral for Direct Scheduling Routine POD/NUT routine appointments, the Office of Community Care requires a standardized administrative community care consult placed with use of the required SEOC for services obtained out in the Community per 10N National Deployment of One Consult Model Memorandum policy implemented November, 22, 2017.
- ROUTINE PODIATRY Approved Community Care Consult Language: VA Authorizes one comprehensive diagnostic podiatric lower extremity evaluation per the Direct Scheduling Routine Podiatric Consult provided. Further, it authorizes treatment for diagnosed conditions during Consult and 1 follow-up visit over a 3-month timeframe. If multiple visits or surgery is recommended, a detailed request along with a full description and medical justification for said treatment/management to be submitted for approval by VA Office of Community Care.
- ROUTINE NUTRITION Approved Community Care Consult Language: VA Authorizes one Medical Nutrition Therapy Nutrition Assessment per the Direct Scheduling Routine Nutrition Consult provided. Further, it authorizes Nutrition Intervention during the Initial Assessment Consult and 2 follow-up visits over 12-month timeframe. For weight management interventions only, these may not exceed 16 total visits in a 12-month period.
- If more visits are recommended, a detailed request along with a full description and medical justification for said treatment/management is to be submitted for approval by VA Office of Community Care.

INTERNAL VA MSA Staff SORTING QUESTIONS for Podiatry & Nutrition

In order to ensure the quality and safety of the Veterans seeking Routine Podiatry and Nutrition care appointments, Standard Sorting Questions at several VA facilities have been

vetted with the National Program Directors for Podiatry and Nutrition. These questions should be provided to the Veteran during their request for a routine scheduled VA clinic appointment to ensure their request for Routine Exams are clearly routine and Veterans are not seeking care for things other than routine exam purposes. It will be up to VA facility leadership (COS or designee, Podiatry Chief or Nutrition Chief or Chief of Medicine for Primary Care) to decide the VA staff who will review the Sorting Questions with the Veteran. Staff will be responsible to report any YES answers to the Sorting Questions that would indicate something other than routine and would need immediate evaluation. If immediate evaluation is needed, the MSA or VA Staff within the VA facility would not continue forward with scheduling and follow the established communication to the appropriate clinician within their VA facility for evaluation and plan.

PODIATRY SORTING QUESTIONS:

- Within the past 7 days have you developed any new pain in your feet? (Y/N)
- Within the past 7 days have you noticed any color changes to your feet? (Y/N)
- Within the past 7 days have you noticed any open wounds or skin breaks on your feet? (Y/N)
- Are you experiencing numbness or pins and needles sensation in your feet? (Y/N)

If the Veteran answers YES to any of the following questions, the MSA or VAMC Staff must follow local guidance and contact i.e., PACT Triage Nurse, Podiatry Clinic Provider or other clinical staff to evaluate the Veteran to determine urgency of a Podiatry Consult or Visit:

If patient answers NO to all questions, proceed with submitting a Community Care-DS Routine Podiatry consult.

NUTRITION SORTING QUESTIONS:

- Are you a Nutrition Support patient (i.e. prescribed oral nutrition supplement drinks, feeding tube, intravenous nutrition)? (Y/N)
- Have you unintentionally lost a significant amount of your body weight (i.e., 5% or more of your body weight)? (Y/N)
- Do you have a new diagnosis or condition that requires immediate dietary changes? (Y/N)
- Do you have a surgical wound, pressure ulcer ("bed sore") or another open wound? (Y/N)
- In the past 3 months, did you ever run out of food, and you were not able to access more food or have the money to buy more food? (Y/N)

If ANY questions were answered YES by the Veteran (who has called the VA), transfer Veteran to Triage Nurse for evaluation.

If the Veteran has walked into VA Clinic and answered YES to any Sorting Questions, refer to Primary Care or a Dietitian

If ALL questions answer by Veteran as NO, continue to schedule for COMMUNITY CARE-DS ROUTINE NUTRITION Consult

For Return to Clinic (RTC) Orders

(Pre/Post CCN)

- VA providers generally enter an RTC order when follow-up appointments are required for Veterans established to a VA clinic. If the PID on the RTC is within the community care wait time standards (WTS) (20 days for Primary Care, Mental Health and Non- Institutional Extended Care Services or 28 days for Specialty Care) and there are no available appointments in the VA within the WTS, then the Veteran is eligible for community care and a conversation should take place to discuss the options for the Veteran to obtain care either within the VA or the community.
- of the CID/PID and the Veteran opts into community care, the VA staff or provider creates a Community Care consult using one of the three following pathways:
- Pathway 1. The scheduler hands-off to an RN who creates a Community Care consult in the name of the VA Provider and "Releases without MD signature" by policy.
- Pathway 2. The scheduler hands the consult back to the VA provider and the VA provider then directly orders the consult with community care.
- Pathway 3. Administrative staff enters the consult in the name of the VA provider and "Hold until Signed" by local policy or follows the VCCPE consult process.
- Additional detail describing each pathway can be found in the "Return to Clinic" section of the One Consult Standard Operating Procedure.

For Consults Created from an Order

(Pre/Post CCN)

- A Community Care consult is created from an order when a scheduler receives an order in CPRS (e.g. for radiology services) and identifies that the service requested in the order cannot be provided in a VA clinic within 20 days for Primary Care or Mental Health or 28 days for Specialty Care of the CID / PID. The scheduler must confirm with the ordering provider before initiating the process for a Community Care consult. When it is determined that community care is required, the VA provider creates a Community Care consult directly, adding a provisional diagnosis code.

  Note For additional steps regarding radiology services, please refer to the One Consult Model Radiology Training.

- VA schedulers and providers follow similar processes to refer an established Veteran to VA Community Care. A Community Care consult is created when he or she requests an appointment at a specialty clinic, or a specialty clinic provider needs to reschedule an existing appointment.

  Note: The same process will apply for Procedures. A Community Care consult must be created if the Procedure service will be required to be obtained from Community Care. Additional steps for this scenario are described in the "Community Care Consult Directly from an Order" section of the One Consult Standard Operating

Procedure. VA Procedure Orders cannot be forwarded to Facility Community Care Office.

Note: As described in the VHA Office of Community Care (OCC) Operating Model, a strong relationship with internal VA clinics that opt Veterans into community care are critical. It is recommended that the Facility Community Care Office departments establish a hotline for internal VA clinics to contact. In the event of an access issue within an internal clinic, a scheduling clerk may call the hotline to facilitate a warm hand off of the Veteran to community care staff in real time.

It is critically important that the Facility Community Care Office department coordinates the type of care the providers are requesting, how it is performed in the community, and the method in which the information is transferred back to VA. Defining clear roles and responsibilities is an important role of the Chief of Staff when defining service level agreements between VA and community care resources. Managing these critical transitions is a key step in strengthening partnerships for both primary and specialty care. Particular attention should be paid to the coordination of mental health services for Veterans receiving episodic or long-term care in the community. Additional information is available on the OCC Operating Model SharePoint.

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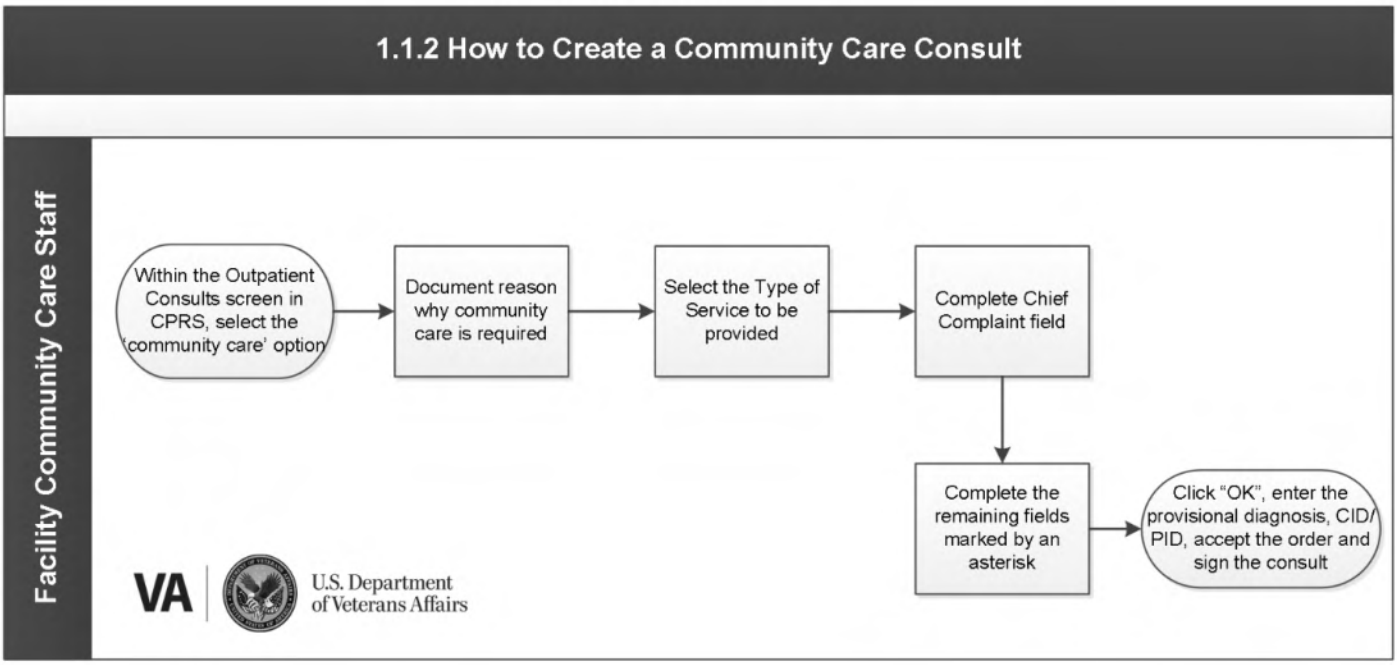
2.15 How to Create a Community Care Consult

(Pre/Post CCN)



PROCEDURES

General Considerations:

A VA provider can create a community care consult when they know the service is not available at their location, or if the provider determines that it is in the best medical interest of the patient. The Delegation of Authority process still applies for these consults. Directly creating a community care consult reduces the need for VA providers to enter an internal consult, which will need to be forwarded to a community care consult title. The delegation of authority review process still applies for all community care consults.

Below are activities all providers must complete when creating a new community care consult.

Throughout the process of managing community care consults, users may use the Consult Toolbox. Users must first ensure that Consult Toolbox is enabled on the workstation via the Tools menu in CPRS. To access the functions of Consult Toolbox from an actionable consult, users will select the Action menu of CPRS, then Consult Tracking. They will then choose the appropriate function for the needed workflow: Discontinue, Forward, Add Comment, Significant Findings, or Administrative Complete. Under Consult Toolbox Version 1.9.0078: If the Add Comment function is selected, the user will then need to right click in the Comments field of the Add Comment to Consult pop-up to access more Consult Toolbox options. These options include: Scheduler Functions, Community Care Functions, Clinical Review Options, and Launch Decision Support Tool (DST). Under Consult Toolbox Version

2.0, the user can select the Open Consult Toolbox button, for options which include: Consult Review, CC Eligibility (DST), Contact Attempts and Patient Preferences.

Steps	Activity
1	Within the Outpatient Consults screen in CPRS, select the 'community care' option from the menu of available reasons for a consult and then select the appropriate community care option from the list of community care consults. **Note:** In accordance with the One Consult Model, all community care consults must follow the standard national naming convention (e.g., Community Care-Anesthesia, Community Care-Dermatology).
2	**Document the reason why VA Community Care is required** by selecting the appropriate Justification for Community Care' reason from the drop-down menu in the CPRS consult template:

Consult Justification Reason	Definition
BMI-Hardship	Allows a Veteran to obtain some or all of their care in the community as opposed to Best Medical. BMI Hardship approvals are for 6 or 12 months and a specific consult will be needed for each episode of care that will be approved during the hardship duration period.
BMI-per episode of care	An episodic hardship that allows the Veteran to obtain their care in the community for a specific episode of care. If the care is offered within the VA, the preferred process is for an internal VA consult to be entered and allow for the specialty clinic or RCT to review the consult to determine if the care can be offered within the VA.
No Full-Service VA in State	Veteran resides in a U.S state or territory without a full-service VA medical facility (Alaska, Hawaii, New Hampshire, and the U.S territories of Guam, American Samoa, Northern Mariana Islands, and the U.S Virgin Islands.)
Service Not Available	Veteran needs a service that is not available at the VA
1703e Eligibility	Veteran needs care from a VA medical service line that VA determines is not providing care that complies with VA's quality standards.

	<table><tr><td></td><td>This option has not yet been approved for use.</td></tr></table> **Note:** These reasons are based on the justification reasons that may prompt for a consult to be entered directly to community care. You will notice that wait time or drive time are no longer included, as these consults should be entered directly to the internal service to allow them to appropriately review and determine if the care can be rendered within the VA. Additionally, BMI-per episode of care has been included, but if the service is offered within the VA the consult should also be entered directly to the internal consult title to allow for the specialty service to review and determine if the care can be rendered within the VA. In the scenario, where the Veteran is eligible for community care due to drive time and you are entering the consult directly to community care, please use "Service Not Available" from the justification drive time and run DST(pre CTB v2.0) or the CTB (post CTB 2.0) to capture the drive time eligibility reason. If you are referring the Veteran to community care due to wait time, than an internal consult would need to be entered and forwarded to community care using the CTB (guidance is in Chapter 2, Section 2.18 below) and capture the wait time eligibility using CTB at the time of forwarding. This may occur when a request for services (RFS) is received and the community care office has the delegation of authority (DOA) to process the RFS at their level. If a consult is entered with an incorrect justification reason the facility community care staff should confirm the appropriate eligibility for community care and add a comment with the appropriately eligibility captured. If the Veteran is eligible for community care, the consult should not be discontinued or cancelled, but staff education should take place. Staff responsible for entering consults should be educated at the local level on the community care consult justification reasons and when to use each reason.
3	Select the Type of Service to be provided and other specialty-specific clinical elements, inclusive of the consult template. If applicable, indicate the Standardized Episode of Care (SEOC) and Category of Care for the Veteran's clinical need using the Consult Toolbox. Note; The latest version of the Consult Toolbox needs to be enabled to activate SEOC capabilities. **Note:** In the forwarding scenario, either the in-house specialty clinic staff OR the Facility Community Care Office may select the SEOC, depending on the local site's processes and best practices; responsibilities will vary at each medical center. For the scenario where CC Consults are ordered directly, nothing changes – the SEOC is selected by the provider creating the community care consult.
4	**Complete the Chief Complaint field** and fill out patient history details as applicable.

5	**Complete the remaining required fields marked by an asterisk** including questions regarding third-party billing, the need for Community Care services and transportation needs for the Veteran. **Note:** The community care consult includes standardized information applicable to all consults, but further information can be customized at the local site level for each specialty. As a result, providers may have to complete additional fields.
6	**Click "OK", enter the provisional diagnosis, CID/PID, accept the order and sign the consult.** **Note:** This action of signing the consult will trigger an automatic CPRS alert to the Facility Community Care Office to process the consult.

2.16 Ordering a Consult

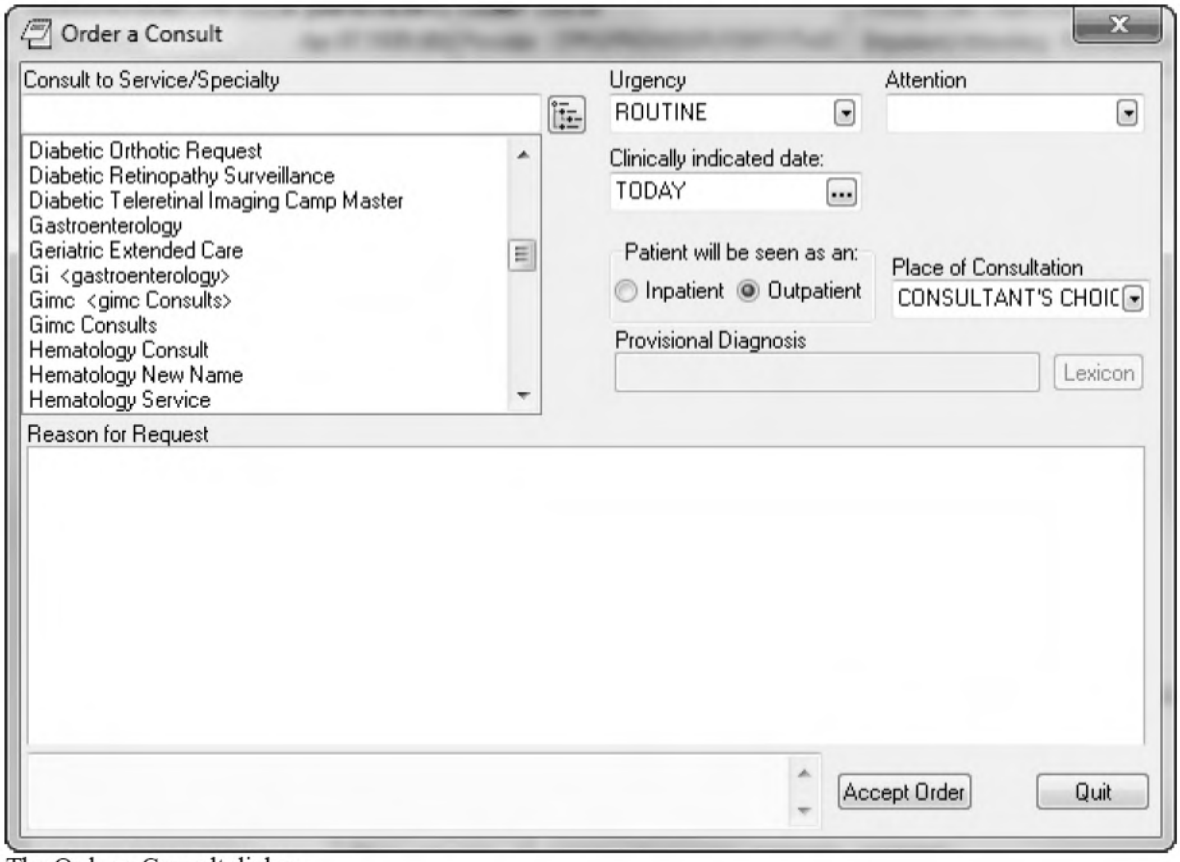
To order a consult from the Orders tab follow these steps:

- Select the Orders tab.
- Select the active orders view from the View Orders pane -or- select View | Active Orders (includes pending, recent activity).
- Select Consult in the Write Orders list.

Note: The consults order may be labeled differently or may not be available from your Write Orders field.

Note: If encounter information has not been entered, the encounter information dialog will appear before the Order a Consult dialog. You must complete the encounter information dialog before proceeding.

(CTB Version 1.9.0078)

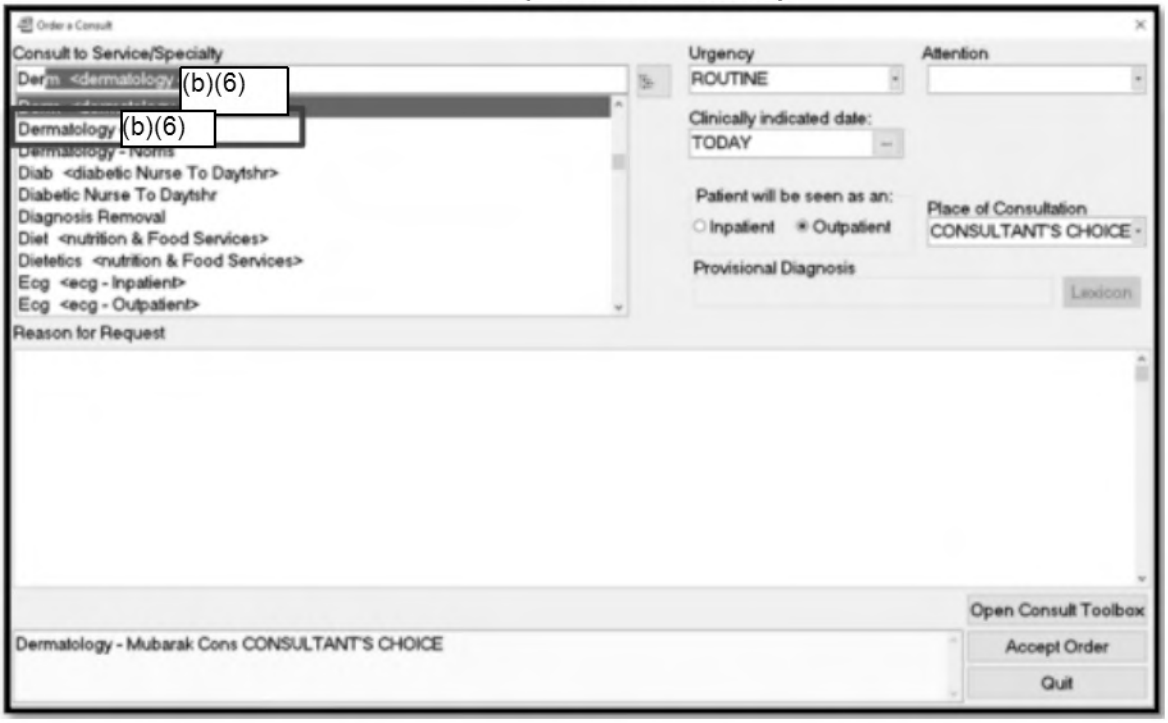


The Order a Consult dialog

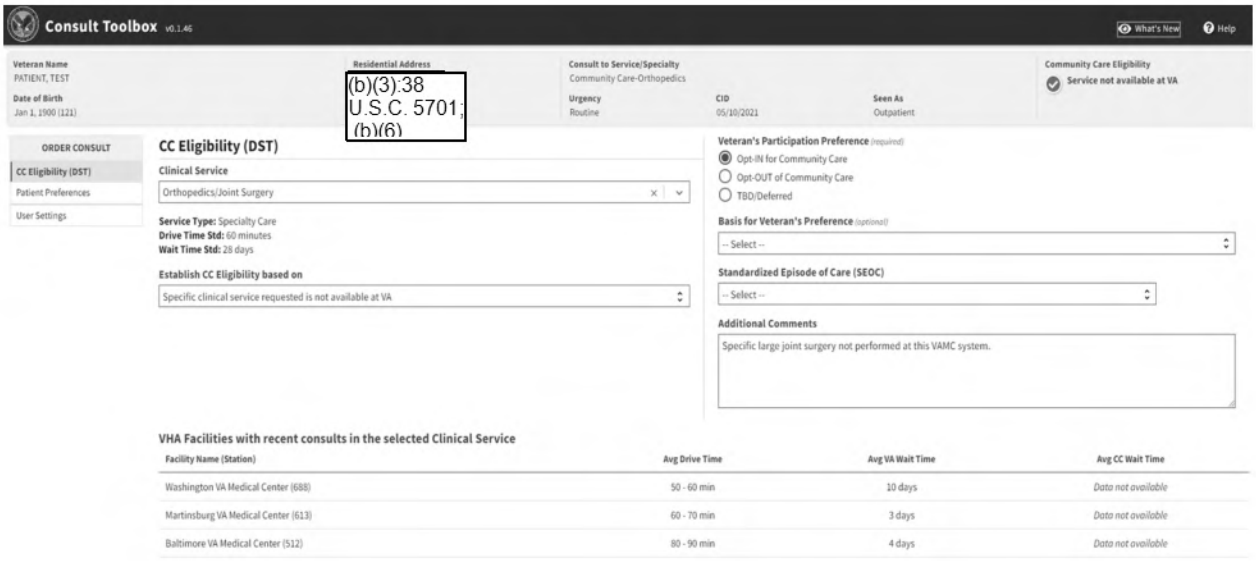
- Select a type of consult from the Consult to Service/Specialty field. When you select the Consult Service or Specialty, several things may happen.

- If the service has some prerequisites, a dialog will display stating what those are and will allow you to print the information, continue to place the consult order, or cancel the order.
- In addition, any predefined text or template will display to help the user fill out the Reason for Request field.
- The Provisional Diagnosis field becomes active as well.
- Select the urgency from the Urgency field
- Select an individual from the Attention field.

- **(CTB Version 2.0)**



- Select a type of consult from the Consult to Service/Specialty field. When you select the Consult Service or Specialty, several things may happen.
- If the service has some prerequisites, a dialog will display stating what those are and will allow you to print the information, continue to place the consult order, or cancel the order.
- In addition, any predefined text or template will display to help the user fill out the Reason for Request field.
- Select Open Consult Toolbox
  1. Select Clinical Service, Establish CC Eligibility Based on, Veterans Participation Preference and Basis, and standard episode of care. Select Save Changes and Close.



- Select Provisional Diagnosis in the consult dialogue box utilizing the Lexicon.
- Select the urgency from the Urgency field
- Select an individual from the Attention field

Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:
The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules.

- When no division is listed for a provider, no division is displayed.
- If only one division is listed, this division is displayed.
- If the site has multiple divisions or more than one division is listed and one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
- If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
- Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)
- If needed, designate a different Clinically Indicated Date.

Note: The Clinically Indicated Date field does not apply to Prosthetics consults services, and the field is not available when the user selects a Prosthetic service.

- Choose inpatient or outpatient from the “Patient will be seen as an:” option group.
- Choose a location from the Place of Consultation drop-down box.
- Enter a provisional diagnosis.

Note: If a user tries to enter a diagnosis with an inactive code, CPRS will bring up a message indicating that the code must be changed and giving the user the chance to choose a diagnosis with an active code. For each consult, this field is either set up to require that

- The user type in an answer (the box will be white and the Lexicon button unavailable),

- The user must select a response must be from the Lexicon (the field will be yellow, and the Lexicon button is available).
- CPRS will search for diagnoses that contain the search term. The matching terms will display in the bottom portion of the Problem List Lexicon Search dialog. The search now looks for SNOMED Concepts Terms (SNOMED CT) items. Most items will also be mapped to an ICD-9-CM code. The list will show the SNOMED concept text, the SNOMED code, and the ICD-9-CM code if the term is mapped to one.
- If you do not see the appropriate problem listed, select the Extend Search button. The Extend Search button extends the search to the ICD-9-CM clinical hierarchy to find additional terms.
- Enter a reason for the request in the Reason for Request field.
- Sites can help users by putting in predetermined boilerplate text, text with TIU objects, and/or it could be linked to a template that users can fill out. Users can then add to the text already present. Or the field may be left blank for the user to fill in the reason. However, a reason for request is required and the consult cannot be saved without a reason for request.
- Select Accept Order.
- Enter another Consult or select Quit.

Note: You may sign the consult now or wait until later.

Future Care Community Care Consults

Facility community care offices should continue to accept future care consults as appropriate based on clinical need. Future care consults, per VHA Directive 1232, are those consults that have a PID >90 days from the File Entry Date.

 Facility community care offices will schedule future care consults as follows:

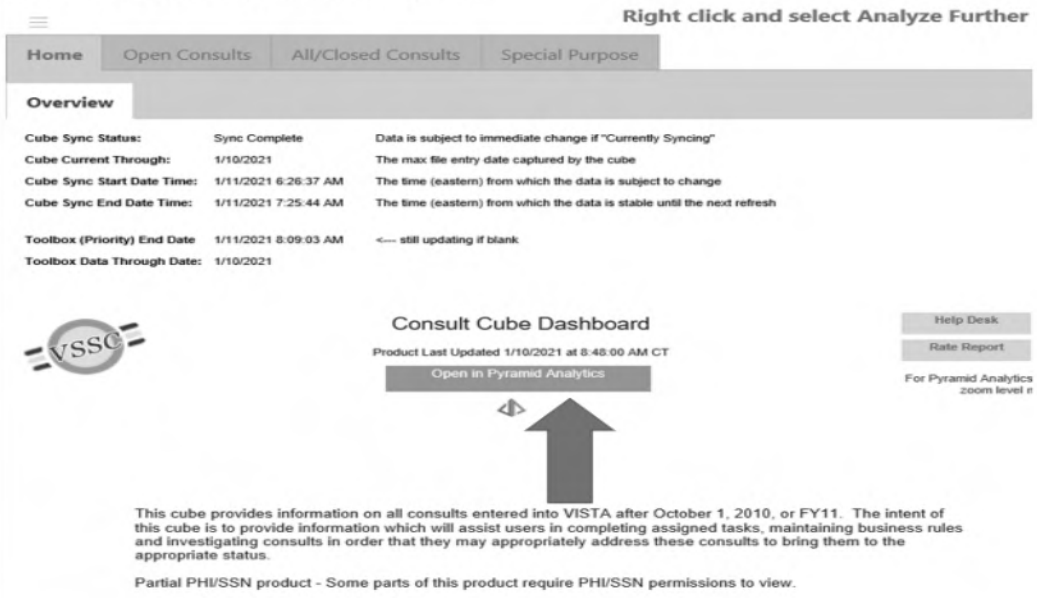
- Optional Task: Future care consults must not be sent to the Third Party Administrator for Optional Task scheduling purposes.
- Facility community care offices have the option to schedule the care, based on the PID upon receiving the consult. This can occur in the scenarios where the community provider is agreeable to scheduling into the future.
- Facility community care offices also have the option of scheduling the future care consult closer to the PID. Normal practice is to begin scheduling attempts 30 days prior to the PID.

 It is important to note that consult timeliness reports will exclude future care consults. These consults must still be acted upon timely and managed appropriately.

The Community Care Top Metrics Report is being updated by VSSC is order to reflect the updated timeliness metric expectations and to apply certain exclusions.

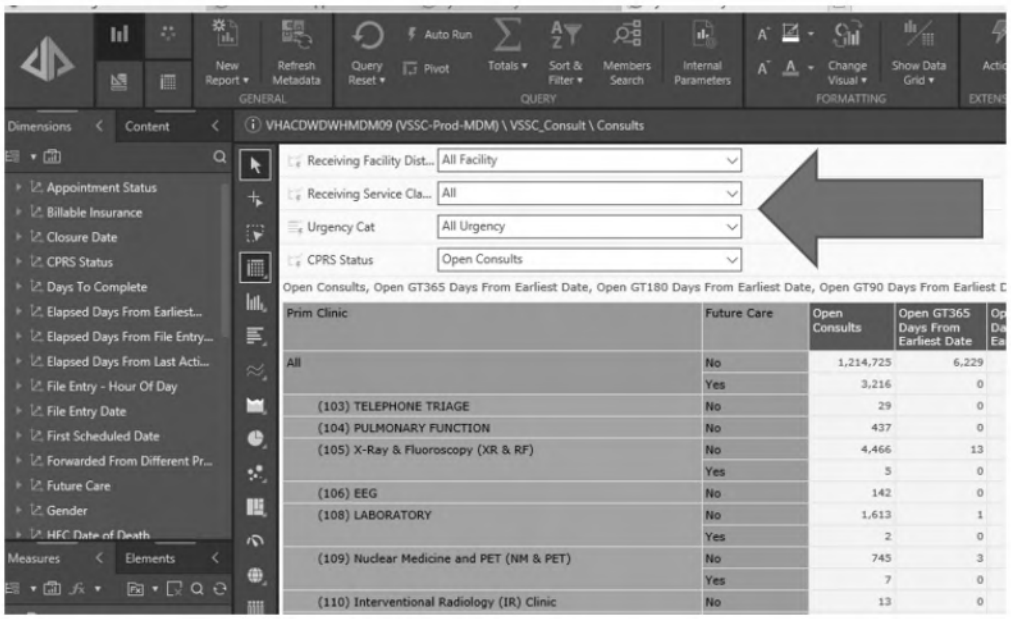
- These exclusions include:
  - Removing CC Bene travel consults
  - Removing Emergency Care consults

- Excluding self-scheduling consults from timeliness calculations
- Future Care consults

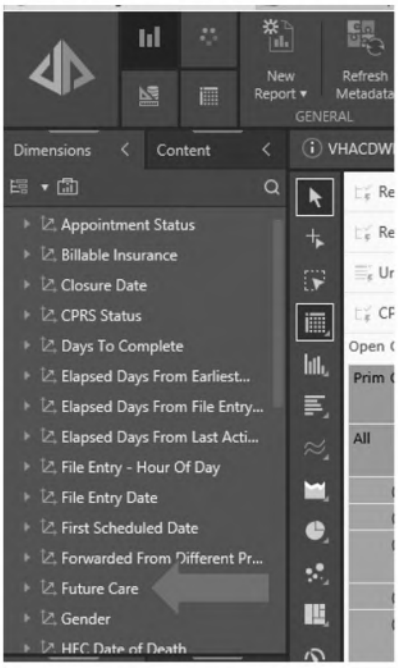
PROCEDURES	
General Considerations: Sites can track their unscheduled consults and their unscheduled Future Care consults via the consult cube.	
STEP	**ACTIVITY**
1	Select Open in Pyramid Analytics. 
2	Select Receiving Facility.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES



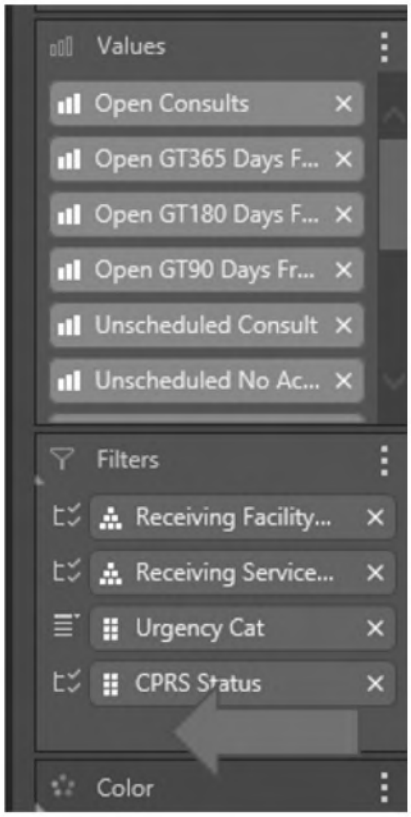
3 Select Future Care from the Dimensions box in the upper left-hand corner.



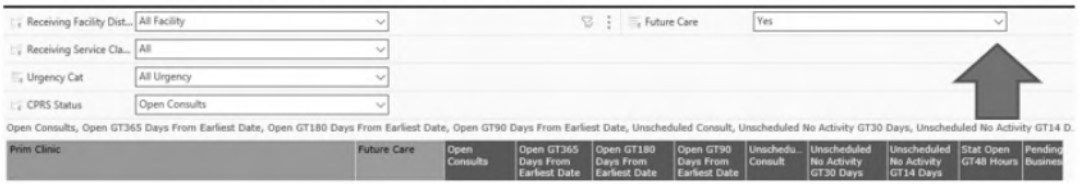
And drag to the Filters section on the right-hand side.

Last Modified on: Tuesday, August 3, 2021

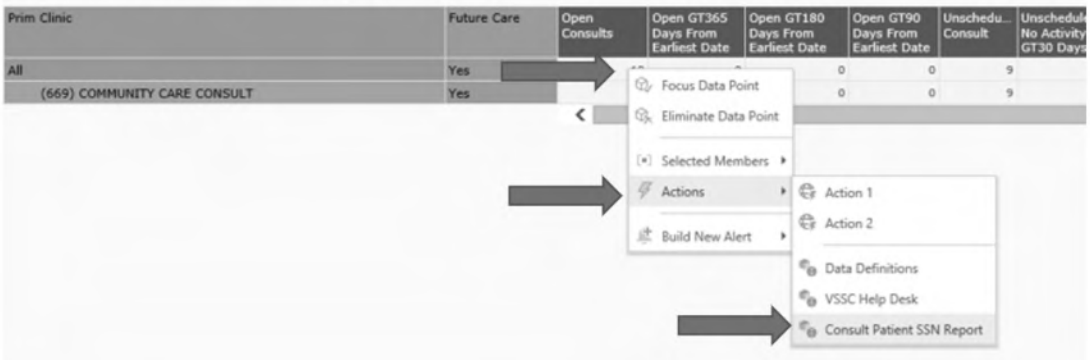
PROCEDURES



4 Select Yes under now-available Future Care Filter.



5 Right click on the number of open Future Care consults, select Actions, select Consult Patient SSN Report.



Last Modified on: Tuesday, August 3, 2021

PROCEDURES	
6	ConsultCellAction report will pop up. To pull into Excel for review distribution Select CSV from the Save Icon drop down. 

Last Modified on: Tuesday, August 3, 2021

2.17 Guidance on Decision Support Tool Contingency Operations

(CTB Version 1.9.0078)

In the event unexpected challenges occur with the Decision Support Tool (DST) or underlying IT systems on June 6th and beyond:

- The Medical Center Director will decide whether a shift to contingency processes is necessary and will ensure this is immediately communicated to the Executive Leadership Team, MISSION Champion, IT Area Manager, Group Practice Managers, and also to the Network Director.
    - MISSION Champions and Group Practice Managers are responsible for ensuring employees are immediately aware of the shift to contingency operations.
    - Network Directors will escalate the issue to the MISSION Act Joint Operations Center.
    - The Joint Operations Center will engage subject matter experts to resolve the issue and will regularly update the Network Director and Medical Center Director on progress toward resolution.
    - Once the issue is resolved, the Medical Center Director will decide the timing of a shift back to standard operations and will ensure this is immediately communicated to the Executive Leadership Team, MISSION Champion, IT Area Manager, Group Practice Managers, and also to the Network Director.
    - MISSION Champions and Group Practice Managers are responsible for ensuring employees are immediately aware of the shift back to standard operations.

Reference the Office of Community Care Decision Support Tool Contingency SOP **for the step by step guidance on the process to follow in the event of a DST Contingency.**

(CTB Version 2.0)

Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

Reference the Office of Community Care Decision Support Tool Contingency SOP **for the step by step guidance on the process to follow in the event of a Community Care Eligibility (DST) tab outage.**

Last Modified on: Tuesday, August 3, 2021

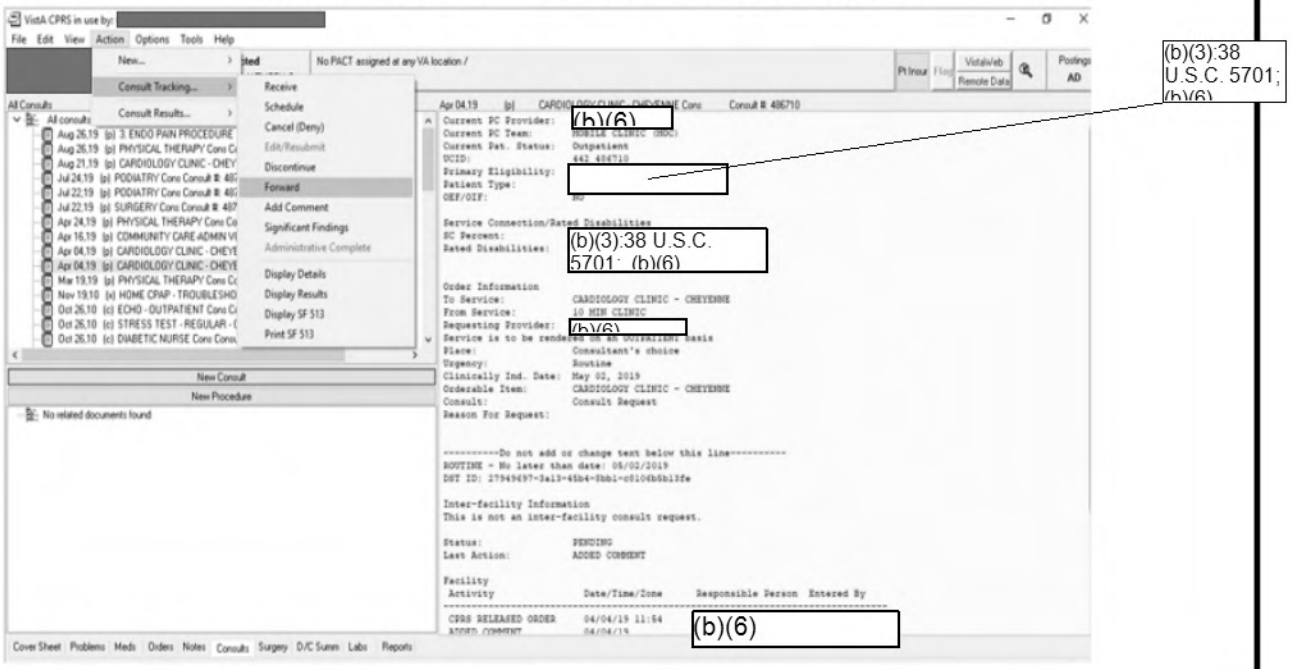
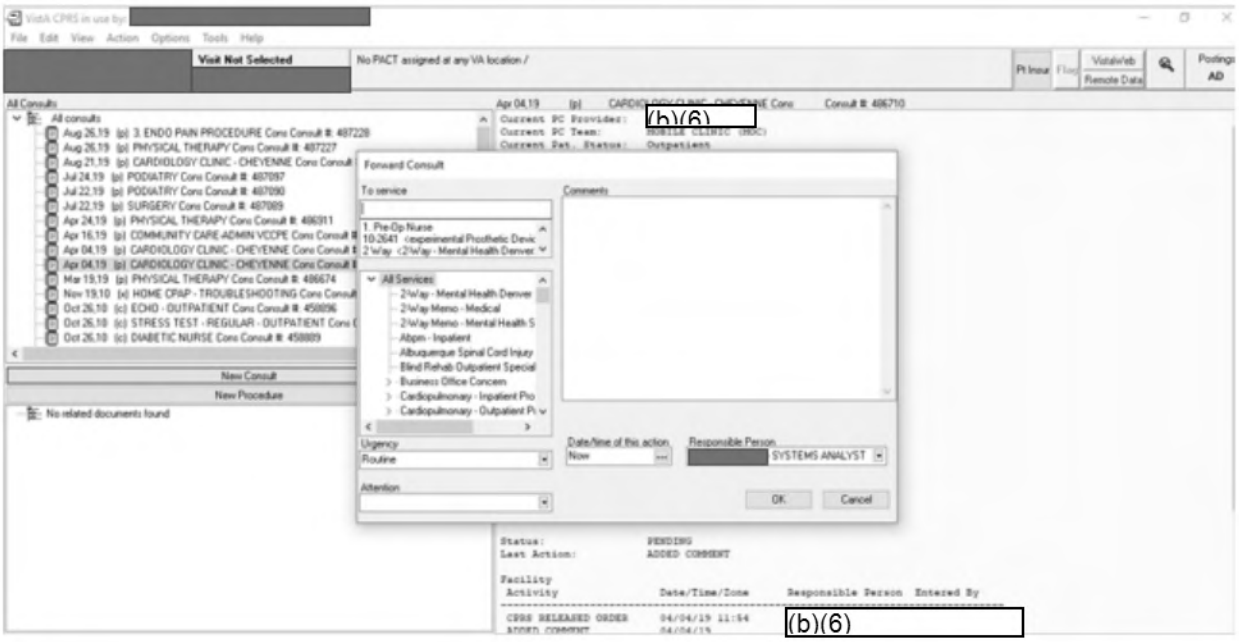
2.18 How to Forward an Existing In-House Consult to Community Care

(Pre/Post CCN) Post MISSION

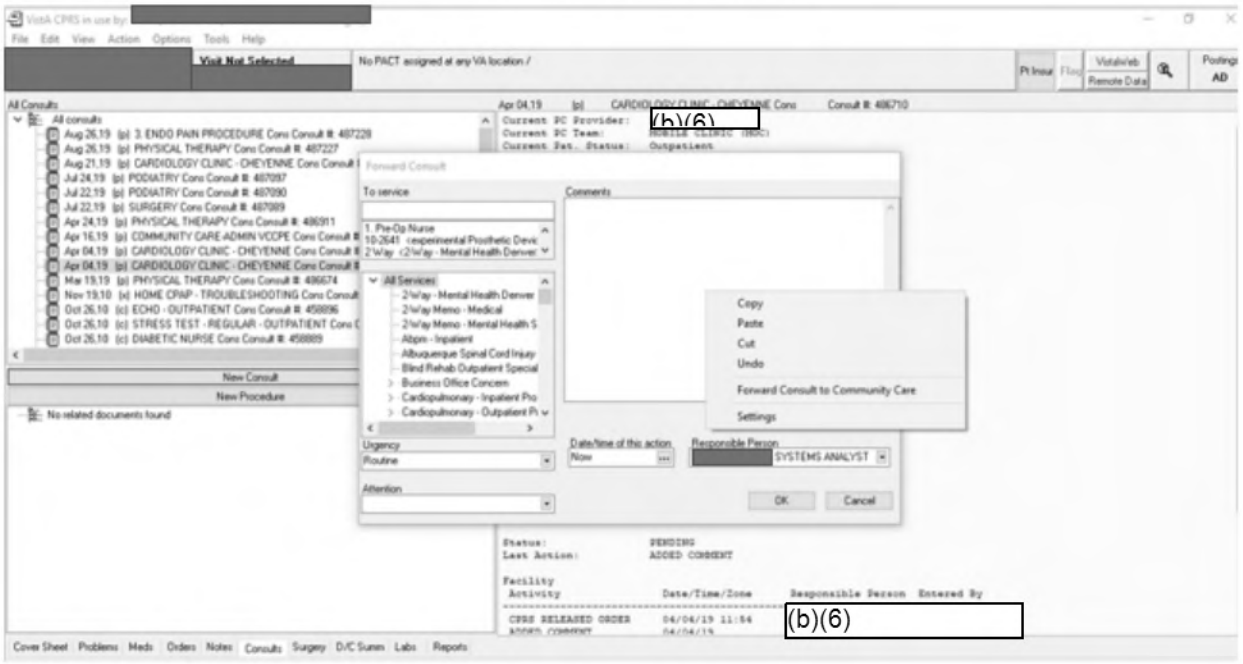
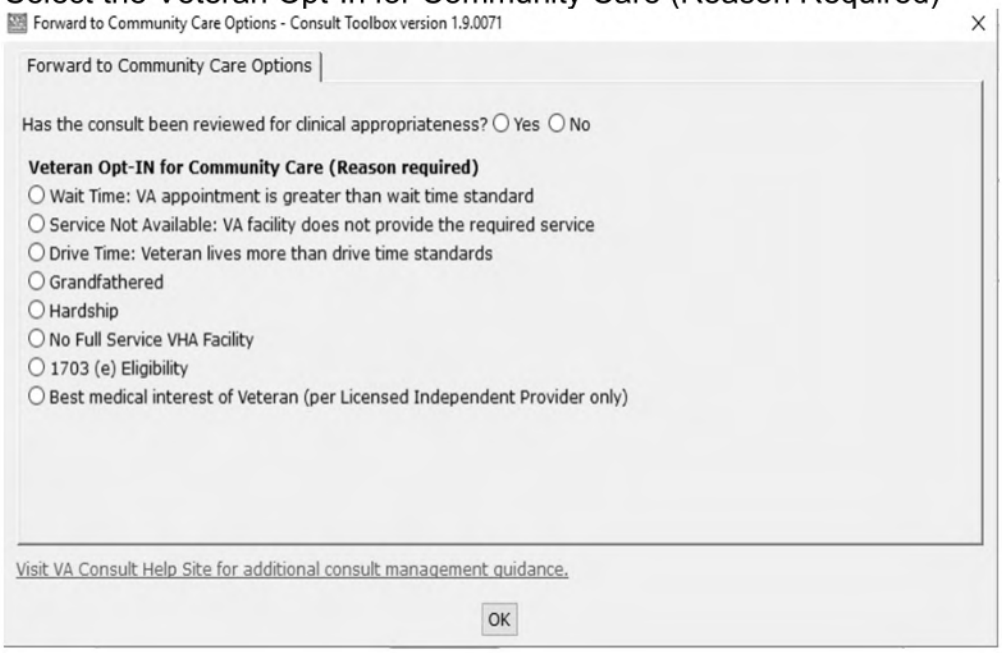
PROCEDURES
Guidance on forwarding in-house consults (and interfacility consults for sites with an integrated Vista) to community care **(CTB Version 1.9.0078)** At the time Veterans or providers (on behalf of Veterans) request care, MISSION act eligibility must be taken into consideration using the Decision Support Tool (DST). Guidance is set forth in the Executive In Charge memo dated May 30, 2019 titled "Guidance on Discussions of Veteran Eligibility for Community Care" If a Veteran opts in (chooses community care), it is expected that the consult will be forwarded to a community care consult title as early as possible. To facilitate this process, facilities must ensure: • All users of the DST, including providers and other employees, have the technical ability to forward consults in the CPRS consult package • All providers have the technical ability to create and release community care titled consults • Employees understand that when a provider enters a new in-house consult for an eligible Veteran who has opted into community care, it is best practice for that ordering provider or team to forward the signed in-house consult (and interfacility consults for sites with an integrated Vista) directly to community care. **Note:** While this is a best practice, it is not required. • Employees understand that when a reviewing provider or team determines a consult to be clinically appropriate for an eligible Veteran who has opted into community care, the reviewing provider or team are required to forward the signed in-house consult (and interfacility consults for sites with an integrated Vista) directly to community care. • Group Practice Managers ensure consults, both in-house and community care, are moved forward within timing guidelines. Reference the step by step process below for guidance on forwarding internal consults to community care consults.

STEP	ACTIVITY

Last Modified on: Tuesday, August 3, 2021

1	• When forwarding an internal consult to a community care consult title, the Consult Toolbox (CTB) must be used to document community care eligibility. • Within CPRS, select the consults which needs to be forwarded • Click Action • Click Forward and wait for a Forward dialog to appear 
2	Once “forward” has been selected from the consult tracking tab, a window opens allowing the user to select the desired consult title. 

Last Modified on: Tuesday, August 3, 2021

3	• Right Click in Comments box within CPRS • Then Click on “Forward Consult to Community Care” 
4	• The Forward to Community Care Consult Options window in the Consult toolbox will open • Indicate whether the consult was reviewed for clinical appropriateness • Select the Veteran Opt-In for Community Care (Reason Required) 

(CTB Version 2.0)

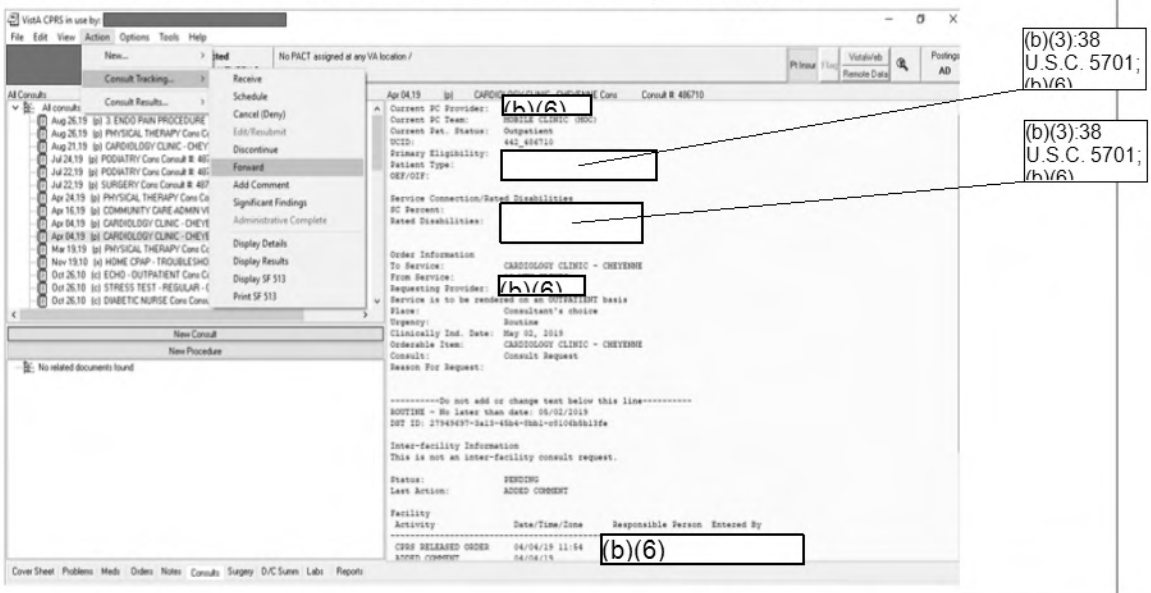
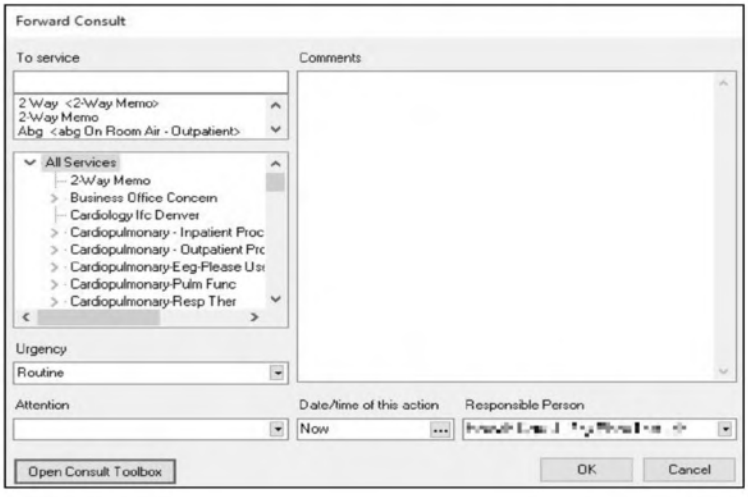
At the time Veterans or providers (on behalf of Veterans) request care, MISSION act eligibility must be taken into consideration using the Consult Toolbox. Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0. Adjusting the setting is for the Screening Triage Tool is not required due to the advanced coding of the CTB 2.0.

If a Veteran opts in (chooses community care), it is expected that the consult will be forwarded to a community care consult title as early as possible. To facilitate this process, facilities must ensure:

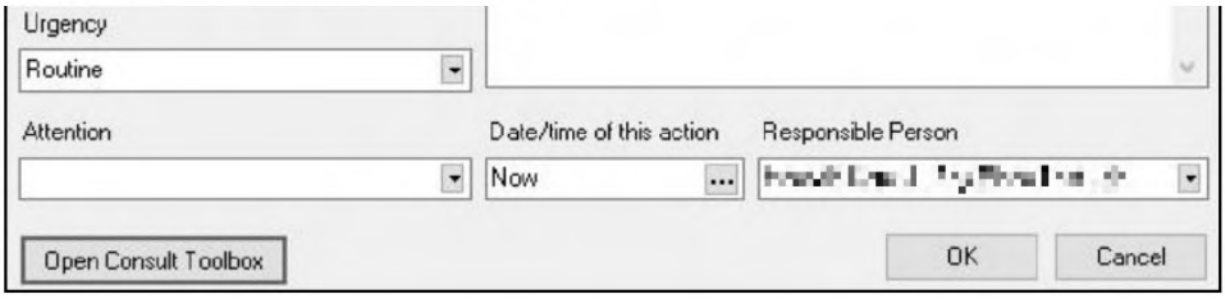
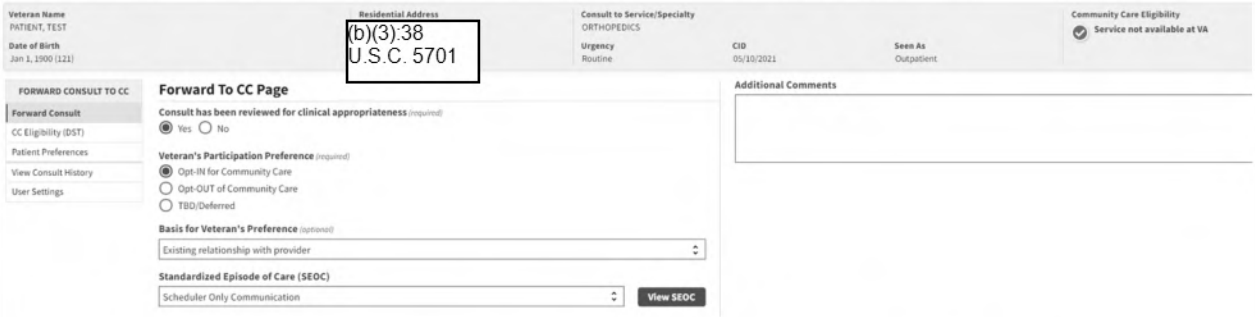
- All users, including providers and other employees, have the technical ability to forward consults in the CPRS consult package
- All providers have the technical ability to create and release community care titled consults
- Employees understand that when a reviewing provider or team determines a consult to be clinically appropriate for an eligible Veteran who has opted into community care, the reviewing provider or team are required to forward the signed in-house consult (and interfacility consults for sites with an integrated Vista) directly to community care with provider preferences already documented. **Note:** While this is a best practice, it is not required
- Group Practice Managers ensure consults, both in-house and community care, are moved forward within timing guidelines.

Reference the step by step process below for guidance on forwarding internal consults to community care consults.

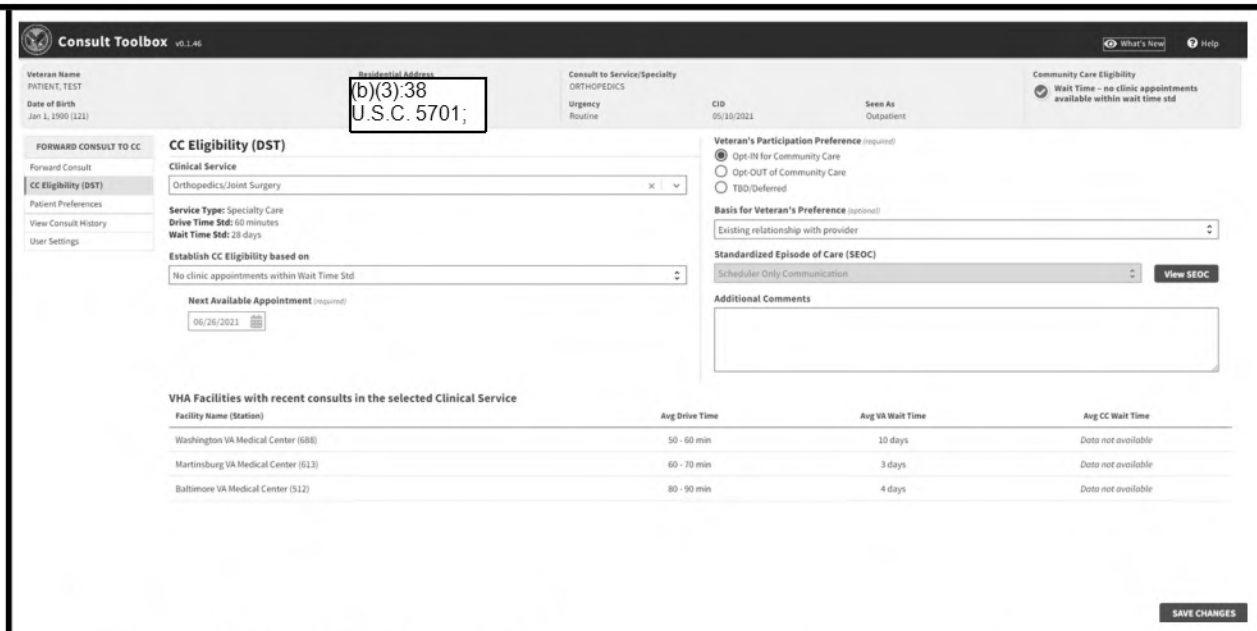
Last Modified on: Tuesday, August 3, 2021

STEP	ACTIVITY
1	• When forwarding an internal consult to a community care consult title, the Consult Toolbox (CTB) must be used to document community care eligibility. • Within CPRS, select the consults which needs to be forwarded • Click Action • Click Forward and wait for a Forward dialog to appear 
2	Once "forward" has been selected from the consult tracking tab, a window opens allowing the user to select the desired consult title. 

Last Modified on: Tuesday, August 3, 2021

3	**Then Click on "Open Consult Toolbox"** 
4	• **The Forward to Community Care Consult Options window in the Consult toolbox will open to "Forward Consult to CC."** • **Indicate whether the consult was reviewed for clinical appropriateness** • **Select the Veteran Opt-In for Community Care (Reason Required)** • **Select the Basis for Veterans Preference** • **Select the Standardized Episode of Care** **Note: SEOCs will be available based on the service line of the consult. Scheduler Only Communication is available for MSAs forwarding consults.**  **This page will not be available if the CC Eligibility has not been provided.** **Click on the CC Eligibility (DST) Tab** • **Select Clinical Service** • **Select Establish CC Eligibility Based On** • **Provide Next Available Appointment Date if applicable.** • **Opt-in, Preference, and SEOC will populate if already done.**

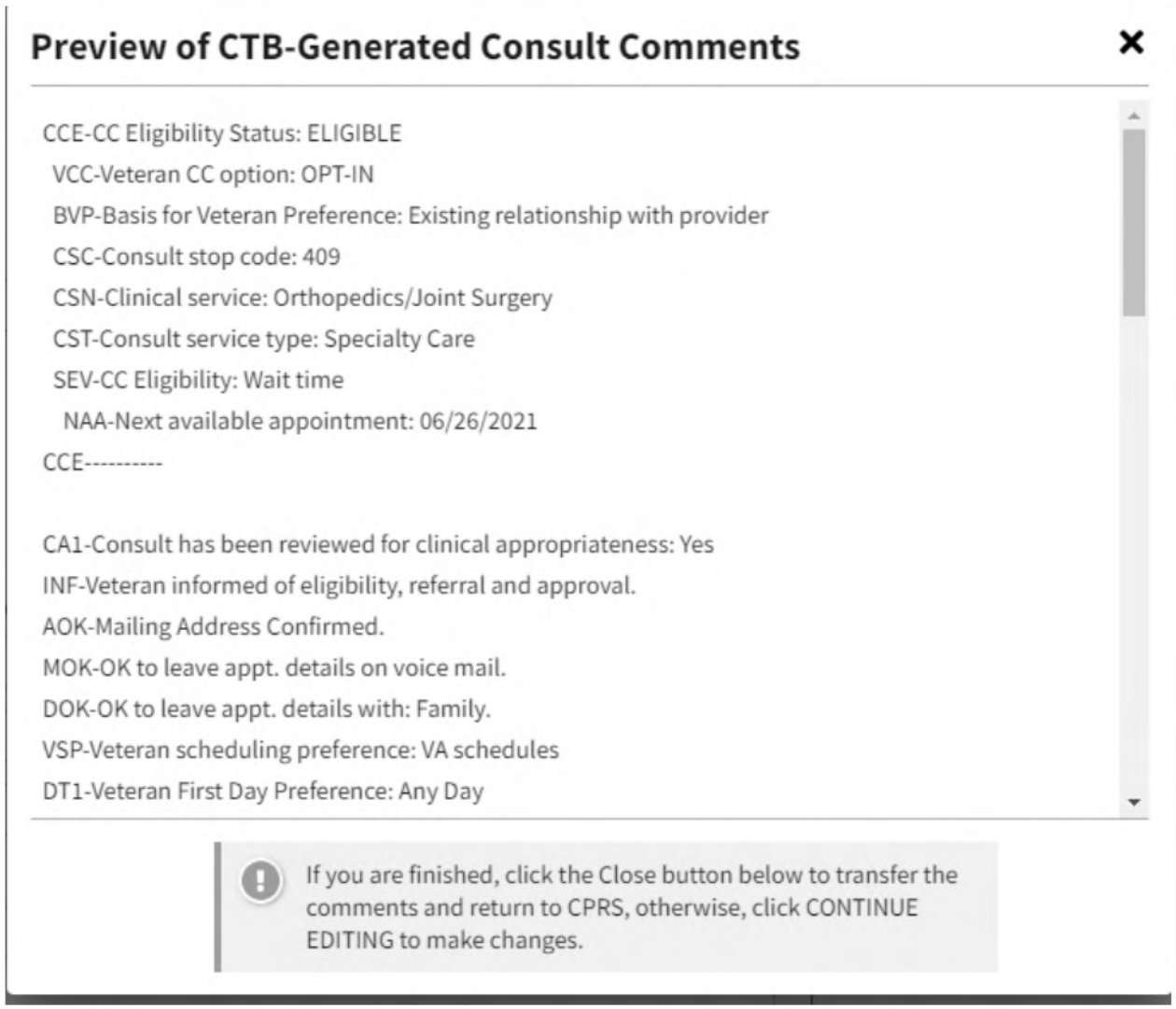
Last Modified on: Tuesday, August 3, 2021



- **Select Patient Preferences Tab**
- **Select applicable Veteran Contacted, Veteran Scheduling Preferences, Veteran Participation Preferences and Veteran Provider Preferences.**
- **Non-community care staff may select the CPL to search for in-network providers.**

- **Select "Save Changes".**
- **Preview of CTB-Generated Consult Comments will appear:**

Last Modified on: Tuesday, August 3, 2021



- **If you are finished, click the Close button to transfer the comments and return to CPRS, otherwise, click CONTINUE EDITING to make changes.**
- **Once closed, the CTB generated comments should be located in the Forward Consult dialogue box, and consult may be forwarded to Community Care.**

(Pre/Post CCN)

PROCEDURES

General Considerations:

Consults can be ordered from a variety of clinical settings (e.g. Primary Care, Specialty Care, Emergency Dept., Specialty Clinics, etc.), and can be forwarded from internal VA to the Facility Community Care Office, for Veterans eligible for Community Care.

Note: Each VA facility must create a Community Care consult that follows the standard national naming conventions for any VA in-house procedure that may have to be sent out to the community.

- A Community Care Consult is required for every episode of care and follows Veteran through the entire consult process for obtaining Care in the Community
- VA in-house consults that are forwarded to Community Care must follow the One Consult Model and must include the required Provisional Diagnosis Code (ICD-10)
- Sites will not be able to forward VA Procedures to Facility Community Care Office and will continue to use their prior Specialty Named Procedure consults with the new pre-fix COMMUNITY CARE
- All sites must have their CAC or identified VA Staff create the appropriate COMMUNITY CARE-<Specialty Name> Procedure type consult
- NVCC Version 6.2 consult template must be associated with the newly created consult service.
- For all in-house Consults placed, a Provisional Diagnosis code/Lexicon (ICD-10) is required for all in-house consults that may be required to forwarded to Community Care
- VA In-house Consults are forwarded to Community Care with original content
- Works collaboratively with Single Booking - -no need to make internal VA appointment
- When forwarding an internal consult to a community care consult title, the Consult Toolbox (CTB) Forward to Community Care Options must be used to document community care eligibility.

One Consult Service Highlights

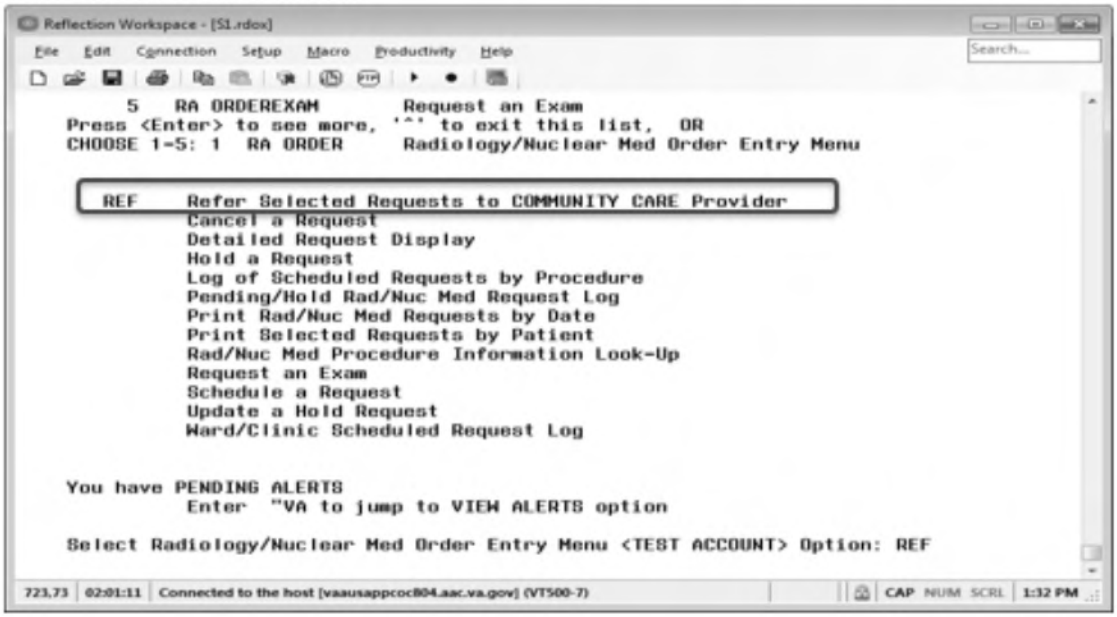
Radiology Order to Community Care-Imaging consult:

VA PROVIDER NO LONGER NEEDS TO ENTER COMMUNITY CARE IMAGING CONSULT.

- RA Order menu option allows user to convert Radiology Order to Community Care-Imaging consult placed under Ordering Providers name and Radiology Order is automatically placed on HOLD
- Community Care-Imaging consult is created with a Provisional Diagnosis
- pre-populated with ICD-10 Code: Encounter for other General Examination Z00.8
- Radiology MSA/Tech no longer need to enter progress note alerting the

- Ordering Provider to enter a Community Care-Imaging consult
- Radiology MSA/Tech no longer need to run daily reports to identify when a Community Care-Imaging consult has been entered

Below are key activities that VA staff will perform when forwarding an in-house VA Radiology Order to Community Care-Imaging consult.

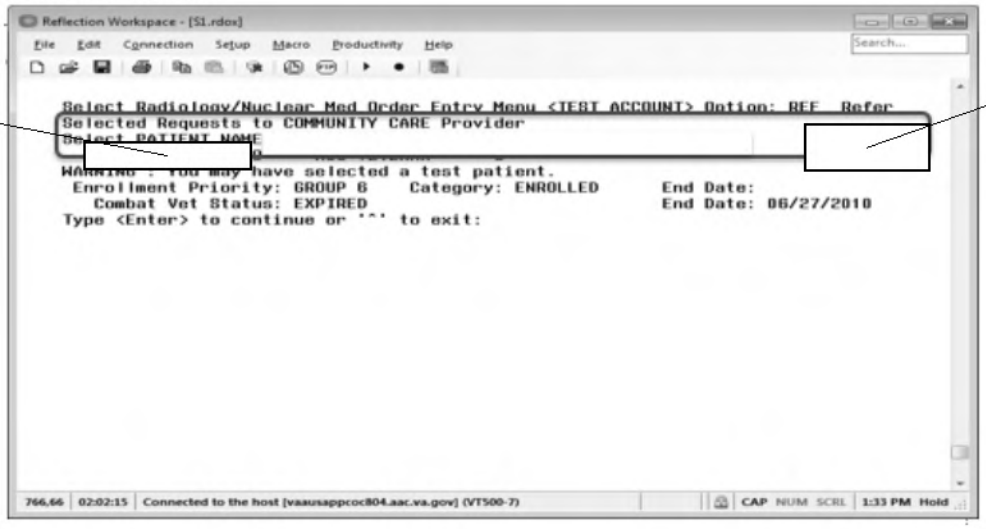
STEP	ACTION
1.	**Radiology order is entered by VA Provider and received by Radiology Staff using current practice.** 
2.	**Select "REF Refer Selected Requests to COMMUNITY CARE Provider: from the RA Order Menu.** 

Last Modified on: Tuesday, August 3, 2021

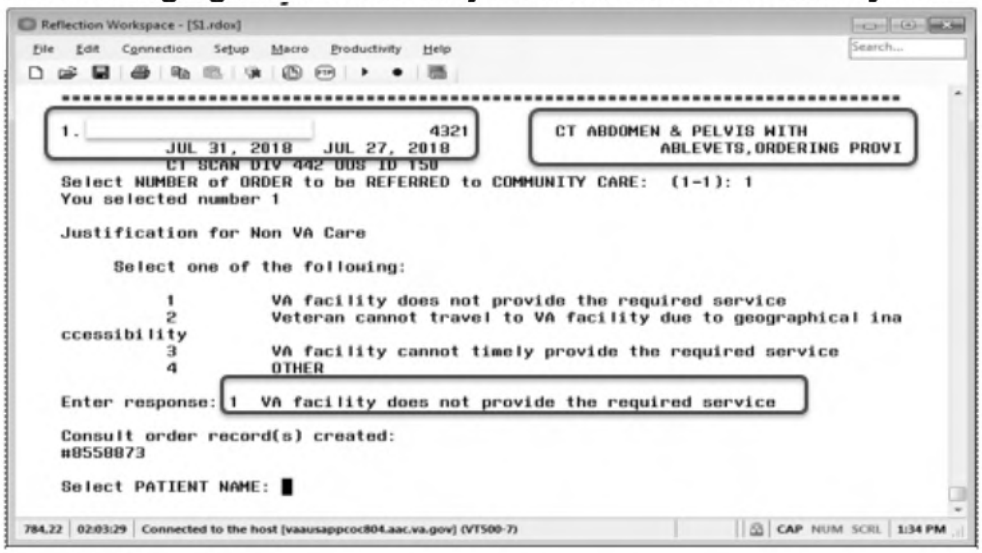
(b)(3):38 U.S.C. 5701; (b)(6)

(b)(3):38 U.S.C. 5701; (b)(6)

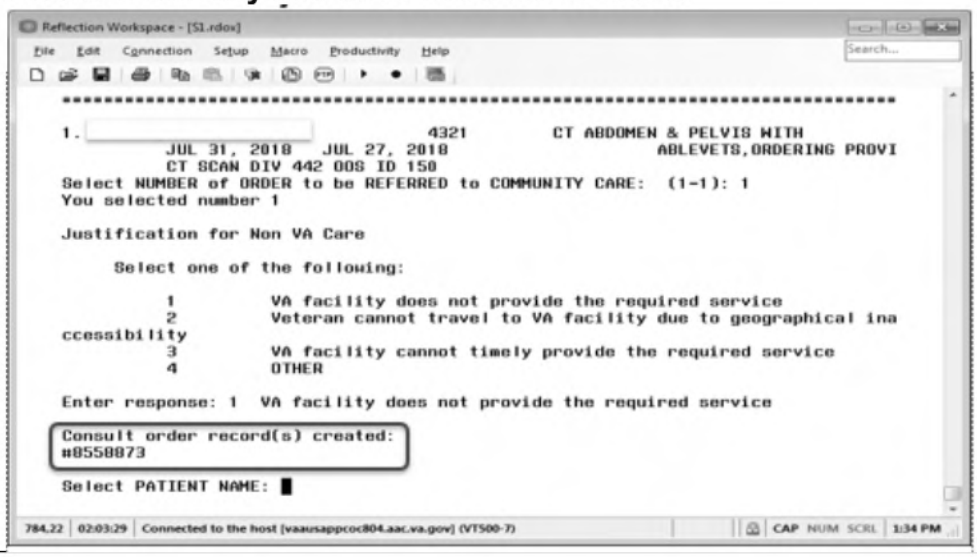
3. **Select Patient**

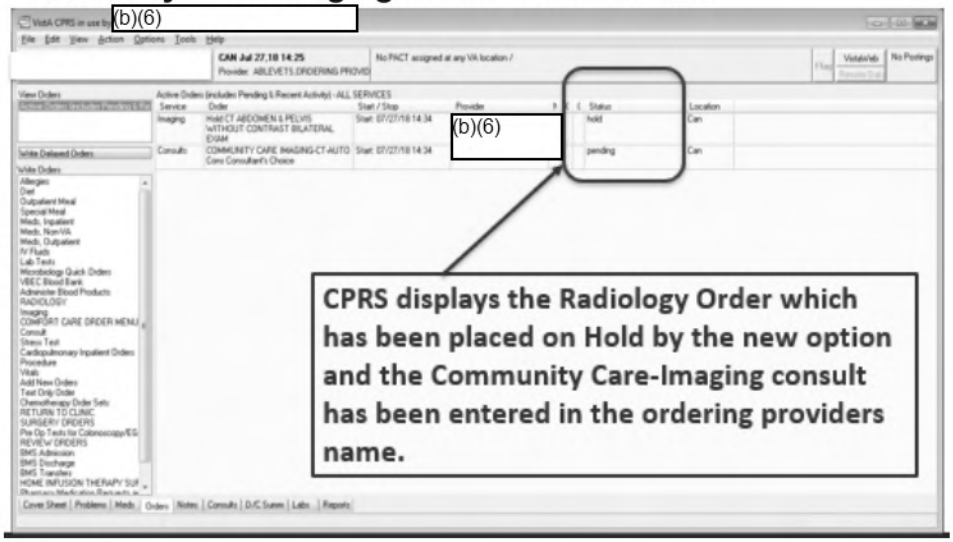
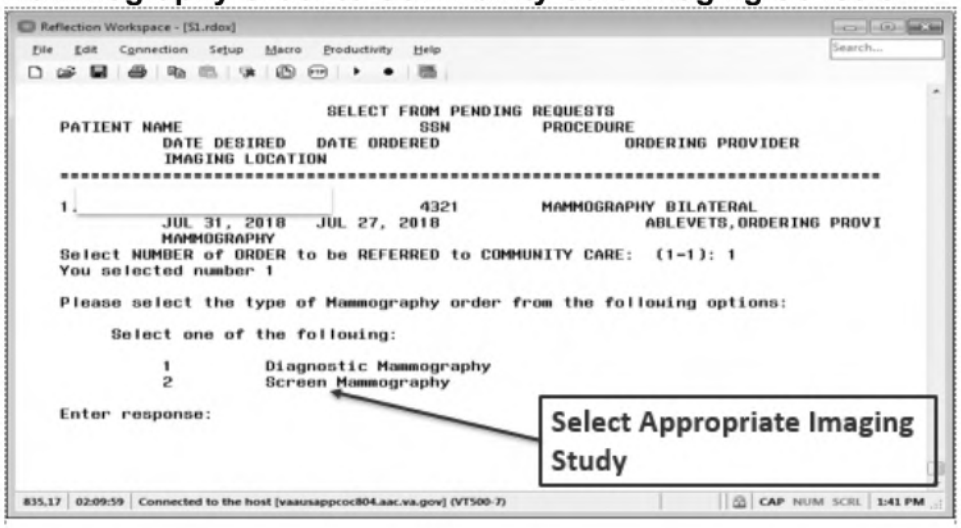


4. **Select Imaging Procedure and justification for Community Care**

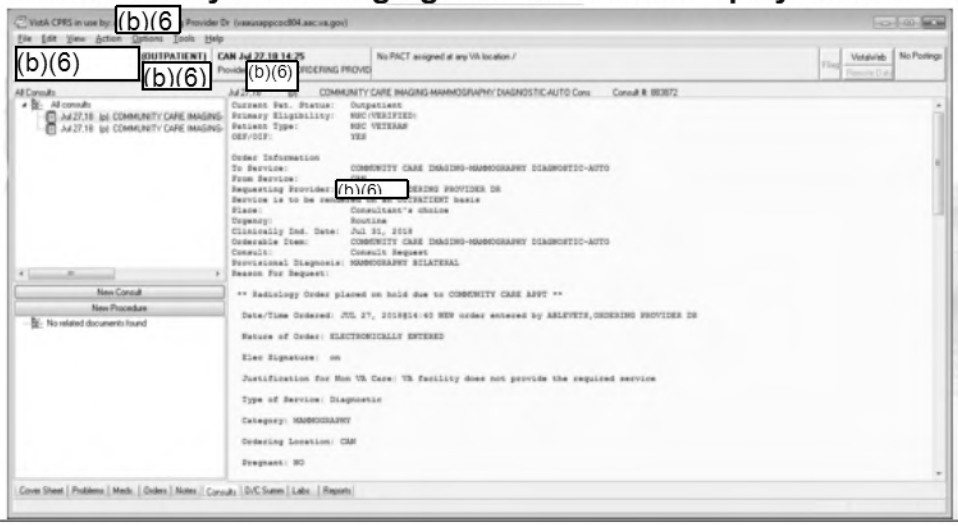


5. **Hit the Enter Key and the Consult is Created.**



6.	**Review and confirm the original imaging order, is now on HOLD and the Community Care-Imaging Consult is PENDING.** 
NOTE:	**New option REF identifies the patients' sex from the file. Female patients require selection of Diagnostic or Screen when processing a Mammography Order to Community Care Imaging Consult.** 

Result	The Community Care-Imaging Consult will be displayed on Consult tab



Inter-Facility (IFC) Exceptions:

Inter-facility Consult (IFC) is also an exception to forwarding under the One Consult Model.

- If the IFC is sent to another facility due to access and that site cannot see the patient, the IFC should be discontinued.
- The IFC should be returned to the sending facility to generate a Community Care consult.

Below are key activities that VA staff will perform when forwarding an in-house VA consult to the Facility Community Care Office. Additional information on how to forward an existing in-house consult to OCC can be found in the One Consult Standard Operating Procedure.

STEP	ACTIVITY
1	(VA Ordering Provider) Create an in-house specialty consult and provide instructions for scheduling the service in either the CPRS comments or by using the Consult Toolbox. A provider may use the Consult Toolbox with the Provider Options enabled to document the scheduling instructions, by using the "Add Comment to Consult" action in CPRS. **Note:** Always add Provisional Diagnosis/Lexicon (ICD-10) Code and update the newest CTB version as released by VHA Office of Community Care per your VA VISN and Facility IT update to the menu.
2	(VA Specialty Provider or Designee) Conduct a clinical review and select the care options that best meet the Veteran's need on the 'Receive Routine Consult Options'/Consult Review screen of the Consult Toolbox, if applicable. Refer to the Consult Toolbox User Guide for a description of the Routine Consult Options.

3	(VA Specialty Provider or Designee) Work with the scheduler to determine if an internal appointment is available within 28 days of the CID / PID in VSE-VS GUI along with VistA Appointment Management. **Note:** If Community Care is needed, the staff member will select the appropriate SEOC and appropriate details relating to the Community Care request. Either the in-house specialty clinic staff OR the Facility Community Care Office may select the SEOC and depending on the local site's processes and best practices; responsibilities will vary at each medical center.
4	(Scheduler) If an in-house appointment is not available within 20 days for Primary Care or mental health and 28 days for specialty services of the CID/PID, assess whether a nearby VA facility can provide the care. If a nearby VA facility is available and drive time standards are met request that the VA provider or designee forward an Inter-Facility Consult (IFC).
5	(Scheduler) If an IFC is not appropriate, check that the Veteran is eligible for community care based on MISSION eligibility criteria. **Note:** The Veteran's Opt-In/Opt-Out information will be recorded in the Consult Toolbox. If the Veteran opts out, schedule an internal VA appointment in VSE-VS GUI along with VistA Appointment Management and document the opt out decision with #COO#.

Last Modified on: Tuesday, August 3, 2021

2.19 Enhancement to Expedite Community Care Appointing Process

(Pre/Post CCN)

Note: The Community Care Scheduling Enhancement Office Hours presentation from November 9, 2020 and November 12, 2020 is now available for review.

Procedures

When an eligible Veteran opts into community care, scheduling staff shall capture the Veteran's scheduling preferences as shown in the Consult Toolbox (i.e. preferred provider, day/time week). This is consistent with the Referral Coordination Initiative (RCI). Training materials are available in the OCC Field Guidebook (FGB) Ch. 2, Section 2.19. Implementation of the process for capturing Veterans Community Care Scheduling Preferences is mandated. This process is mandated in order to assist with expediating the appointment coordination for Veterans that opt-in to community care.

Collecting Veteran preferences helps streamline the community care appointing process

- Multiple attempts to contact the Veteran were identified as the rate limiting steps in community care scheduling
- Capturing preferences prior to check-out or before the consult is forwarded to community care will minimize delays and ensure the Veteran receives timely care in the community
- Staff members that are responsible for consult management (e.g. Referral Coordination Team (RCT)) will document the Veteran's community care scheduling preferences in the following scenarios:
    - **At the time of forwarding internal VA consults to community care –**
        - For services offered internally within the VA but it is determined the Veteran is eligible for community care, and after discussion about options available for care (within VA or in the community) and the Veteran still chooses to opt-in to community care. Community care scheduling preferences will be captured prior to the consult being forwarded to community care.
    - **At the time of check-out from an internal VA appointment, when a community care consults has been ordered directly to community care for services not offered in-house –**
        - For community care consults requested directly by a VA provider (services not offered in the VA facility), Veteran preferences are captured at check-out for the requested community care service

NOTE: Capturing Veterans preferences for community care scheduling occurs after the Veteran's eligibility has been verified and the Veteran has opted-in for community care services. Official memo and training are forthcoming.

When a Veteran is eligible for community care due to wait time and opts in, the VAMC staff member who forwards the internal consult/referral to community care should place the date of the next available internal VA appointment on the consult/referral when forwarding to community care.

Internal VA scheduling staff will review the next available internal VA appointment in VistA Scheduling Enhancement (VSE) and capture the information as an added comment on the consult at the time of forwarding to community care

- **In instances when staff are unable to capture the Veteran's community care scheduling preferences, the facility community care office will contact the Veteran to document preferences.**
- **NOTE: This should be the exception. Every effort will be made to document community care scheduling preferences prior to check-out or before the consult is forwarded to community care**
- Consults will not be cancelled or returned to the internal VA clinic, by the facility community care office, if preferences are not available.
- If the Veteran chooses to self-schedule, only the preferred provider (or indication of no provider preference) information must be captured.

Staff members that are responsible for consult management, to include RCT, will document the following Veteran's community care scheduling preferences:

- **Capture Veteran's preference on how he/she would like to be scheduled**
  - Veteran self-scheduling
    - Staff will Check the 'Veteran prefers to self-schedule' box in the CTB
- **Facility community care staff to schedule with the community provider, on behalf of the Veteran, using the documented preferences unless the Veteran selects to self-schedule. Guidance on community care self-scheduling can be found in Chapter 3 of the Office of Community Care Field Guidebook.**
  - It is important to note there may be instances when the community provider prefers to contact the Veteran directly to schedule the appointment. In this case, staff must document whether the community provider can contact the Veteran directly.

- **Veteran's preferred community provider (to include no preferred provider)**
  - Staff will attempt to document up to three (3) preferred providers when possible. It is important to note that most Veterans do not have a provider preference in which case "no provider preference" is noted.

NOTE: The VA Community Provider Locator (CPL) was released for frontline staff only on July 29, 2020 to utilize to identify the preferred provider. This replaces the RCT requirement for PPMS utilization. No special access is needed to use the CPL.

- ***Facility community care staff MUST continue to use PPMS.***
- For contingency purposes, with the release of CPL, staff (not including facility community care staff) conducting scheduling activities within the clinics may use the VA.gov Facility Locator.
- If the Veteran does not have a preferred provider, the staff must document no preferred provider using the consult toolbox.

- **Day of week, time of day (e.g. AM/PM or specific time*);**
  - Each Veteran **must be informed** that this information will be used to schedule the appointment with the preferences provided
  - The method of scheduling including the day of week and the time of day **must** be documented and agreed by the patient to not be considered **blind scheduling**
  - All preferences should be reviewed and updated, by having a conversation with the Veteran each time a community care consult is generated or when an internal consult is forwarded to a community care consult
  - Collecting this information beforehand allows the community care scheduler to make the Veteran's appointment in the community without having to contact the patient.

Reference the Capturing Veterans Preference Power Point Training in the job aids section.

Reference the Community Care Preference Scripting located in the Job Aids section for VA Staff giving step-by-step guidance on how to gather Veterans Preference for scheduling Community Care Appointments.

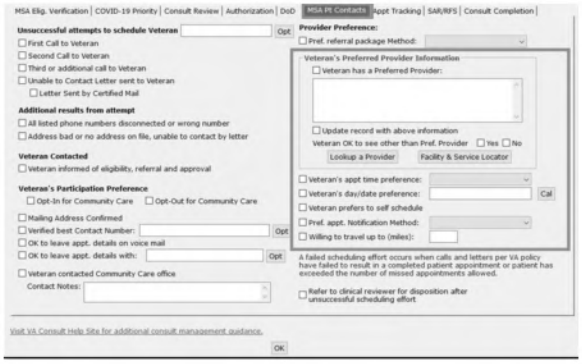
Accessing the CTB to Capture Scheduling Preferences

(CTB Version 1.9.0078)

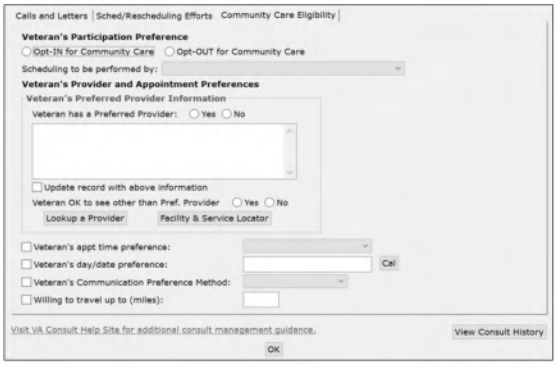
End Users can capture the Veterans Community Care Scheduling Preferences using the Community Care Functions or Scheduler Options within the CTB

Last Modified on: Tuesday, August 3, 2021

Community Care Functions

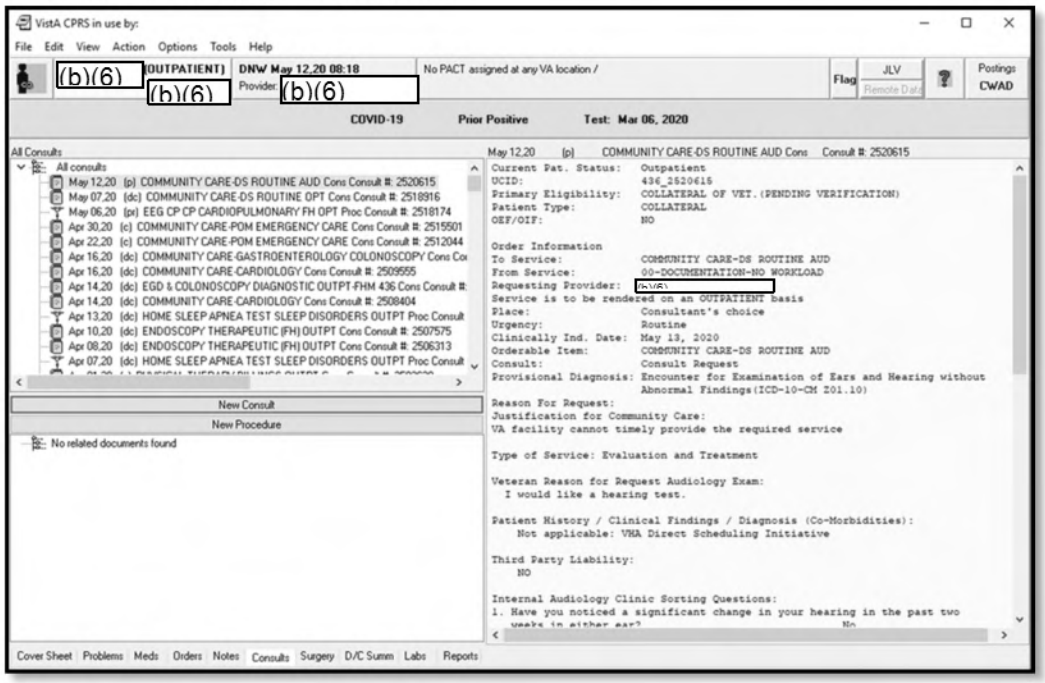


Scheduler Options



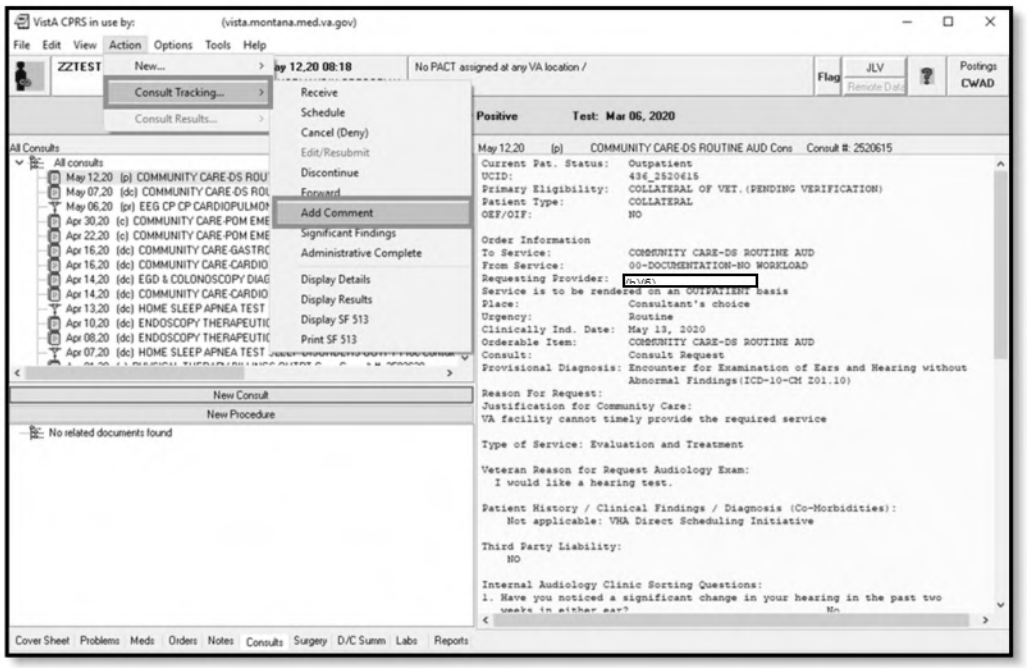
Accessing the CTB to Capture Scheduling Preferences

To access preferences, MSA staff will select the MSA PT Contacts Tab in the Community Care Function (not Scheduler Function) in the Consult Toolbox to review and record the necessary information.

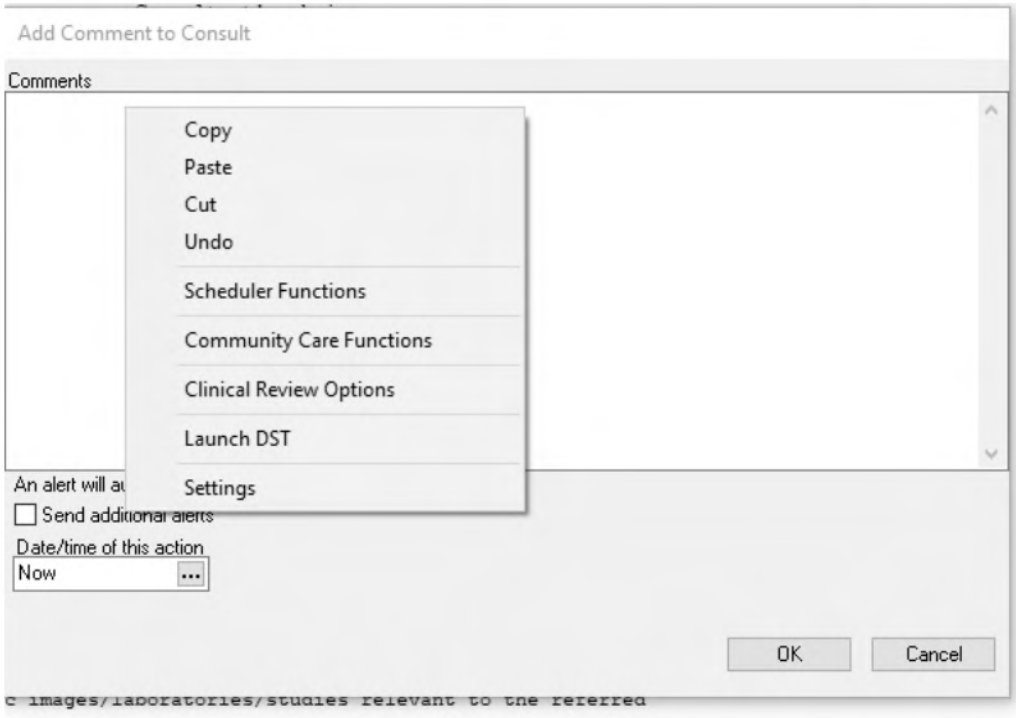


Once the correct consult has been highlighted, you will move your mouse to the tabs line and select, “Action”, then consult tracking, and then “add comment”. And a comment box will open. This process is the same for an internal in-house consult that will be forwarded to Community care and a consult that is originally created as a Community Care consult.

Last Modified on: Tuesday, August 3, 2021



Once the pop-up box is displayed, the staff member will select the “Community Care Functions” to open the consult toolbox (CTB) where the preference screen can be accessed.



Community Care Functions

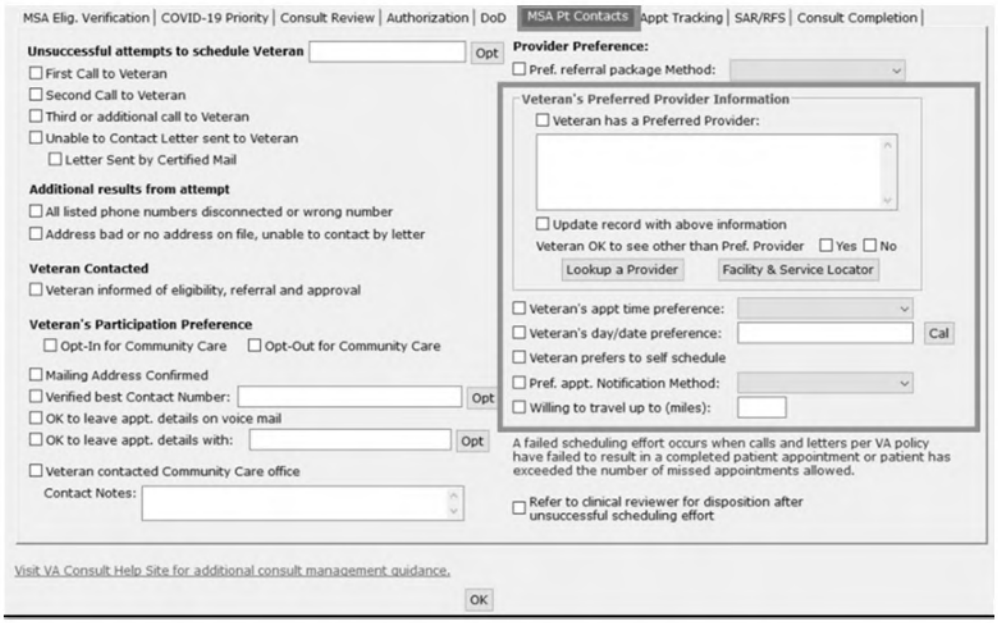
The staff member will need to select the MSA PT Contact tab to see the screen you see on this PowerPoint. The Pref referral package method is not to be captured at the inhouse clinic level.

It is important that the staff member that is completing this information knows the method in which the patient will be scheduled to complete the preference. It is suggested to have this conversation with the patient prior to starting: VA scheduling versus Contractor (ex. TMP) scheduling or Veteran self-scheduling.

Therefore, the staff member will need to have this conversation with the Veteran prior to preferences completion.

Here is where you would capture Veteran's preference on the community care provider the patient prefers and how he/she would like to be scheduled. If the patient wants the VA to schedule the Community Care appointment, the staff member will complete the Provider Preference Information and then the Veterans preference of day and time of appointment.
Documenting "no provider preference"

Step 1: Check 'Update record with above information' box
Step 2: Select 'OK' at the bottom of the window.
See next slide for example of the comments.
Step 3. After clicking OK, staff will see the 'Veteran has not designated a preferred community care provider' in the Add Comment to Consult window.

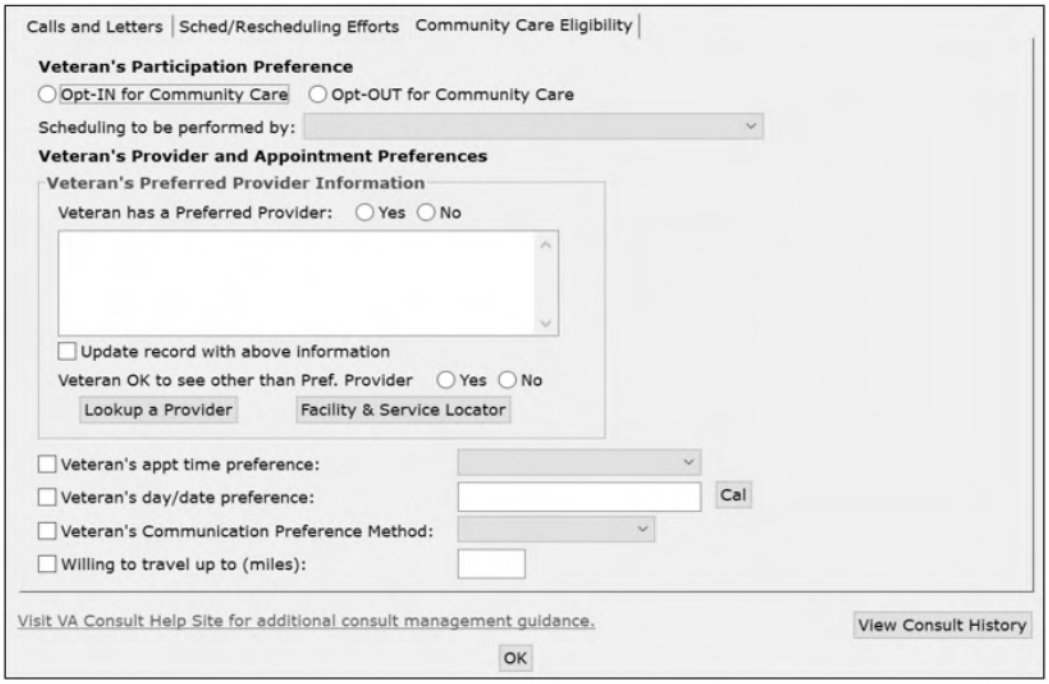


Scheduler Options- Community Care Eligibility Tab
Internal Clinic Staff MUST capture the Veteran's preferences for:

- How the Veteran prefers to be scheduled
- VA staff to schedule on behalf of the Veteran using the documented preferences
- Veteran self-schedule
- Veteran's Community Care provider of choice (to include no preferred provider); three providers should be provided.

- Day of week, time of day (e.g. AM/PM or specific time*); there is radio button for specific time. This will need to be added manually on the verification box that will pop up right before signing the consult.
- Each Veteran must be informed that this information will be used to schedule the appointment with the preferences provided this information must be documented and agreed upon by the patient to not be considered blind scheduling
- Preference for communicating appointment information (text, phone, email, standard mail, MHV Secure Messaging)

Note: That sites where the TPA is scheduling- the Veteran will still get a call for the TPA to coordinate the appointment.

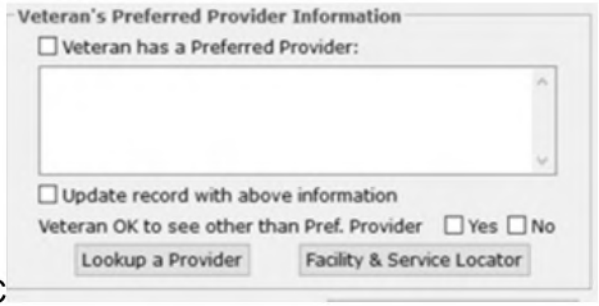


Staff should capture the community care preferred provider information using one of the options below to document in CTB:

Preferred method for capturing the preferred provider to ensure the provider is a Network provider

- VA Community Provider Locator (web-based) for frontline staff to utilize, no special access required. The RCT will no longer need access to PPMS.
- *Community care staff must continue to use PPMS.*
- VA.gov Facility Locator - “Find a VA Location”
- Capture No Preferred Provider information
- Using free text as an added comment to the consult (only when unable to capture using the other methods provided)

Last Modified on: Tuesday, August 3, 2021

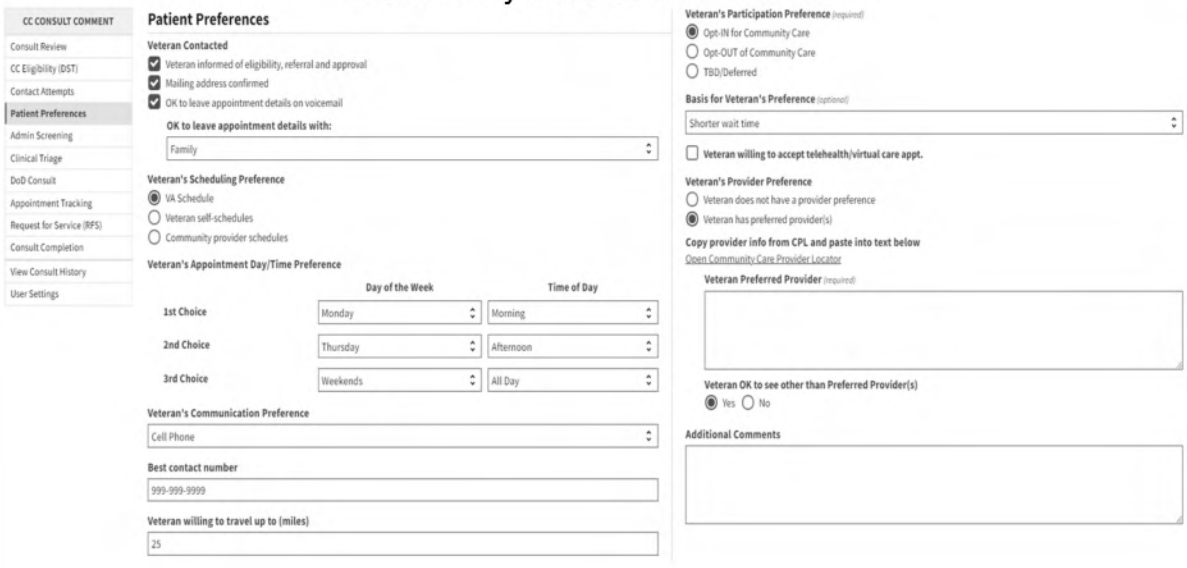


C

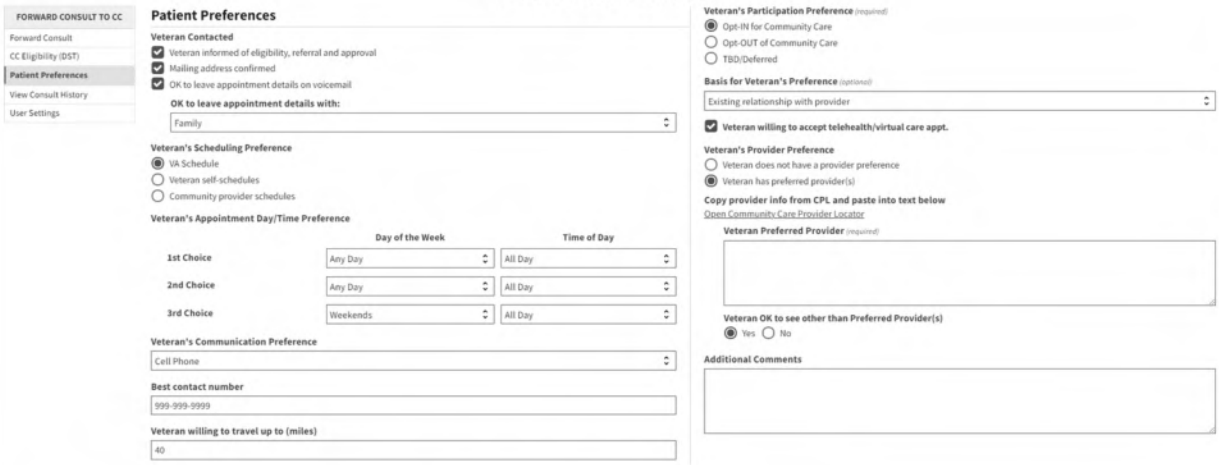
(CTB Version 2.0)

End Users can capture the Veterans Community Care Scheduling Preferences using the Patient Preferences tab either when forwarding the consult to community care or when adding a community care consult comment.

Community Care Consult Comment

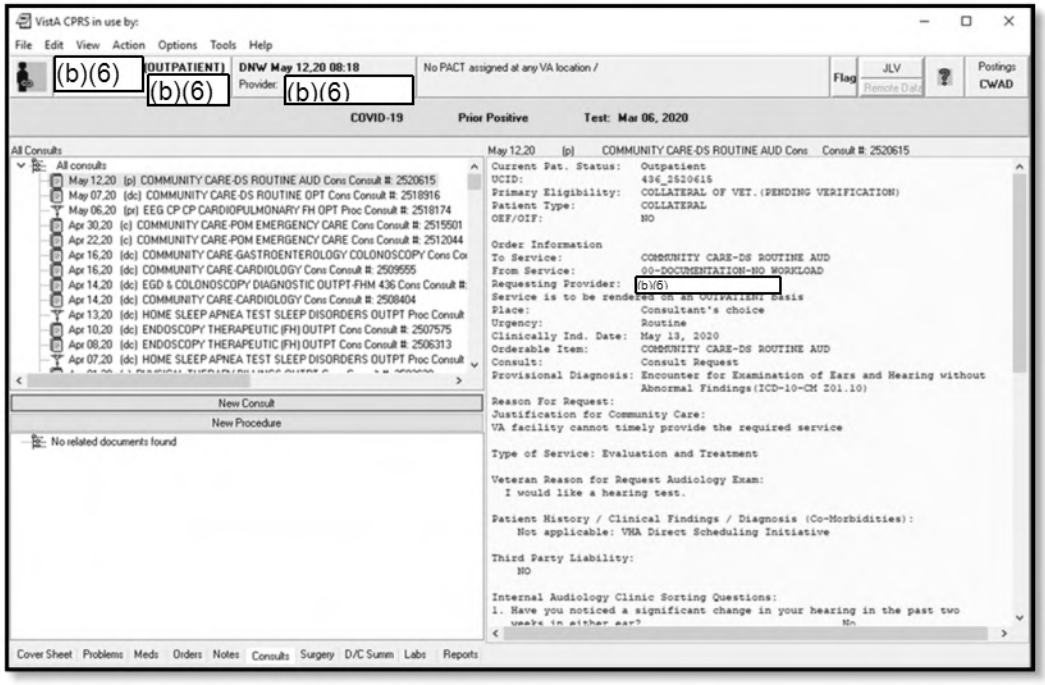


Last Modified on: Tuesday, August 3, 2021



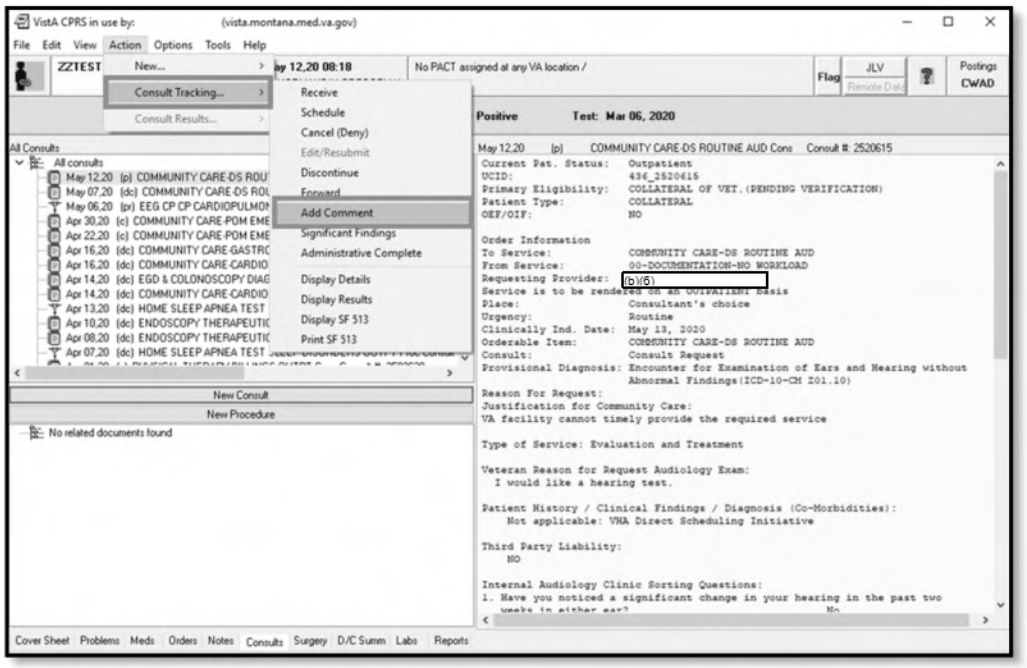
Accessing the CTB to Capture Scheduling Preferences

To access preferences, MSA staff will select the MSA PT Contacts Tab in the Community Care Function (not Scheduler Function) in the Consult Toolbox to review and record the necessary information.

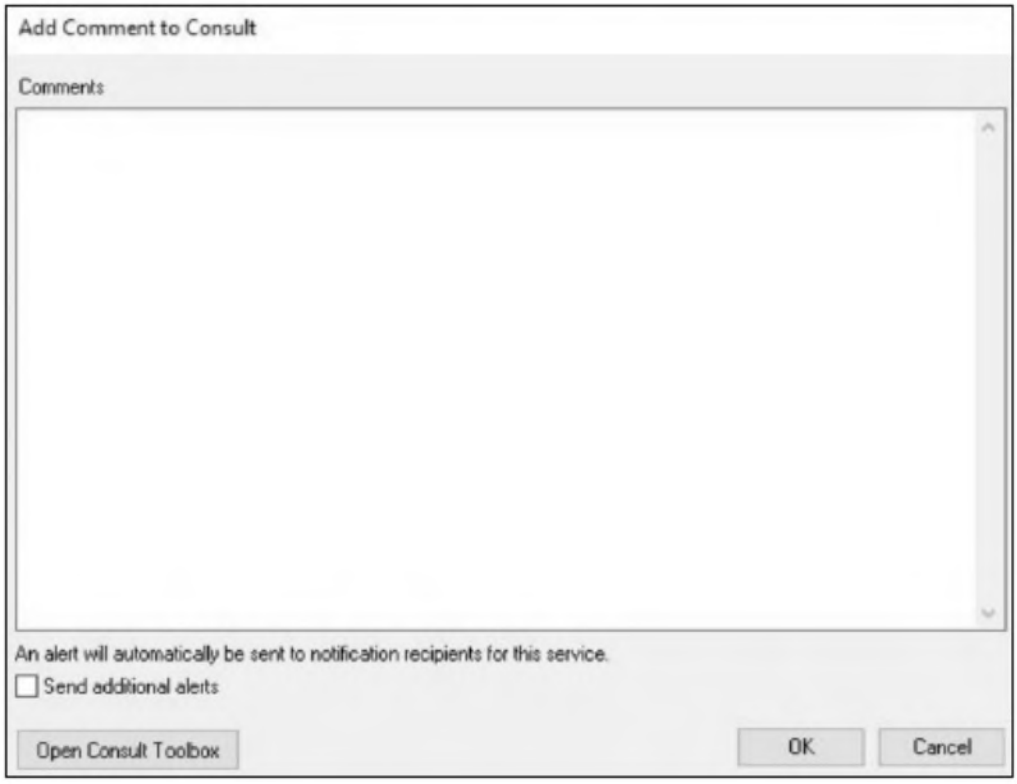


Once the correct consult has been highlighted, you will move your mouse to the tabs line and select, “Action”, then consult tracking, and then “add comment”. And a comment box will open. This process is the same for an internal in-house consult that will be forwarded to Community care and a consult that is originally created as a Community Care consult.

Last Modified on: Tuesday, August 3, 2021



Once the dialogue box is displayed, the staff member will select the “Open Consult Toolbox” to open the consult toolbox (CTB) where the Patient Preferences screen can be accessed.



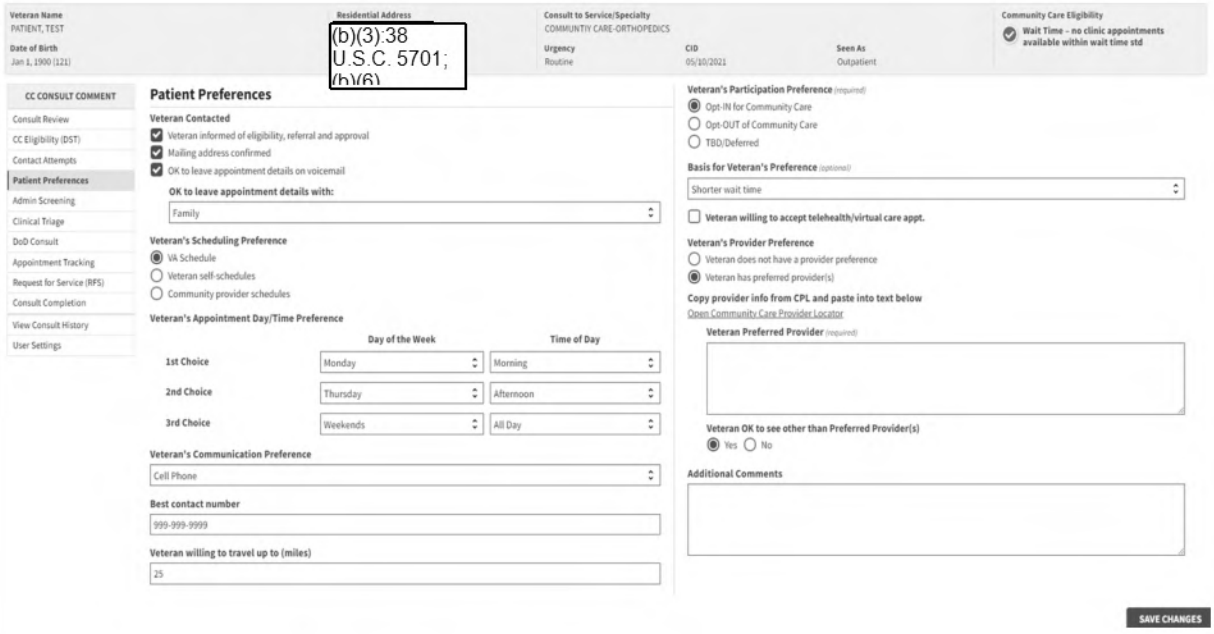
Community Care Functions

The staff member will need to select the Patient Preferences Tab tab to see the screen you see below. This can only be fully access if both the Consult Review and CC Eligibility Tabs have been completed.

It is important that the staff member that is completing this information knows the method in which the patient will be scheduled to complete the preference. It is suggested to have this conversation with the patient prior to starting: VA scheduling versus Contractor (ex. TMP) scheduling, or Veteran self-scheduling.

Therefore, the staff member will need to have this conversation with the Veteran prior to preferences completion.

Here is where you would capture Veteran's preference on the community care provider the patient prefers and how he/she would like to be scheduled. If the patient wants the VA to schedule the Community Care appointment, the staff member will complete the Provider Preference Information and then the Veterans preferences of day and time of appointment (There are three (3) options available for Veteran's Appointment Day/Time Preference.



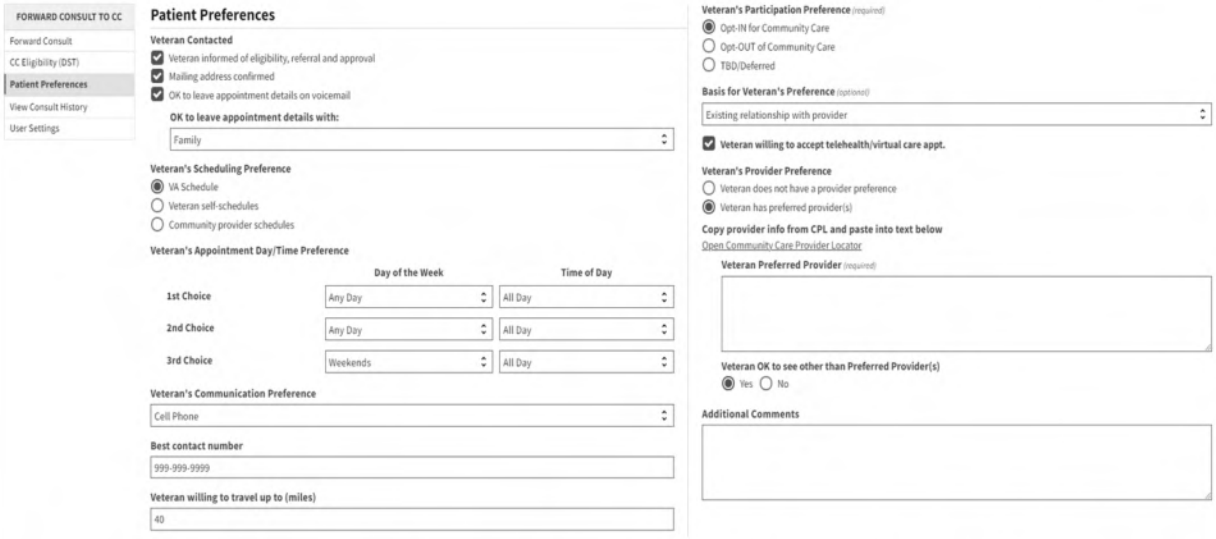
Forward Consult To CC CTB Option

Internal Clinic Staff MUST capture the Veteran's preferences for:

- How the Veteran prefers to be scheduled
- VA staff to schedule on behalf of the Veteran using the documented preferences
- Veteran self-schedule
- Veteran's Community Care provider of choice (to include no preferred provider); three providers should be provided.
- Day of week, time of day (e.g. AM/PM or specific time*); there are drop downs for specific time.

- Each Veteran must be informed that this information will be used to schedule the appointment with the preferences provided this information must be documented and agreed upon by the patient to not be considered blind scheduling
- Preference for communicating appointment information (text, phone, email, standard mail, MHV Secure Messaging)

Note: That sites where the TPA is scheduling- the Veteran will still get a call for the TPA to coordinate the appointment.

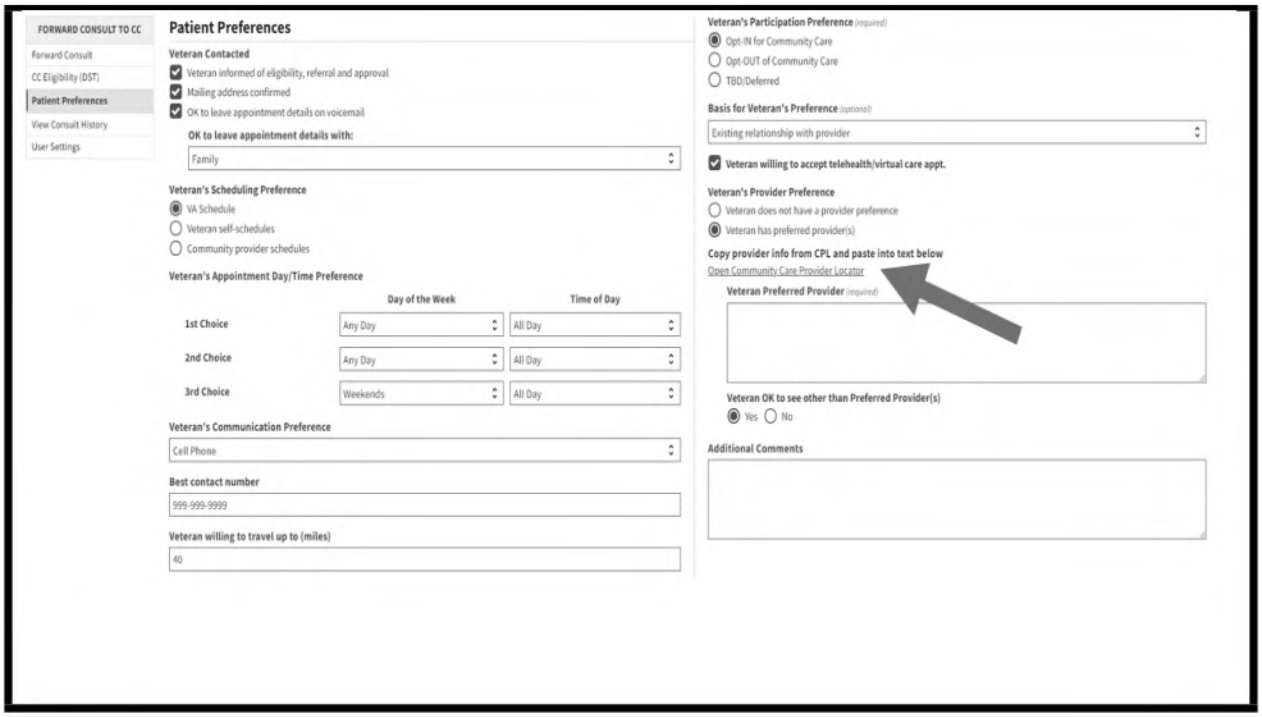


Staff should capture the community care preferred provider information using one of the options below to document in CTB:

Preferred method for capturing the preferred provider to ensure the provider is a Network provider

- VA Community Provider Locator (web-based) for frontline staff to utilize, no special access required. The RCT will no longer need access to PPMS.
- *Community care staff must continue to use PPMS.*
- VA.gov Facility Locator - “Find a VA Location”
- Capture No Preferred Provider information
- Using free text as an added comment to the consult (only when unable to capture using the other methods provided)

Note: CC Eligibility must be documented prior to utilizing the Patient Preferences tab.



Capturing Community Care Scheduling Challenges in CTB

Facility community care office staff will follow the process below once they have received a community care consult for scheduling purposes.

Note: This process applies to all community care consults at the time of scheduling. Facilities are not expected to rework consults that have already been scheduled.

- Staff will search PPMS to locate appropriate in-network providers that can render the care requested.
- Staff should prioritize scheduling with in-network providers with the High Performing Provider (HPP)* designation, when possible.
- Facility community care staff will call up to five (5) community providers to secure an appointment and schedule care accordingly.
- If challenges are encountered with identifying a network provider OR with identifying a network provider who has appointment availability within 90 days of calling to schedule, then facility community care staff will use the CTB to document the failed effort
- This process will lead to local, regional, and national monitoring ability to work with the Community Care Network (CCN) Third Party Administrators (TPA) in enhancing the community care network and to provider better understanding of the local issues related to COVID-19.
- Regarding future care consults, this process applies when the PID of the future care consult is within 30 days of the date the community care staff is attempting to schedule the care.

- For example, future care consult with a file entry date of 5/1/2020 and a PID of 9/30/2020 and staff is attempting to schedule the care on 9/1/2020. This consult would be a part of this process since the PID is within 30 days of the date the staff is attempting to schedule.

*HPP Designation:
The HPP designation evaluates CCN providers based on quality and cost-efficiency criteria. The intent is for Veterans to have the opportunity to be scheduled with high quality CCN providers in the community.

- For further details on the HPP designation (including eligible specialties, the weighting algorithm, and measure sets for the CCN Regions), please refer to the UM HPP Solutions Page
- For further details on scheduling with HPPs, please refer to FGB Chapter 5.2.1 (How to Collect Veteran Preferences When Scheduling Under CCN).

Report Available to Capture Utilization of the Veteran Preferences Fields in the Consult Toolbox:

A report has been created in the Consult Toolbox Reports page titled "Scheduling Preferences with Consult Totals" This report will allow VAMCs to analyze the use of this process in comparison to the total number of community care consults entered in the same timeframe.

https://vaww.cc.cdw.va.gov/sites/CC_ConsultsTB/_layouts/15/ReportServer/RSViewerPage.aspx?rv:RelativeReportUrl=/sites/CC_ConsultsTB/Dashboards/SchedulingPreferencesWithConsultTotals.rdl&Source=https%3A%2F%2Fvaww%2Ecc%2Ecdw%2Eva%2Egov%2Fsites%2FCC%5FConsultsTB%2FDashboards%2FForms%2FAllItems%2Easpx%23InplviewHash3ab21dfb%2D24b9%2D497a%2D822f%2D1ebe3b8cec32%3DPaged%253DTRUE%2Dp%5FSortBehavior%253D0%2Dp%5FTitle%253D%2Dp%5FID%253D48%2DPageFirstRow%253D31

Certify Completion on the Station Dashboard for Veteran Scheduling Preferences

Information on certifying completion of Veteran Scheduling Preferences on the Station Dashboard is located here:
https://dvagov.sharepoint.com/:b:/s/vacovha/DUSHCC/DC/DO/CI/FGB/EZpIS5CBdO9DscsTHio_zsEBhxd3v4dCobITUUuXMzpugg?e=dSgSpR

Searching for Network Provider in PPMS

At the time of scheduling, the facility community care staff should use the following parameters in PPMS in order to search for an available in-network provider that can provide the care requested:

- Staff should search in PPMS by using the Veteran's residential address as the search location (unless the Veteran specifies a different origin/location to search by)
- Staff should input the provider specialty by identifying the correct specialty based on the assigned standardized episode of care (SEOC)

Last Modified on: Tuesday, August 3, 2021

- Staff should identify the appropriate provider network based on their CCN location
- The bottom 2 fields are radius and sort by; the initial search should be by distance using the normal default settings (minimum of 25 miles) used by the facility. Facility community care managers: Please ensure to give guidance to your staff on what the minimum mileage setting should be for your facility community care office. If unable to locate providers within the default radius used, staff should expand search by an additional 45 miles
- Staff should prioritize scheduling with in-network providers with the HPP designation, when possible.

Last Modified on: Tuesday, August 3, 2021

Scheduling Community Care with Identified Providers

Once the end user identifies providers that can render the care in PPMS the next step in the process is to contact the provider to coordinate the care.

Upon contacting the provider, the end user must ensure that the provider has available appointments within 90 days from the date that the facility community care staff is calling to schedule.

If both requirements are met the facility community care staff can proceed with scheduling the appointment as normal, following the guidance in **chapter 3, of the Office of Community Care Field Guidebook.**

If the provider does not offer the care, is not currently scheduling appointments for routine care or is closed for scheduling the staff member should capture an Activity in PPMS to document the outcome of the discussion with the provider office.

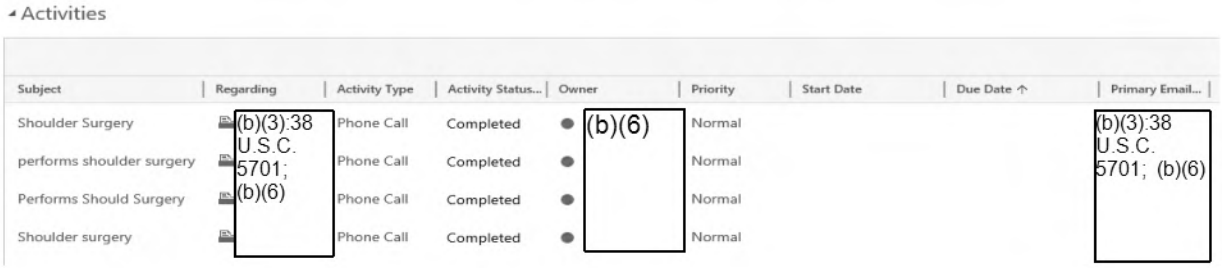
- Staff should then proceed with contacting up to five (5) community providers (based on the initial PPMS search results) to schedule the care.

If the provider does not have available appointments within 90 days from the day of calling to schedule the appointment, the staff member should capture an Activity in PPMS to document the outcome of the discussion with the provider office.

- Staff should then proceed with contacting up to five (5) community providers (based on the initial PPMS search results) to schedule the care.

If the provider does not offer the care or does not have available appointments within 90 days from the date that the facility community care staff is calling to schedule, the staff member should capture an Activity in PPMS to document the outcome of the discussion with the provider office. Guidance on capturing an Activity in PPMS can be found in the Office of Community Care Field Guidebook, Tools Section, PPMS Capturing Provider Activity Section.

Facility community care staff should reference the Activities captured in PPMS when scheduling community care consults in order to identify the appointment availability or clinical service availability captured by staff on their team.



VA-Community Provider Locator (CPL)

The CPL tool allows the user to search the Community Care Network for providers based on selected criteria.

- The ability for the user to search by address, specialty and network

- *Beginning February 12, 2021:* The ability for the user to search by a known NPI (used mostly by pharmacy staff)

The CPL data is sourced from the Provider Profile Management System (PPMS) and link to the Consult Toolbox (CTB). Staff will then document the provider using the consult toolbox (CTB).

Intended Users:

- VA Clinic MSAs (i.e. PACT and Specialty Clinic MSAs)
- Referral Coordination Teams (RCTs)
- Facility Pharmacists

The VA.gov Facility locator tool can be used by the intended users listed above as a contingency only when CPL is not available. Please review the VA.gov Facility Locator Tool PPT and the CPL Reference Sheet for additional guidance.

TMS ID	Course	Description
VA 4562423	VA Community Provider Locator (CPL) Tool	This course provides an overview of the VA Community Provider Locator (CPL) Tool. Users will learn how to access and search the CPL by network, address, distance, and drive time.

Note: Community care office staff must continue utilizing the Provider Profile Management System (PPMS) for identifying providers during the referral process.

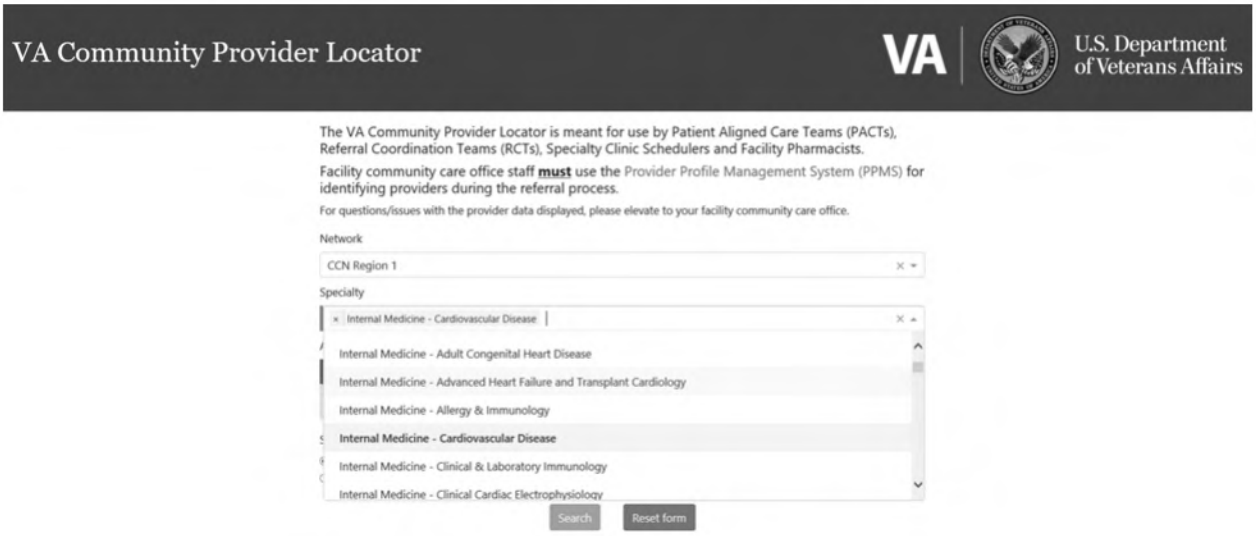
For questions/issues with the provider data displayed, please elevate to your facility community care office.

Document a Preferred Community Provider Using VA-Community Provider Locator**.**

1. Choose the Network from the drop-down listing:

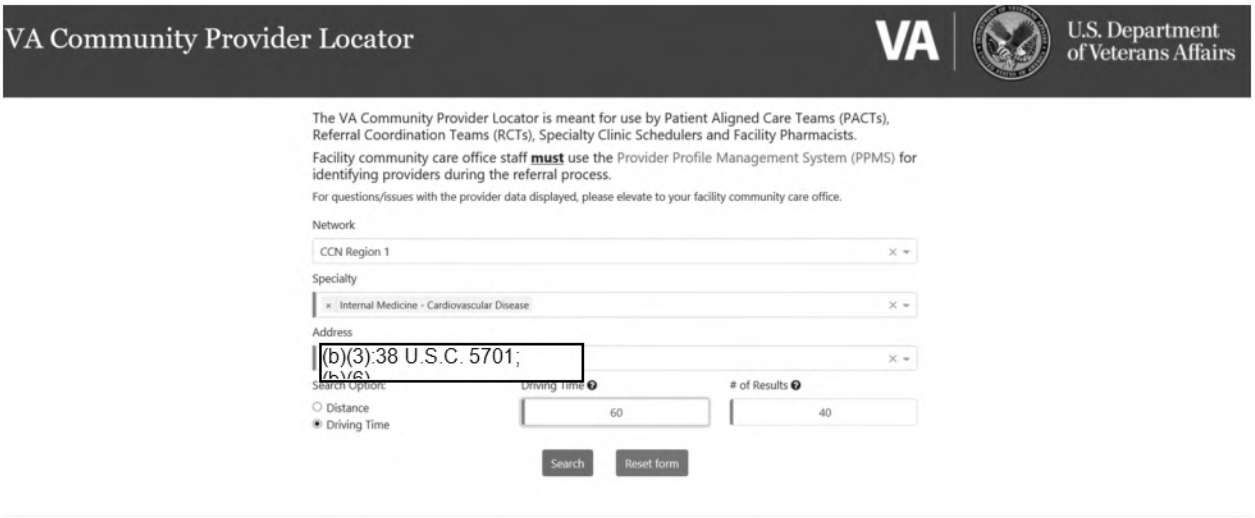
Last Modified on: Tuesday, August 3, 2021

2. Choose the Specialty from the drop-down listing and click on “Search”:



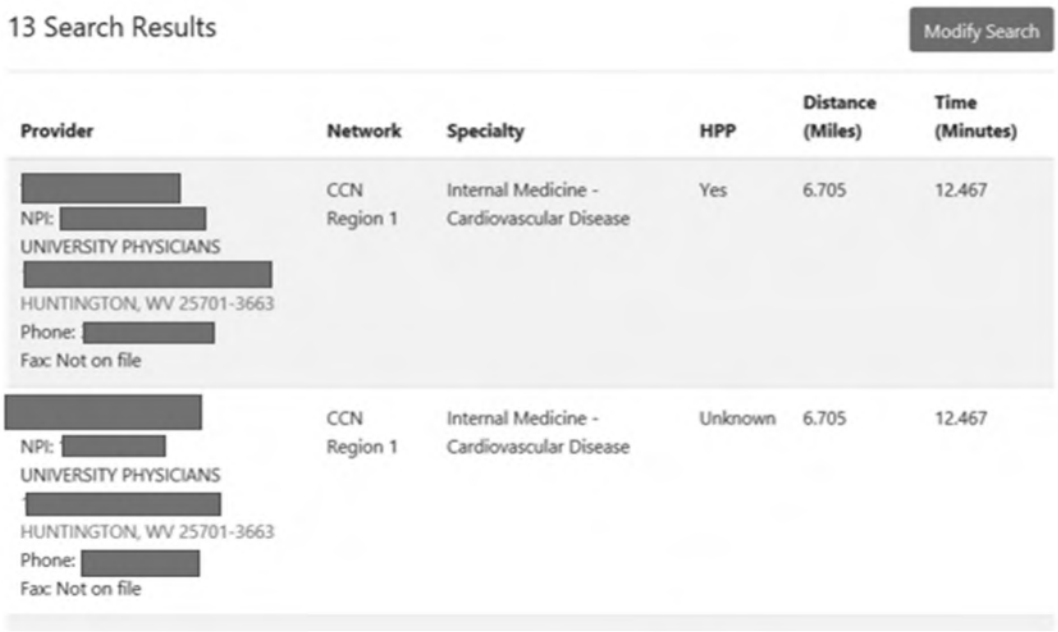
3. Enter Veteran’s Residential Address and the Distance or Driving time and then click on “Search”:

Last Modified on: Tuesday, August 3, 2021



a. Your search results will now appear based on the provider availability within the selected network(s).

- The provider results will show the provider name, address, phone number, fax number (if applicable), distance/minutes from the search location, specialty, network, HPP status, and NPI.

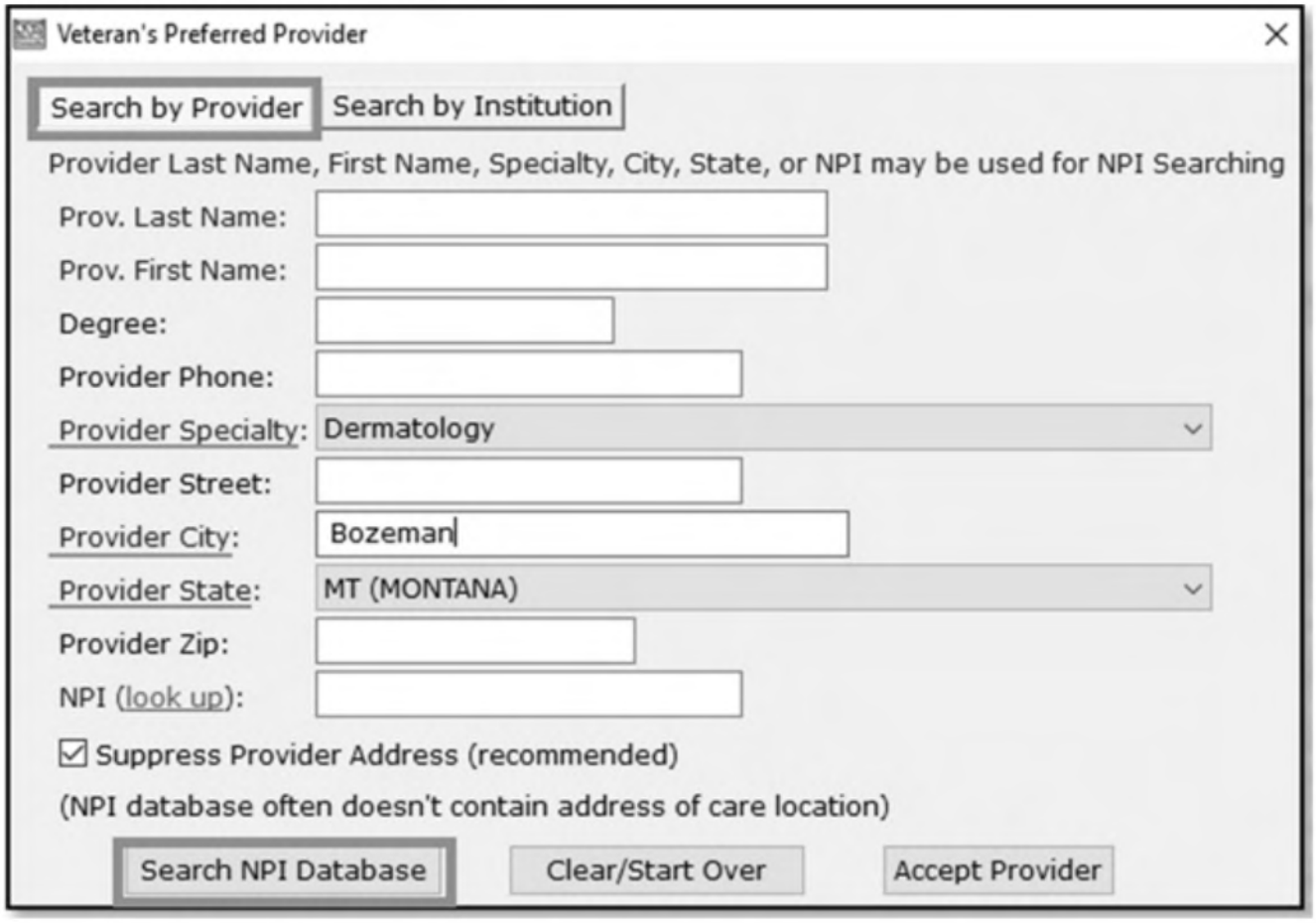


(CTB Version 1.9.0078)

4. Copy the NPI number provided (as shown in the results above) in order to populate the provider information in the CTB.

5. Go to the CTB, click 'Lookup a Provider' and Paste the NPI in the 'NPI (look up):' field.

6. Click 'Search NPI Database'.

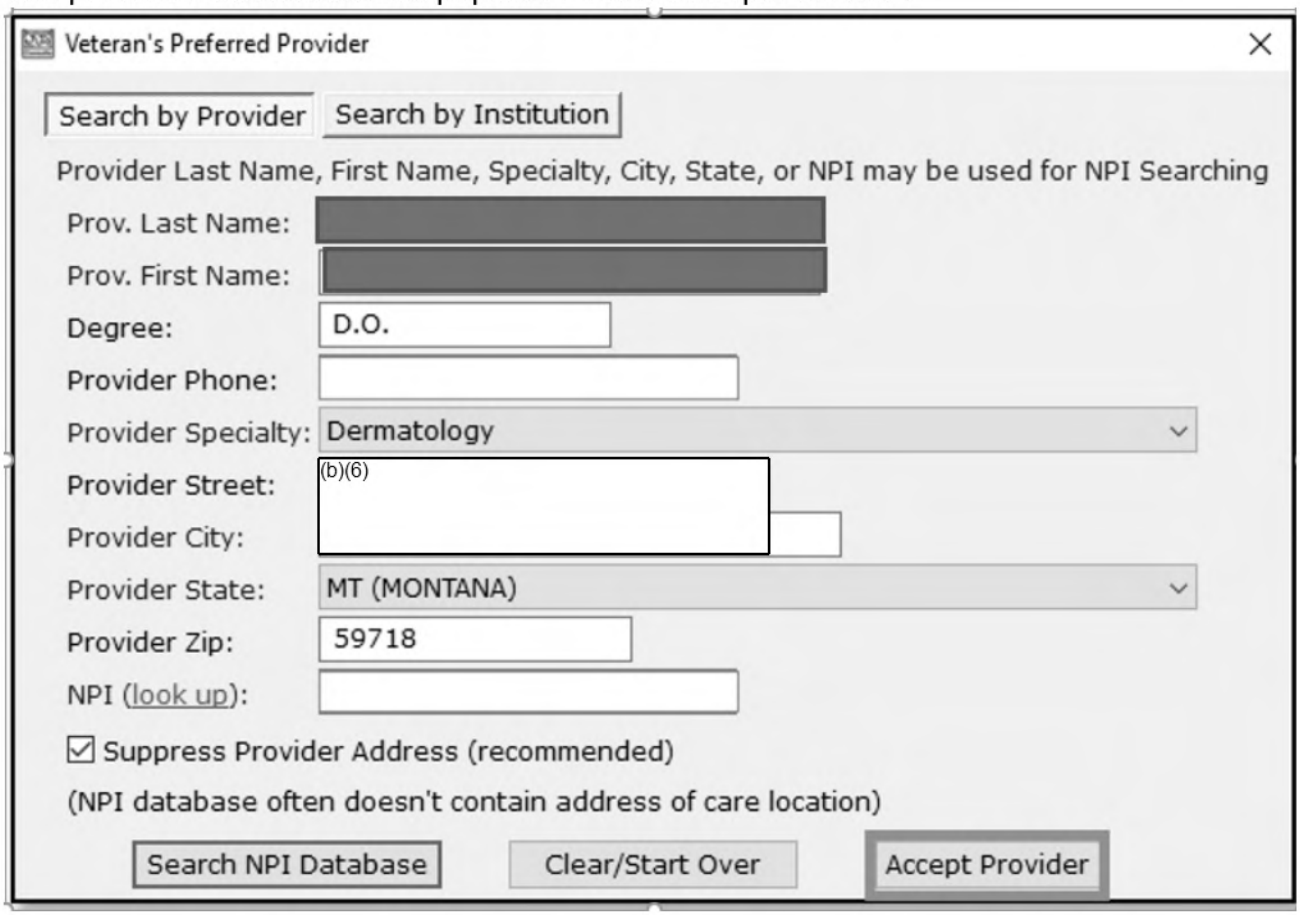


7. Click on the Provide Name.

8. Click 'OK'.

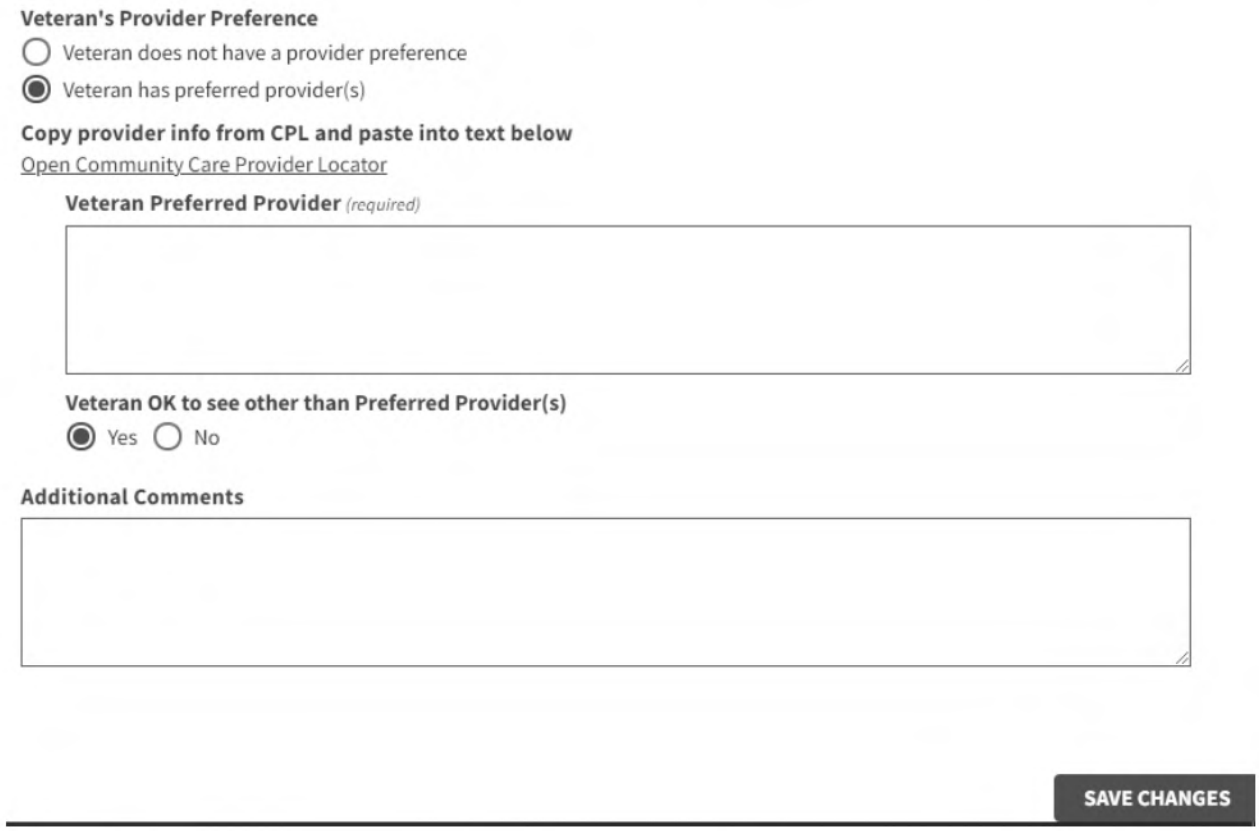
Last Modified on: Tuesday, August 3, 2021

9. The provider's information will populate. Click 'Accept Provider'.



10. The provider's information will appear in the Preferred Provider window. Ensure that the 'Veteran has a Preferred Provider' and Update record with above information' boxes are checked. Click 'OK'.

4. Copy the provider information (as shown in the results above) from CPL or PPMS and paste into the Veteran Preferred Provider box in order to populate the provider information in the CTB.



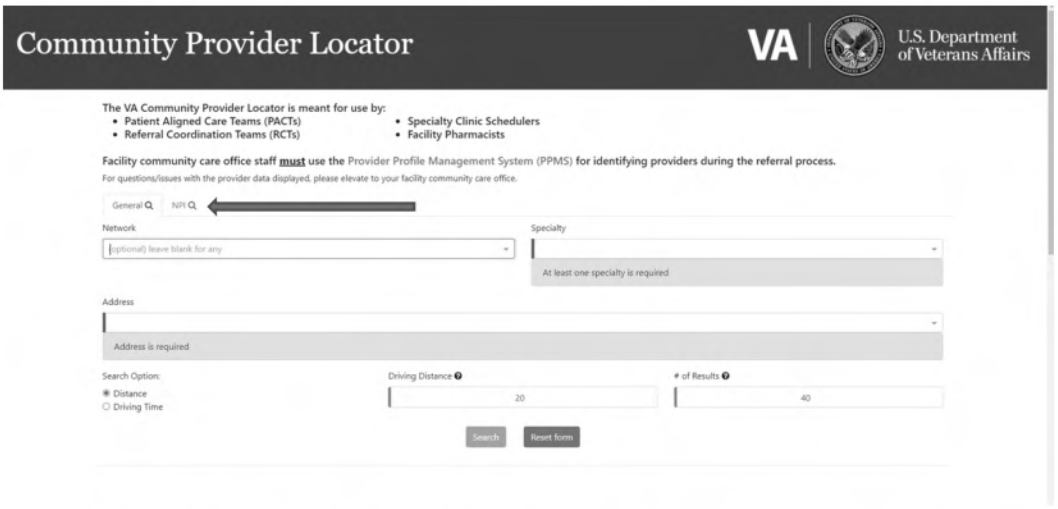
5. The provider's information will appear in the Preferred Provider window. Ensure that the 'Veteran has a Preferred Provider' box is checked. Click "Save Changes".

Last Modified on: Tuesday, August 3, 2021

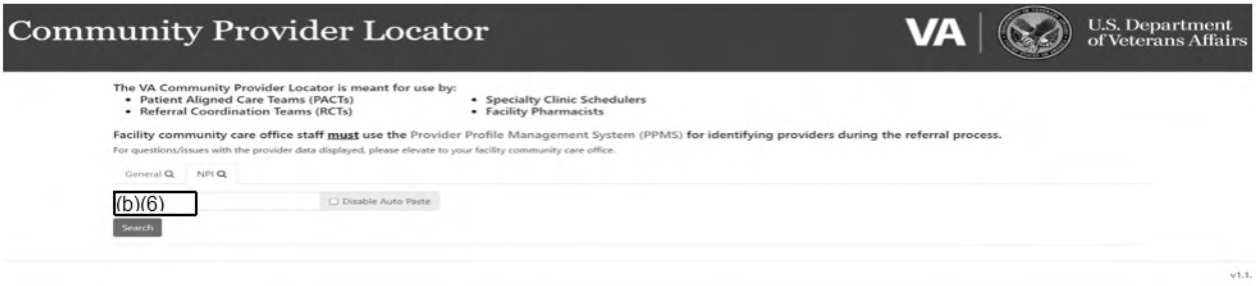
Note: The CPL demo is located in the FGB Landing page under the FGB 2.0 Training Videos section.

The NPI tab is an option that will be used most often by VA pharmacy staff. If the NPI is known and user wants to ensure the provider is within the VA Network, user can search the VA network using the NPI tab *beginning February 12, 2021*.

- Click on the NPI tab:



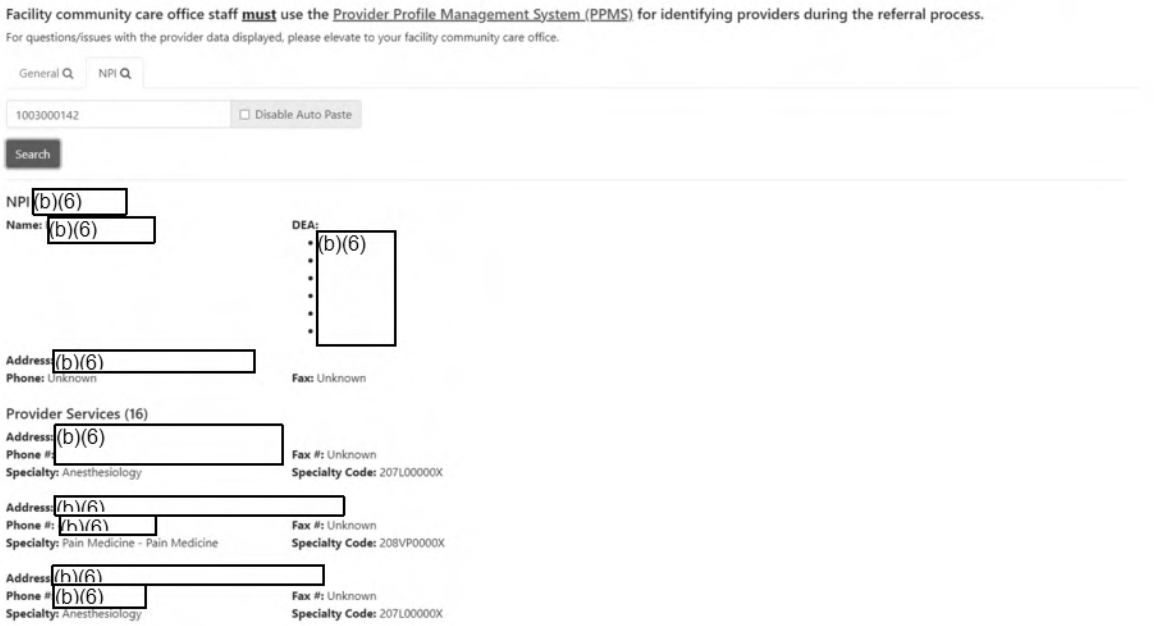
- The below screen will appear.
  - Enter the known ***NPI number*** and then click on ***search***:



Last Modified on: Tuesday, August 3, 2021

The following information will appear:

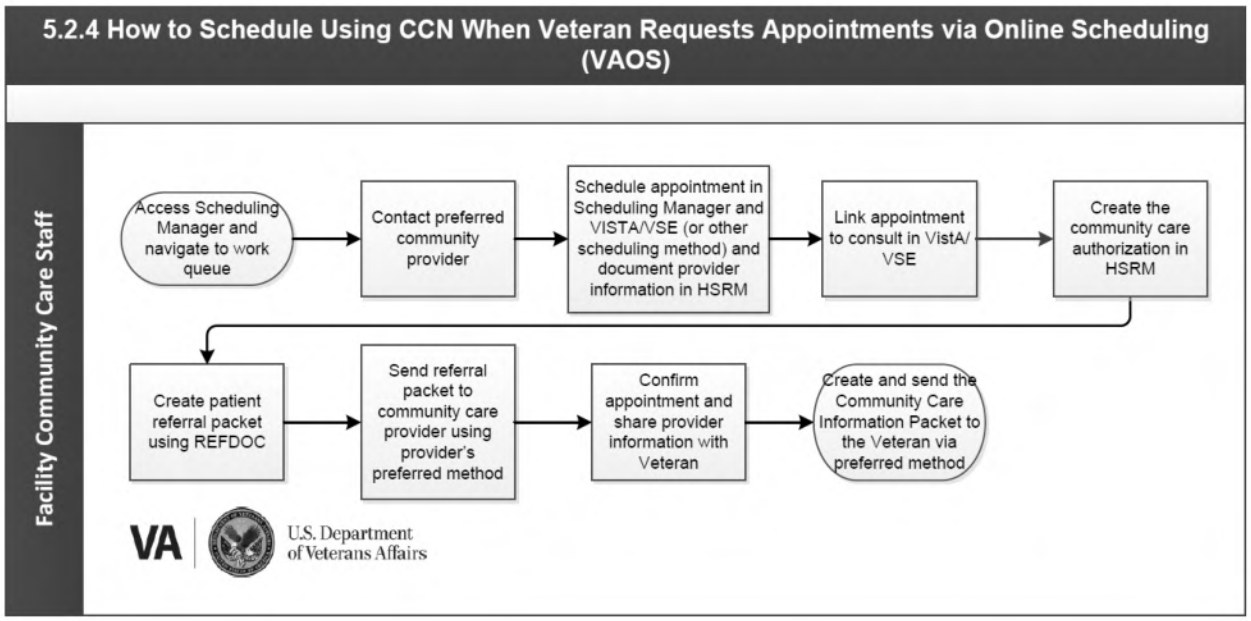
- Patient Aligned Care Teams (PACTs)
- Referral Coordination Teams (RCTs)
- Specialty Clinic Schedulers
- Facility Pharmacists



Last Modified on: Tuesday, August 3, 2021

2.20 How to Schedule Under CCN When Veteran Requests Appointments via VA Online Scheduling (VAOS)

(Post CCN)



General Considerations:

- VA Online Scheduling (VAOS) is a mobile scheduling application that will allow Veterans who meet the following types of MISSION Act eligibilities (states that don't have a full-service VA, grandfathered Veterans, and hardship eligible) in select areas to request a community care appointment and document scheduling preferences.
- VA staff will use the Scheduling Manager (SM) application to review and cancel requests for community care appointments and communicate with the Veteran.
- Drive Times will be available in a future iteration of VAOS.
- Sites are to utilize the VAOS Community Care Comms Plan in order to provide information to Veterans.

STEP	ACTIVITY
1.	Access Scheduling Manager and navigate to work queue. Filter for community care. For additional guidance regarding VAOS and SM, please refer to the VAOS SOP.
2	Contact preferred community provider within three business days of gathering Veteran preferences to: • Identify provider appointment availability and schedule the appointment • Obtain needs for medical documentation to be sent

General Considerations:

- VA Online Scheduling (VAOS) is a mobile scheduling application that will allow Veterans who meet the following types of MISSION Act eligibilities (states that don't have a full-service VA, grandfathered Veterans, and hardship eligible) in select areas to request a community care appointment and document scheduling preferences.
- VA staff will use the Scheduling Manager (SM) application to review and cancel requests for community care appointments and communicate with the Veteran.
- Drive Times will be available in a future iteration of VAOS.
- Sites are to utilize the VAOS Community Care Comms Plan in order to provide information to Veterans.

STEP	ACTIVITY
2a	Schedule appointment in Scheduling Manager and VISTA/VSE (or other scheduling method) and document provider information in HSRM For further details on how to document Veteran appointment in HSRM, please refer to the HSRM User Guide. Community Care Staff at Self-Scheduling Sites may also review the HSRM Quick Reference Guide for VA Facility Community Care Staff at Self-Scheduling Sites. For additional instructions on documenting the appointment in VistA/VSE, refer to appropriate artifact below: • If using Vista - Appointment Management Tutorial • If using VSE -VistA Scheduling Enhancements (VSE) User Guide • For additional instructions on documenting the appointment in Medical Appointment Scheduling System (MASS), refer to the MASS User Guide Once the appointment is scheduled in Scheduling Manager, the Veteran will receive a notification in the VAOS App regarding the details of their appointment.
3	Link appointment to consult in Vista/VSE. Consult status will change to "Scheduled". For additional instructions on linking the appointment to the consult, refer to appropriate artifact below: If using Vista -Appointment Management Tutorial If using VSE -VistA Scheduling Enhancements (VSE) User Guide
4	**Create the community care authorization in HSRM.** For further details on how to create the community care authorization in HSRM, please refer to the HSRM User Guide. Community Care Staff at Self-Scheduling Sites may also review the HSRM Quick Reference Guide for VA Facility Community Care Staff at Self-Scheduling Sites.

General Considerations:

- VA Online Scheduling (VAOS) is a mobile scheduling application that will allow Veterans who meet the following types of MISSION Act eligibilities (states that don't have a full-service VA, grandfathered Veterans, and hardship eligible) in select areas to request a community care appointment and document scheduling preferences.
- VA staff will use the Scheduling Manager (SM) application to review and cancel requests for community care appointments and communicate with the Veteran.
- Drive Times will be available in a future iteration of VAOS.
- Sites are to utilize the VAOS Community Care Comms Plan in order to provide information to Veterans.

STEP	ACTIVITY
5	Create Veteran patient referral packet using REFDOC. Packet contents should include: • Community care authorization from HSRM • Community care consult • Standard Episode of Care (if applicable) • Required medical documentation • Veteran demographics • Check the field "include HSRM Information Sheet" when sending a REFDOC package to community providers that are not provisioned with HSRM For additional information on how to create referral packet with the required contents using REFDOC, please reference REFDOC User Guide
6	Send referral packet to community care provider using HSRM, Fax, eFax, or provider's preferred method. Within HSRM, document that packet was sent to community care provider. For further details on how to send the referral packet to the community provider via HSRM, please refer to the HSRM User Guide. Community Care Staff at Self-Scheduling Sites may also review the HSRM Quick Reference Guide for VA Facility Community Care Staff at Self-Scheduling Sites
7	Create and send the Community Care Information Packet to the Veteran via preferred method (electronic or standard mail). Within HSRM, document that the packet was sent to the Veteran. For further details on how to document that packet was sent to the Veteran in HSRM, please refer to the HSRM User Guide. Community Care Staff at Self-Scheduling Sites may also review the HSRM Quick Reference Guide for VA Facility Community Care Staff at Self-Scheduling Sites.

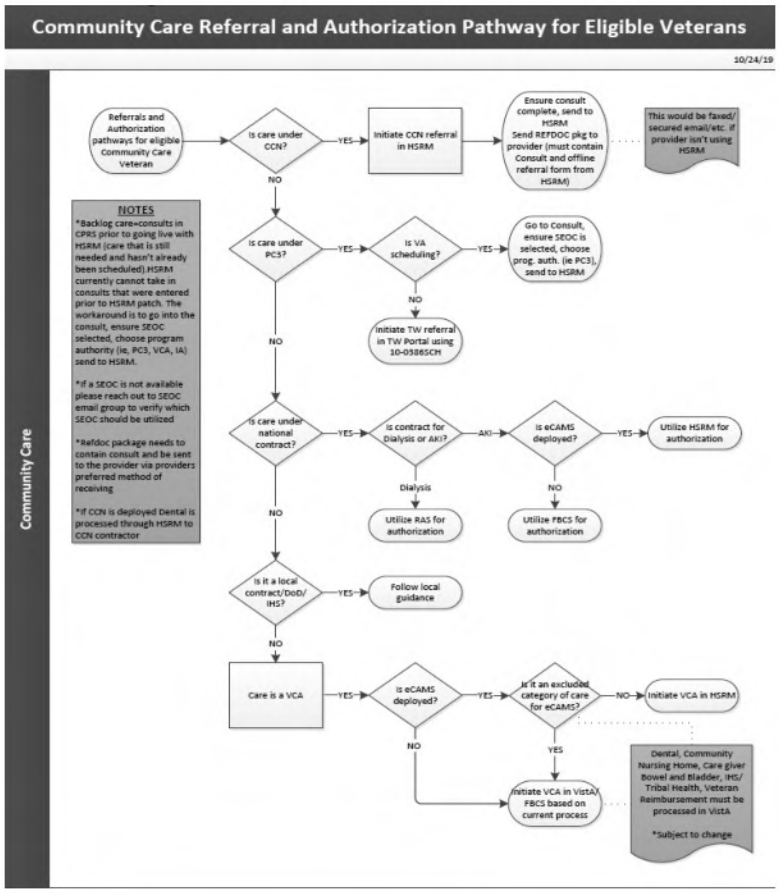
Last Modified on: Tuesday, August 3, 2021

2.21 Routing, Clinical Review of Community Care Consults and Determining What Services to Authorize

(Pre/Post CCN)

After services have been requested and eligibility has been confirmed, clinical review is performed to determine if the requested services are clinically appropriate to be authorized for delivery in the community, or if any service can be delivered at the local VA Medical Center (VAMC). Clinical review is completed by using industry standard tools, evidence-based medicine, and/or local guidance (as defined by the VA facility's Chief of Staff) to determine if a service is needed based on the Veteran's diagnosis and clinical acuity.

In the fourth quarter of FY2021, OCC will release a new national Clinical Review Tool MCG to standardize the review of community care consults prior to referring care to a community provider. It is highly recommended MCG be incorporated into the clinical review process. This tool may be used by clinical reviewers with DOA and Referral Coordination Teams (RCT) to consistently evaluate consults using standardized, evidence-based guidelines to determine clinical appropriateness. Training on the new MCG tool is forthcoming.



2.22 Leveraging the Delegation of Authority for Routing Community Care Consults

(Pre/Post CCN)

Clinical review should be completed by staff who have been given Delegation of Authority (DOA) by the facility's Chief of Staff to review services for clinical appropriateness as documented on the DOA Medical Services (DOAMS) list. The DOAMS list serves as a guide to inform facility staff whether a service/procedure requires a review for clinical appropriateness and by whom, before a community care consult is authorized and an appointment can be scheduled. The DOAMS list includes VHA Office of Community Care (OCC) guidance on which services/procedures are recommended for clinical review as well as the recommended reviewer role (e.g., physician, nurse, administrative staff, etc.). The Chief of Staff at each VAMC uses the DOAMS list to document the decisions applicable to their site. Delegated approval authority is designed to streamline the consult management process and improve Veteran access to timely, clinically appropriate care by efficiently routing consults to the appropriate reviewers.

Note: If the provider entering the consult is also listed as the delegated authority to approve the ordered care, the clinical review requirement is met, and subsequent review is not needed to authorize a referral into the community. Similarly, consults entered by specialty services or reviewed by a Referral Coordination Team (RCT) are considered to have met the clinical review requirement. The RCT members do not need to be listed on the DOAMS list as it is presumed that a clinical member of the RCT is reviewing the community care consult for clinical appropriateness, prior to routing to the facility community care office.

For FY2021, the DOAMS list is updated to include information related to Community Provider Orders (CPO). This section ONLY applies to facilities that have opted-in to the CPO process. Those facilities will use the DOAMS list to (1) indicate which care/services are being processed using CPO and (2) identify staff responsible for transcribing orders for that care. This will provide a clear way to track which care/services CPO is used for, as well as who is responsible for entering the consults/orders for each service.

When a consult is reviewed by the RCI/RCT for a category of care (CoC), a comment should be added to the consult documenting approval by the RCT.

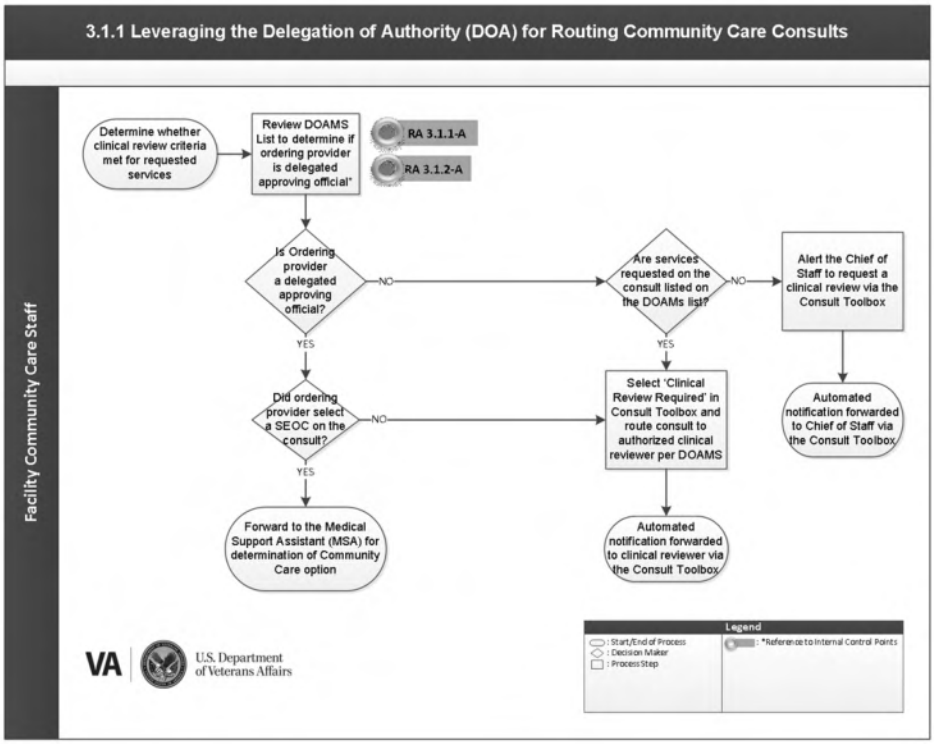
Once the consult is forwarded to the POC for that CoC in Community Care, that person should validate if it has already been reviewed:

- If the ordering provider has been designated as DOA for that category of care – clinical review is considered satisfied, no additional review required
- If the consult has been reviewed by the RCT – clinical review is considered satisfied, no additional review required
    - Keep in mind while they may seem similar, DOA and RCT are different processes
- If the consult is forwarded from specialty services – clinical review is considered satisfied, no additional review required
- If the consult was not entered by an ordering provider with DOA, not reviewed by the RCT, or not from specialty – clinical review may be required (refer to facility DOAMS)*
    - *The DOAMS will explicitly identify those CoC the facility COS has requested a clinical review for appropriateness be conducted

Last Modified on: Tuesday, August 3, 2021

Additional information and detailed step-by-step instructions for completing the DOAMS list and DOA memo are available on the Delegation of Authority (DOA) SharePoint Page and in the Job Aids and Artifacts section of the FGB to include the DOA Reference Sheet and the Instructions Guide_DOA Memo_FY21.

(Pre/Post CCN)



PROCEDURES	
General Considerations: For additional details on this guidance, please refer to the Delegation of Authority (DOA) SharePoint Page	
STEPS	**ACTIVITY**
1	Determine whether clinical review criteria have been met for services requested on the consult.

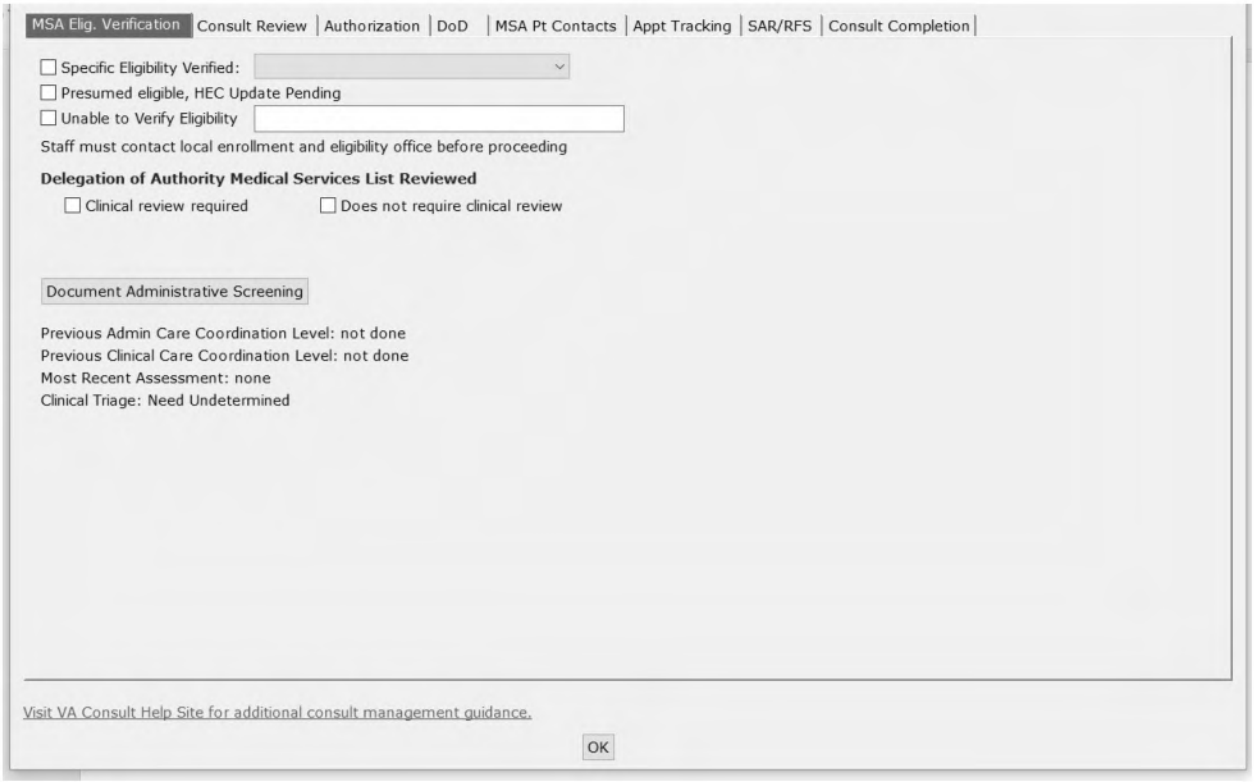
PROCEDURES	
	To assess whether clinical review criteria have been met for the services requested on the consult, review the local facility's DOAMS List to determine if the ordering provider is the delegated approving official. The facility's DOAMS List helps facility Community Care staff determine if the services requested require a review of clinical appropriateness according to the facility's Chief of Staff. • If the ordering provider is the delegated approving official, proceed to Step 2a. • If the ordering provider *is not* the delegated approving official, proceed to Step 2b.
2a	If the ordering provider is the delegated approving official for the services requested, the Facility Community Care staff will determine that the clinical review criteria have been met. Proceed to step 3. **Note:** If the ordering provider has not identified a Standardized Episode of Care (SEOC) for the consult, community care staff will route the consult to the clinical delegated authority indicated on the DOAMS list to identify the appropriate scope of services for advanced clinical review and to attach a SEOC; if/when applicable. In the absence of a SEOC, the clinical reviewer will select the closest SEOC within the same Category of Care and Provider Type. Please refer to Section 3.2.3 for more information.
2b	If the ordering provider is not the delegated approving official for the services requested, determine if the services requested on the consult is listed on the DOAMS list. • If the services requested on the consult is listed on the DOAMS list, proceed to step 4a • If the services requested on the consult is not listed on the DOAMS list, proceed to step 4b
3	If the ordering provider is the delegated approving official for the services requested, assess whether the ordering provider already selected a SEOC on the consult. To assess, please refer to the consult's "Type of Service" entry. • If the ordering provider has selected a SEOC on the consult, select "Does Not Require Clinical Review" under "MSA Elig. Verification" tab of the Consult Toolbox. Skip to Chapter 4 "Determine Community Care Option" • If the ordering provider has not selected a SEOC, proceed to Step 4a.
4a	If the Ordering Provider is not the delegated approving official OR if the Ordering Provider has not selected a SEOC, route the consult to the appropriate clinical reviewer who will conduct clinical review using the "Consult Review" tab in the Consult Toolbox.

Last Modified on: Tuesday, August 3, 2021

PROCEDURES

(CTB Version 1.9.0078)

Select "Clinical review required" under the "MSA Elig. Verification" tab of the Consult Toolbox. This will route the consult to the appropriate clinical reviewer who will conduct clinical review of the consult. Skip to Section 3.2.2.

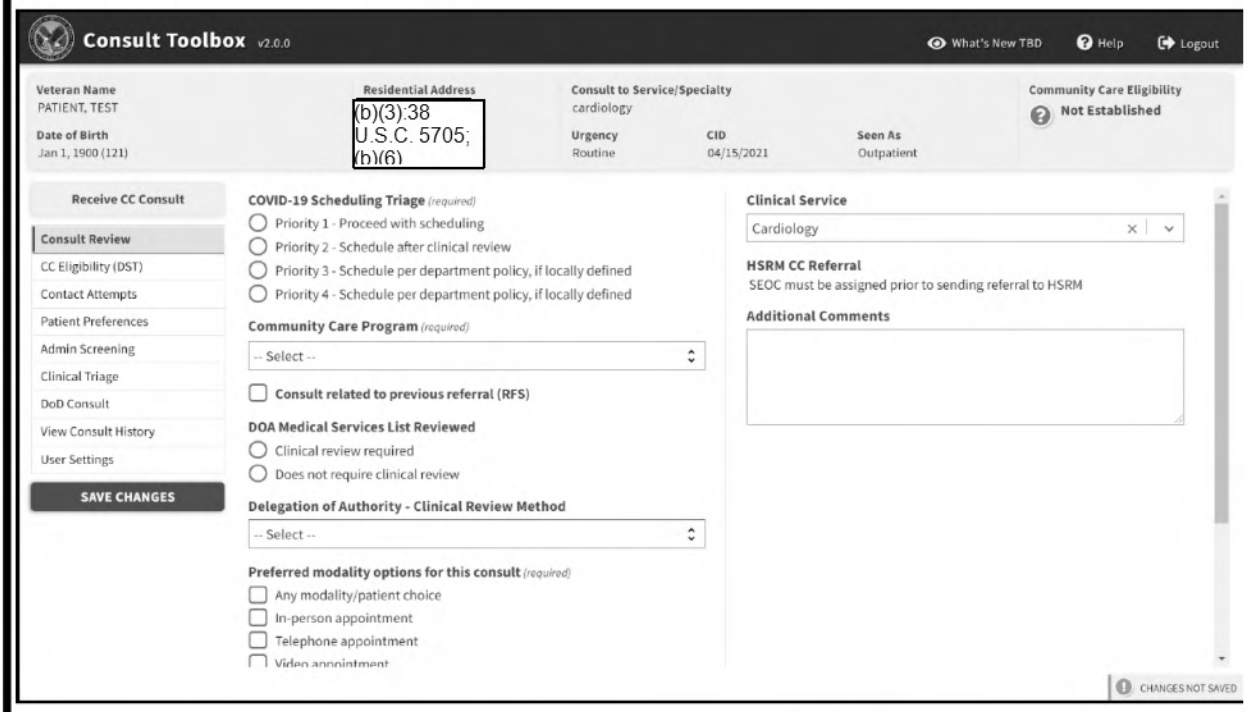


Last Modified on: Tuesday, August 3, 2021

PROCEDURES

(CTB Version 2.0)

Select "Clinical Review Required" under the "Consult Review" tab of the Consult Toolbox Version 2.0. This will route the consult to the appropriate clinical reviewer who will conduct clinical review of the consult. Skip to Section 3.2.2.



4b	If the Ordering Provider is not the delegated approving official for the services requested, and the services requested on the consult is not listed on the DOAMS list, alert the Chief of Staff to request clinical review via the Consult Toolbox. An automated notification will be forwarded to the Chief of Staff via Consult Toolbox. Proceed to Section 3.2.2.

Last Modified on: Tuesday, August 3, 2021

2.23 How to Perform Clinical Review for Services Requested

(Pre/Post CCN)

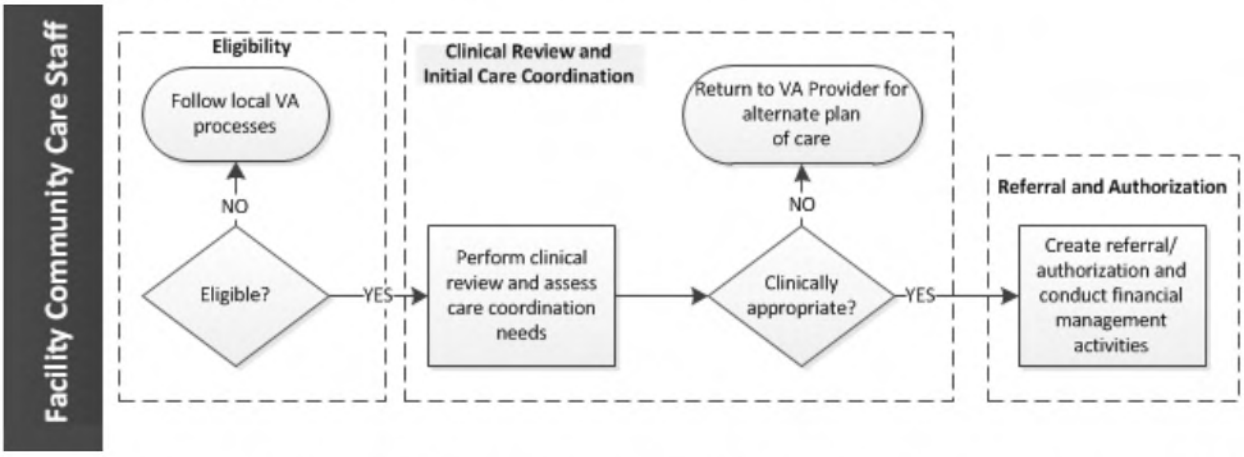
This section contains process information for the clinician performing review of the referral. Care coordination needs are assessed and documented in a standardized manner to ensure continuity of care. A standardized process for care coordination enables the VA to schedule community care services and align resources based on the Veteran's needs. This process is supported by consistent monitoring and tracking of performance throughout the episode of care.

Note: Care authorized through the Veterans Choice Program (VCP) (including VCP Provider Agreements) can no longer be furnished as of June 6, 2019. In addition, individual authorizations (IAs) or medical care authorized under traditional community care can no longer be furnished as of September 30, 2019 or the date VAMC transitions to the new Community Care Network (CCN) contract.

As facilities should consider options as outlined in the memorandum titled "Community Care Purchasing Authorities", one principle to conducting clinical review is to determine if the service is clinically appropriate and/or whether it can be delivered at the local VAMC prior to sending the consult to the community.

Remember: Clinical appropriateness should be determined by clinical staff who have been given DOA for services identified in the consult. Community Care staff assigned DOA (e.g. Registered Nurses) will assess clinical appropriateness using the evidence-based guidelines in the MCG Clinical Review Tool, which OCC will deploy in the first quarter of FY2021. Training is forthcoming. The clinical determination should be documented by the DOA reviewer using the Consult Toolbox and documented within the "Consult review" tab (see Consult Toolbox User Guide).

Clinical Review and Initial Care Coordination Process Flow



The review to determine clinical appropriateness should be based in accordance with the "Community Care Utilization Management Program Guidance" memorandum and including the following considerations:

- Can the service be provided within the VAMC; other VAMC, or Department of Defense (DoD) medical facility in a timely manner? If services cannot be provided; does the Veteran qualify for community care? Following clinical review and determination that none of these services are available, the Veteran may be referred to the community (in addition to these instructions, please refer to local guidance on locally offered services and availability).

- Is the service clinically appropriate according to an industry-standard Clinical Review Tool (CRT), clinical experience/acumen, and/or local clinical review guidelines? Note: Community Care staff assigned DOA (e.g. Registered Nurses) will assess clinical appropriateness using the evidence-based guidelines in the MCG CRT, which OCC will deploy in the first quarter of FY2021. Training is forthcoming.

- Is additional documentation required? If the information provided on the consult is not sufficient or if medical documents are incomplete, a request for additional documentation will need to be made to determine clinical appropriateness (see REFDOC and Documentation and Care Management instructions).

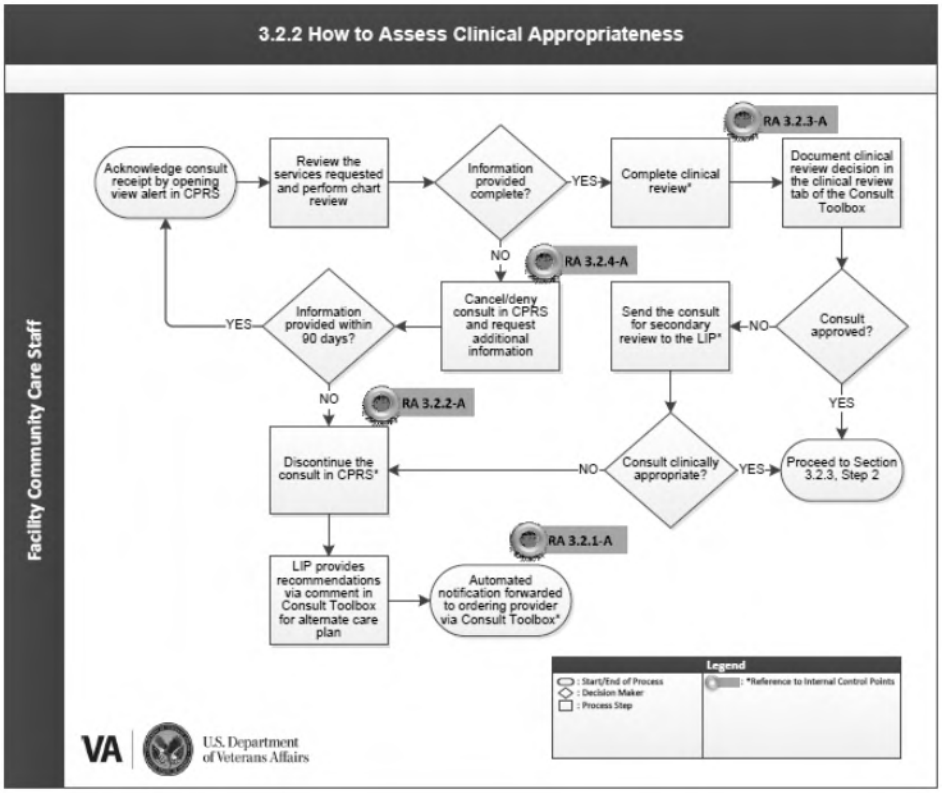
- Note: Information and resources on the clinical review process using InterQual and NUMI established by the Office of Utilization Management are available under the 'Resources' section at https://vaww.qps.med.va.gov/divisions/ncps/um/umDefault.aspx.

2.24 How to Assess Clinical Appropriateness

(Pre/Post CCN)

Clinical appropriateness determinations should be documented using the Consult Toolbox "Consult Review" tab Consult Toolbox User Guide based on:

- Industry-standard CRT (e.g. MCG)
- Clinical acumen/experience, and/or
- Local clinical review guidelines

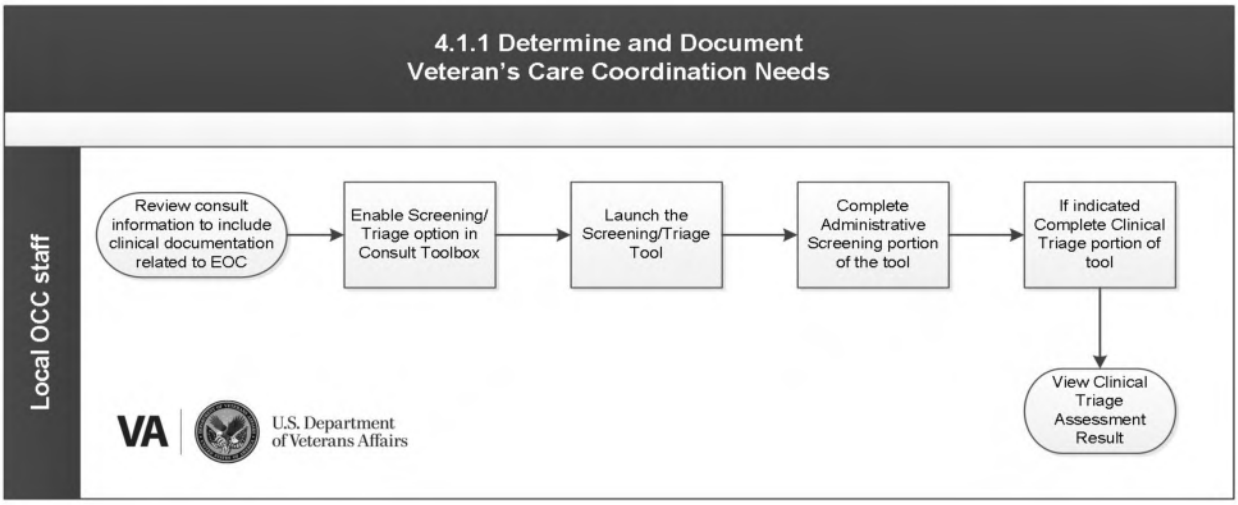


PROCEDURES	
General Considerations: For additional details on this guidance, please refer to Consult Toolbox Training.	
STEPS	**ACTIVITY**
1	Acknowledge consult receipt by opening View Alert in CPRS. **Note:** Some alert functionalities of CPRS may be disabled if the clinical reviewer has turned off personal notification preferences in CPRS. However, the Consult Request Resolution and Consult Request Cancel/Hold alerts cannot be disabled

2	Review all clinical information and perform chart review, including prior clinical results related to the consult and the SEOC, if it is present (for more information on SEOCs, refer to section 3.2.3). • If information is incomplete, refer to step 4a • If information is complete, proceed to step 3
3	Complete clinical review based on industry standard criteria and/or clinical acumen/experience. Refer to community care leadership for clinical review guidance. Note that community care staff assigned DOA (e.g. Registered Nurses). will determine clinical appropriateness using the new national MCG Clinical Review Tool, which OCC will release in the first quarter of FY2021. Training is forthcoming.
3a	Document clinical review decision in the "Consult Review" tab of the Consult Toolbox (Consult Toolbox User Guide). The ordering provider will be alerted automatically whenever the consult has been approved or not approved. • If the consult is approved, proceed to section 3.2.3, step 2 • If the consult is disapproved, proceed to step 4
4	Send consult for secondary review to the physician or non-physician provider if the consult is not approved and if the primary reviewer is NOT a Physician or non-physician provider**, based on the following: • If consult does not have appropriate information/supporting documentation to complete the clinical review, proceed to step 4a • If consult is not clinically appropriate, proceed to step 4b • If the decision was overturned, meaning the physician or non-physician determined the service is appropriate, proceed to section 3.2.3, step 2 **NOTE:** Second opinions when clinically indicated are allowable. If a provider is available in the VA and the Veteran does not meet other CC eligibility, then they should see another VA provider. If there is no other VA provider, or they meet other CC eligibility such as drive time, then a community provider can be seen.
4a	Cancel consult in CPRS and request additional information or an alternate plan of care. Once additional information is received, return to step 1 in Section 3.2.2 above. **Note:** The ordering provider can provide additional information and resubmit the consult for clinical review. Cancelled consults can be resubmitted within 90 days per VHA Consult Directive 1232. If a cancelled consult is resubmitted after 90 days, it should be discontinued with instructions to resubmit a new consult. If no additional information or clarification is required, proceed to step 4b below.

4b	Discontinue the consult in CPRS if the consult is not clinically appropriate. Note that the physician or non-physician provider should provide clinical recommendations, e.g. develop an alternative care plan, via a comment in the Consult Toolbox. The comment is automatically submitted back to the ordering provider to establish an alternate care plan for the Veteran. **If needed, refer to the local guidance of your Chief of Staff to determine if the reviewer is a physician or non-physician

2.25 How to Determine and Document Veteran's Care Coordination Needs



PROCEDURES

General Considerations:

Facility Community Care Administrative Clinical staff will assess a Veteran's care coordination needs using the S/T tool within the Consult Toolbox. The S/T tool will provide a care coordination level (basic, moderate, complex/chronic, or urgent) with recommended care coordination activities for the Veteran.

The tool ultimately assigns the Veteran to one of four care coordination levels, which are reflective of the intensity, frequency, duration and care coordination services required. The table below depicts the four care coordination levels along with services corresponding to that level and the recommended frequency of contact.

Care Coordination Level	Care Coordination Services	Recommended Frequency of Contact with Veteran
Basic*	• Navigation • Scheduling • Post-Appointment Follow-Up • E-Communication to referring provider	As needed
Moderate**	• Basic Care Coordination Services* • Monitoring and coordination of Rehab/PT services • Direct communication to referring provider • Chronic disease management, if appropriate	Monthly to Quarterly
Complex/Chronic	• Moderate Care Coordination Services** • Case Management if appropriate • Direct communication with interdisciplinary team • Chronic disease management, if appropriate	Weekly to Monthly
Urgent	• Immediate facilitation of requested services and direct communication with the Veteran providers	Hourly to Daily

A Veteran's care coordination needs depend on urgency, psychosocial, clinical, and episode-specific factors. For example, a relatively healthy Veteran obtaining community care for a routine eye exam will require less resources to coordinate his care than a Veteran with several comorbidities, lack of social support and a need for inpatient surgery.

To assess the Veteran's care coordination needs, the integrated team should review the Veteran's social situation and pertinent documentation. This documentation can include the referral request, authorization information, medical records, doctor orders, supporting imaging/lab and other supporting information.

Staff will then have to answer a specific set of questions based on their understanding of the Veteran's clinical and psychosocial status. The S/T tool will record and score these responses and assign a care coordination level based on an evidence-based algorithm. Refer to the Screening/Triage Tool Training and Consult Toolbox User Guide for more details.

Steps	Activity
1	**Review Consult Information to include clinical documentation** related to this episode of care (EOC).

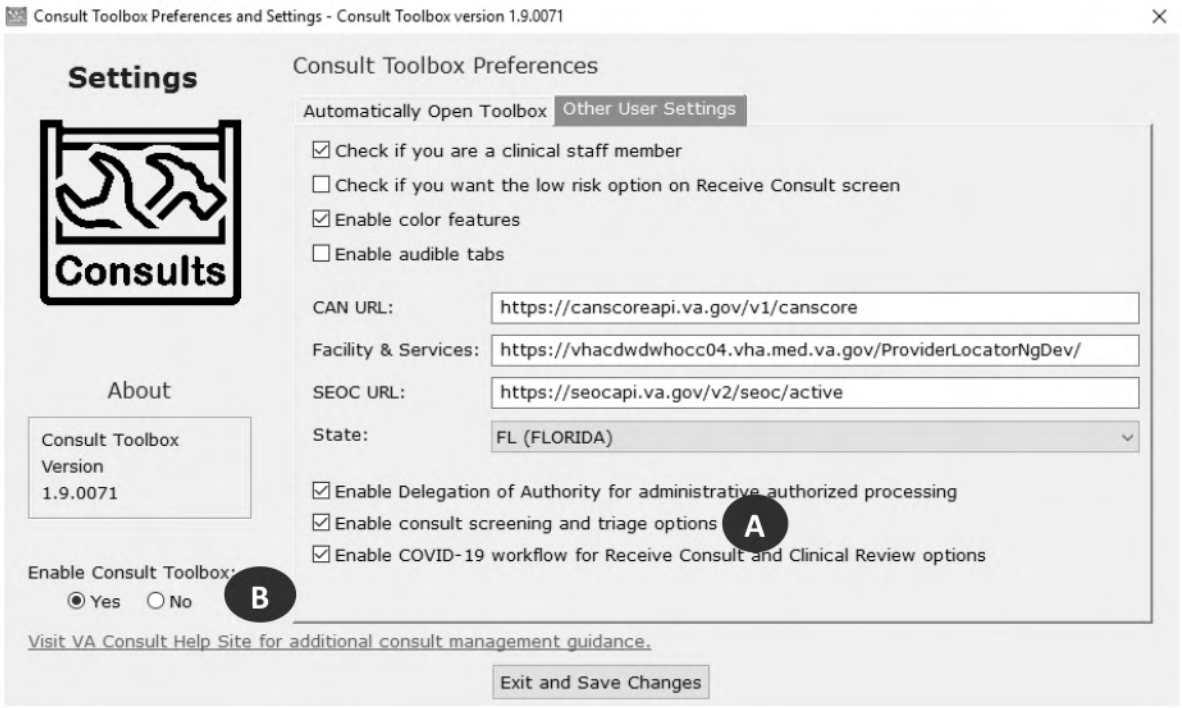
Administrative documents can include:

- Referral request
- Billing information
- EOCs/Authorizations (a clinician will perform the authorization review)

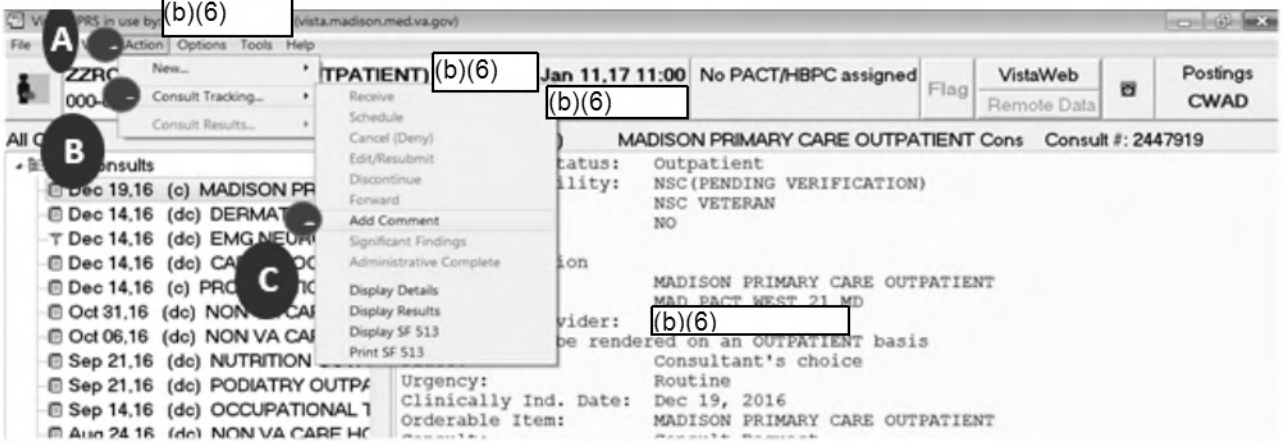
These administrative documents can be obtained by using the Screening/Triage Tool. For additional instructions on how to do so, please refer to the Screening/Triage Tool SOP.

Clinical documents can include:

- Medical records
- Doctor orders
- Supporting imaging/lab

2	**Enable the Screening/Triage option in the Consult Toolbox** If the S/T tool is not enabled in Consult Toolbox; navigate to the Preferences and Settings section.  To enable the Screening/Triage tool: A. Click the checkbox for "Enable consult screening and triage options" B. Check "Yes" for "Enable Consult Toolbox" prompt in the lower left Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0. Adjusting the setting is for the Screening Triage Tool is not required due to the advanced coding of the CTB 2.0
3	How do Launch I the Screening/Triage tool? After the Screening and Triage options have been enabled, the Screening/Triage Tool is launched via the Comments section of the Consult Toolbox. NOTE: Need to open the

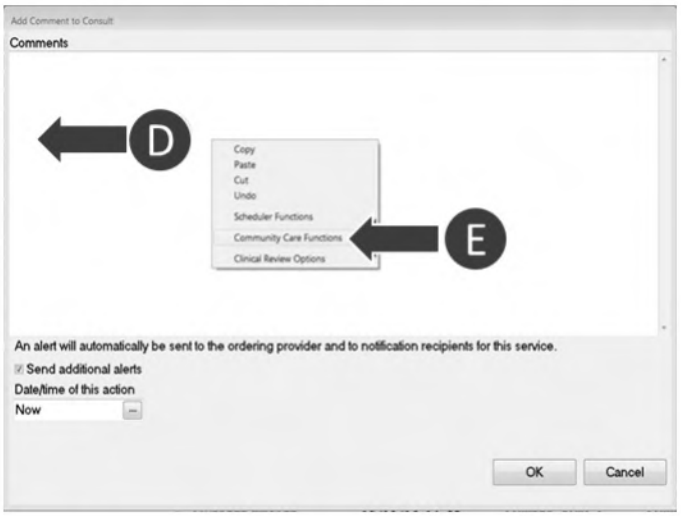
community care consult on the consult tab



To launch the S/T Tool, the comment window should be opened via the following steps:

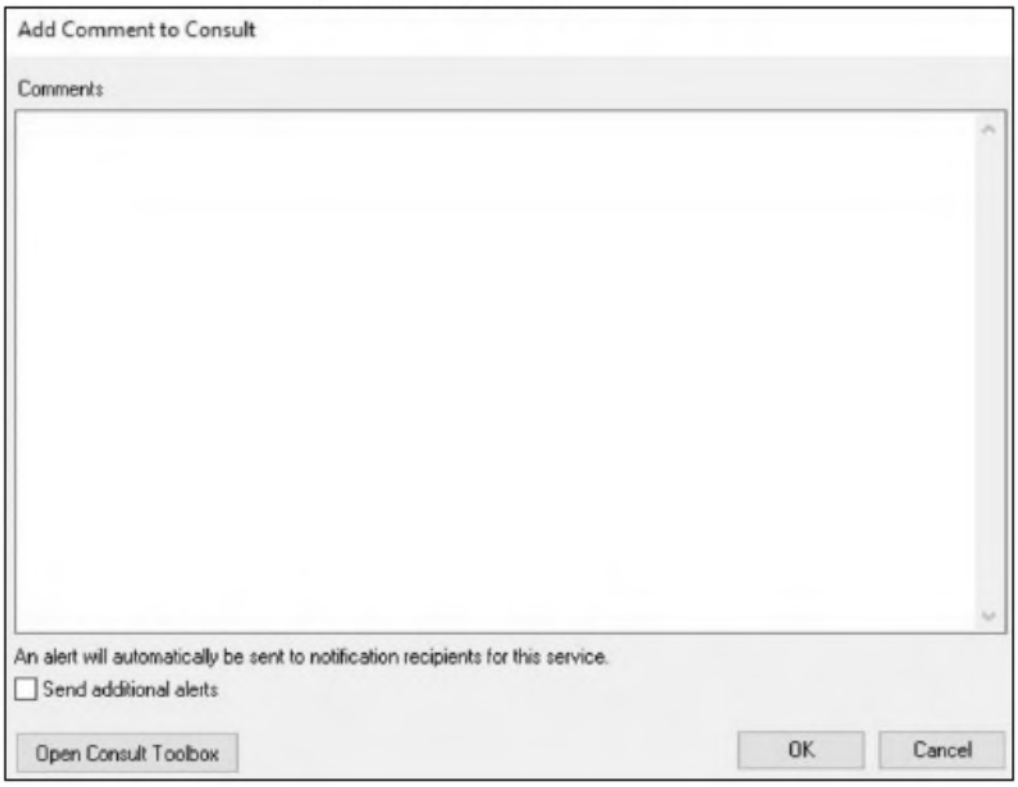
A. Click on "Action" in the top toolbar.
B. Hover over "Consult Tracking"
C. Select "Add Comment" from the menu

(CTB Version 1.9.0078)



D. If the Consult Toolbox does not open automatically, right-click anywhere in the white space of the Comments section.
E. Click on “Community Care Functions” to open the Consult Toolbox

(CTB Version 2.0)

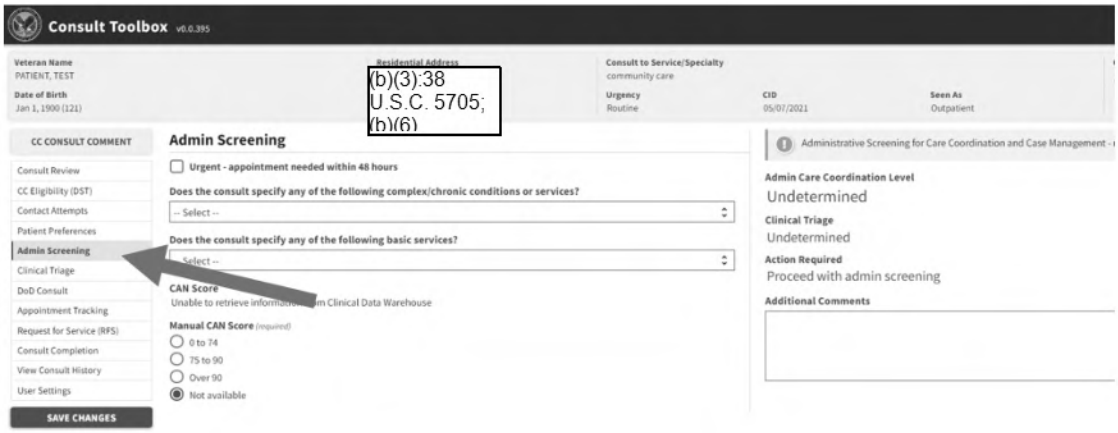


Select the “Open Consult Toolbox” button.

4 **Complete the Administrative Screening Portion of the tool**

(CTB Version 2.0)

The first step is to begin the Administrative Screening process. Click on the Admin Screening Tab:



The Admin Screening section includes the following questions:

A. Select if appointment is Urgent.
B. Does the consult specify any of the following complex conditions or services? If the consult specifies any complex conditions or services, select one of the following from the drop-down menu:
    1. New Cancer diagnosis
    2. Coronary Artery Bypass Grafting (CABG)
    3. Chronic Heart Failure
    4. Chronic Obstructive Pulmonary Disease/Pneumonia
    5. Inpatient Hospitalization (any cause)
    6. Outpatient Surgery
    7. None of the above

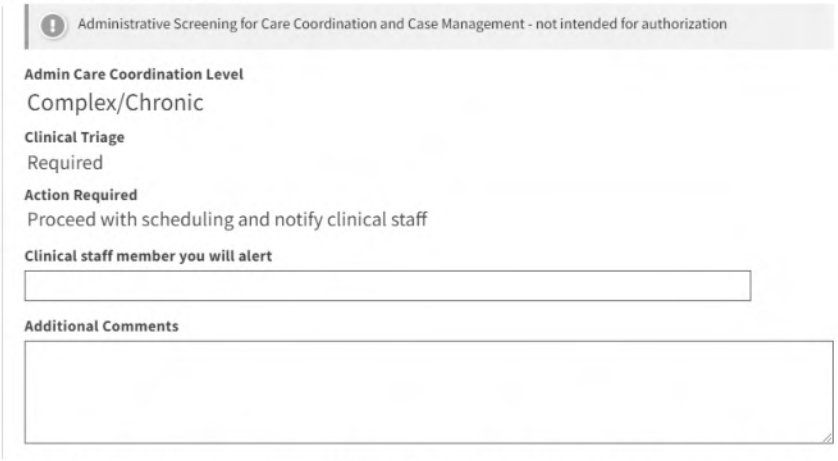
b. Does the consult specify any of the following basic services? If the consult specifies basic services, select the applicable service from the following drop-down menu:
    1. Routine Follow-up Therapeutics (Pre-scheduled services Dialysis, OT, PT, RT)
    2. Routine Mammography
    3. Direct Scheduling
    4. Cervical Ca Screening (PAP Test)
    5. Complimentary and integrated medicine
    6. Routine Screening Colonoscopy
    7. Low Dose CT Scans
    8. None of the above

C. CAN score will automatically populate (does not for testing environment). Care Assessment Need (CAN) Score:

The Care Assessment Need (CAN) score reflects the estimated probability of hospital admission or death within a specified time frame (90 days or 1 year). The CAN score that is auto-populated in the S/T tool is the 1-year time frame indicator. The score is expressed as a percentile, ranging from 0 (lowest risk) to 99 (highest risk) and indicates how a given patient compares with other VA patients in terms of likelihood of hospitalization or death. Patients with a very high score (e.g., 99) have a risk of admission or death that approaches 74 percent in the next year, while for those with a low score (e.g., 5) that risk is only about 2 percent. The CAN score is generated using sophisticated statistical prediction models that utilize demographic data (e.g., age, gender) and clinical information (e.g., medical conditions, use of VA health care, vital signs, medications, and laboratory tests) from VHA administrative data. The model also considers social-economic status based on patient residence and census tract level data obtain from the U.S. Census Bureau. The goal is to identify groups of patients at high risk for whom care coordination may be valuable.

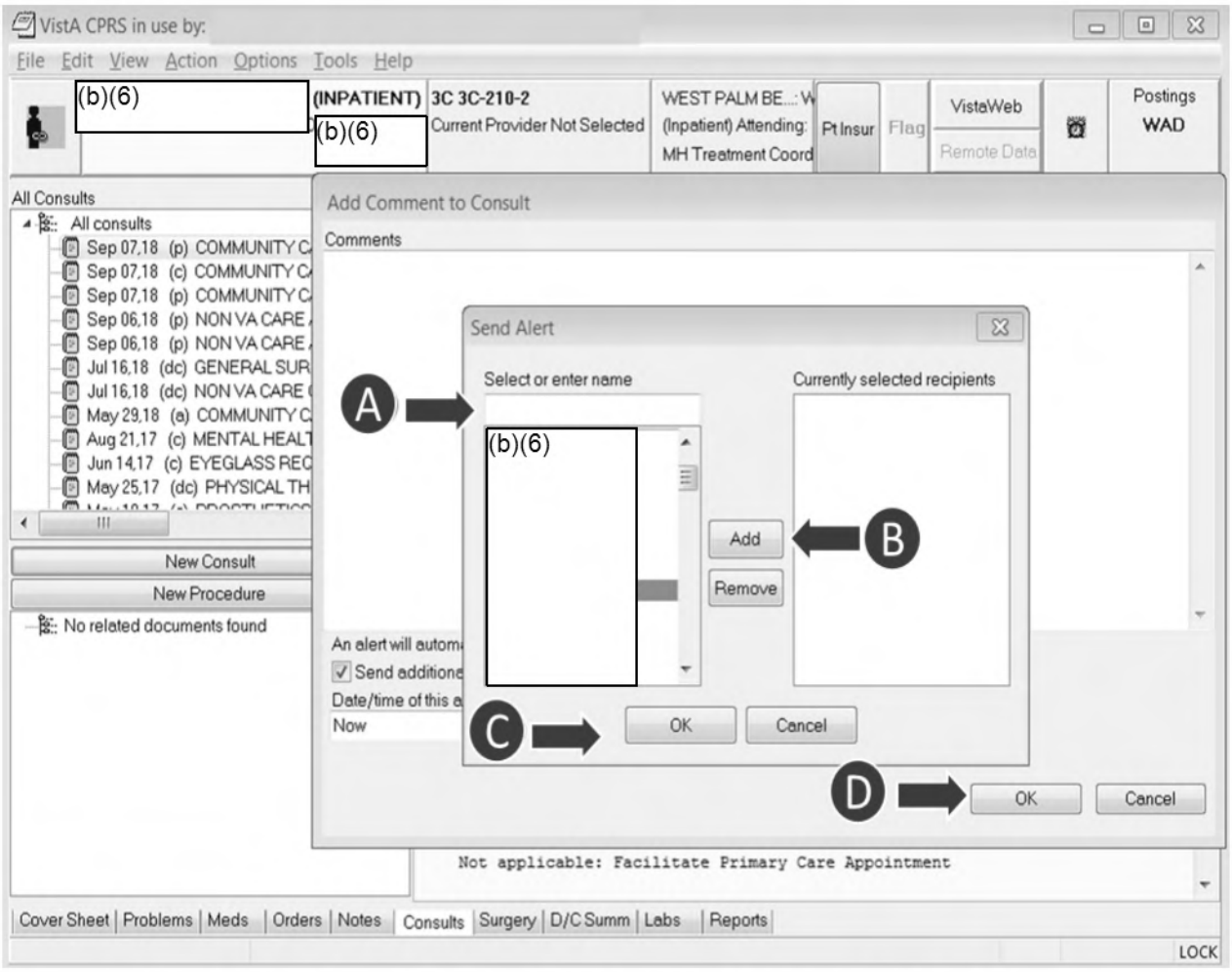
D. Admin Care Coordination Level, Clinical Triage requirements and Action Required will automatically populate.
   a. Current Coordination Level Assessment will populate in one of four levels: basic, moderate, complex/chronic, or urgent. Review to care coordination levels in the Overview section.
   b. The care coordination level of the Veteran will appear once the CAN score is auto populated. The result will be one of the four levels: basic, moderate, complex/chronic, or urgent. Refer to care coordination levels in the Overview section.

E. If Clinical Triage is required, scheduler will be prompted to add name of Clinical staff member they will alert.



   a. Click Close to complete the Administrative Screening portion and return to CPRS.

	Once the Administrative Screening is complete, the results will populate within the "MSA Elig. Verification" tab of the Consult Toolbox. i. If the level of care coordination is "basic," an administrative member of the integrated team may proceed to coordinate the appointment. ii. If the level is NOT "basic," a clinical member of the team will be required to assist in coordinating the episode and establishing a care coordination plan or notify Clinical Staff to complete the Clinical Section of the assessment. Once the Screening/Triage is complete, the S/T tool will populate comments in the body of the consult detailing the level of care coordination, directions for proceeding with care coordination, and a list of required care coordination services for the Veteran. The comments will also provide guidance on the frequency of contact and need for warm handoff, if necessary. Results will be displayed in the "Comments" section. Note: Do not manually adjust the format or delete any content in the comment box; as it will affect the data resulting in inaccurate reports and incorrect workflow data reporting. F. If the care coordination level is anything other than "basic," a box will open to input the name of the clinical staff member responsible for completing the clinical triage portion of the tool. This is not shown for clinical staff and the scheduler will need to select the appropriate Clinician to assess the Veteran based on the triage tool by checking the box "Send additional alerts." By checking the box, the "Send Alert" window will open.
5	**(CTB Version 1.9.0078)** How do I submit for clinical triage? Once the "Send additional alerts" box is checked, and the "Send Alert" window opens, the tool will prompt the user to select the appropriate Clinician to complete the clinical portion of the triage review.



A) From the “Send Alert” window, enter the name of the appropriate clinician, or select from the list on the left-hand side.
B) Once a name has been chosen, click “Add” to move the name into the right-hand side titled “Currently selected recipients”. Confirm you have selected the correct recipient.
C) Click “OK” to assign the Clinical Triage portion of the S/T Tool to a facility community care clinical staff.
D) Click “OK” once more on the “Add Comment to Consult” window to complete the process.

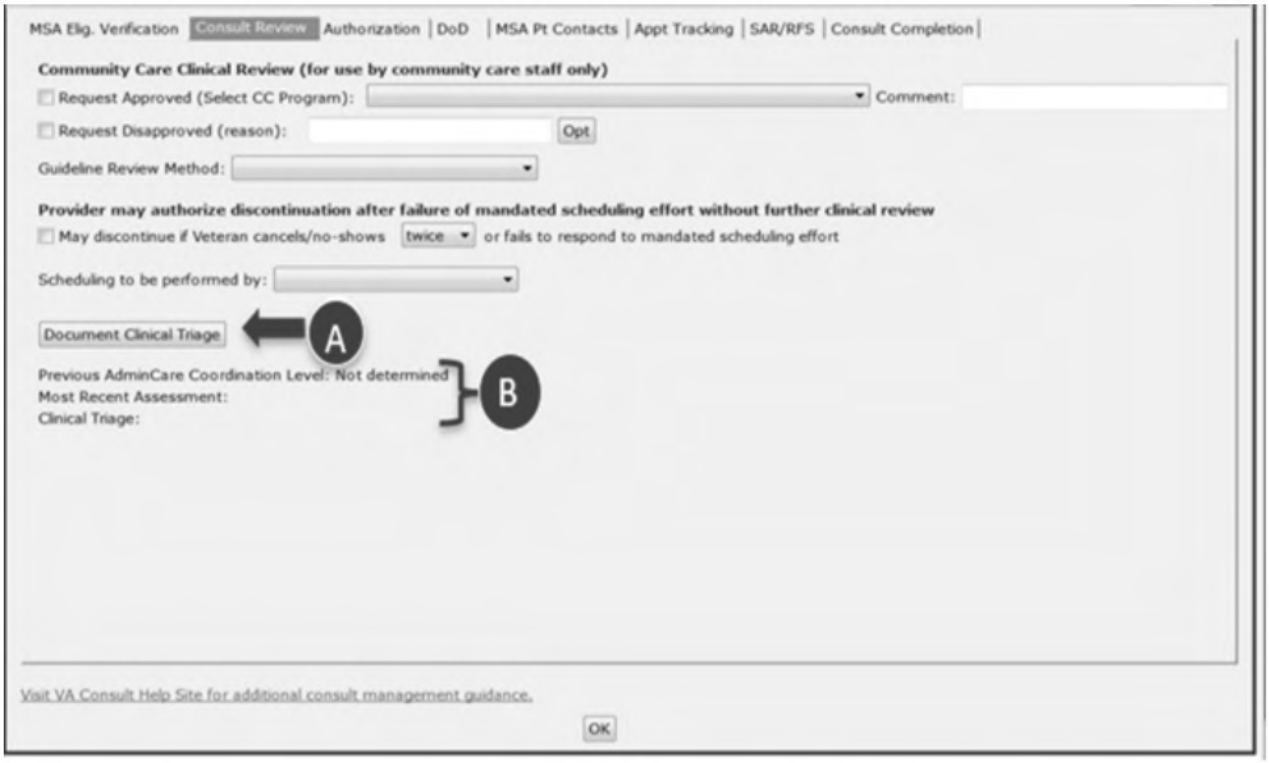
How do I complete clinical triage?

If the level of care coordination determined in the Administrative Screening section is not “basic,” the Administrative staff member will alert a Clinician to complete the Clinical Triage section. The Clinical section consists of questions regarding the Veteran’s comorbidities, social factors, and need for assistance with ADLs. These questions will be completed based on information in the consult, review of the medical record, and clinical judgment.

The clinical staff completes the required questions in the ‘Clinical Care Coordination Assignment’ window.

Last Modified on: Tuesday, August 3, 2021

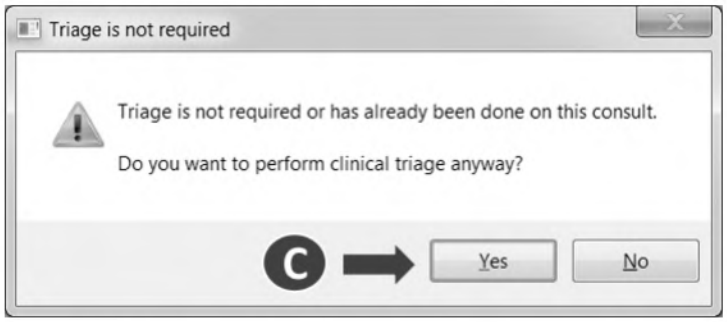
NOTE: The Administrative screening portion will need to be completed prior to beginning the clinical triage process. It is important to check to see if the process has already been completed for that consult. If clinical triage has not been performed or needs to be updated, the Clinical staff should click on the “CC Consult Review” tab in the Consult Toolbox to view three indicators which are found below the “Document Clinical Triage” button.



A) The staff will click on "Document Clinical Triage" button

B) The clinical staff can view three fields:

- Prior Admin Screening Care Coordination: Specifies the previous care coordination level assigned during the Administrative Screening, please note the Screening/Triage must be performed on a consult level basis.
- Most Recent Assessment: Indicates the most recent type of assessment (Administrative or Clinical)
- Clinical Triage: Indicates whether Clinical Triage is required

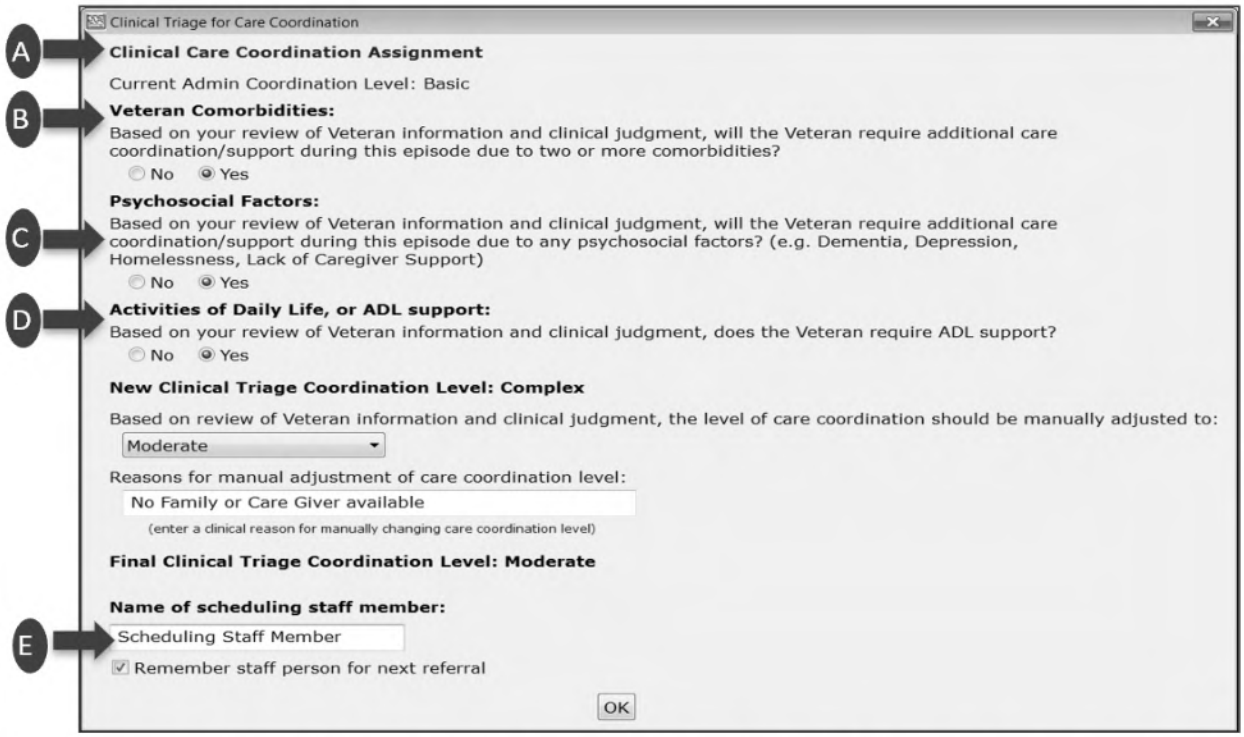


Note: The warning pop-up will appear if:

- Triage is not required — the consult was assessed at a Basic level of care coordination during Administrative Screening
- Triage has already been done — someone has already performed clinical triage on the consult

C) If a Clinical Triage has already been completed, a small window will appear to ask if you want to repeat the triage. If it hasn't been completed, the Clinical Triage portion will appear.

- Clicking "Yes" will enable the previous entry to be replaced with new information (Only click "Yes" if you believe that a significant change has occurred to the factors in the Administrative Screening section for that consult).
- Clicking "No" will maintain current results



A) Clinical staff reviews the care coordination level previously assigned during the Administrative Screening

B) Veteran Comorbidities:
- Select "Yes" or "No," if based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to two or more comorbidities

C) Psychosocial Factors
- Select "Yes" or "No," if based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to any psychosocial factors (e.g. Dementia, Depression, Homelessness, Lack of Caregiver Support), etc.

D) Activities of Daily Life, or ADL Support:
- Select "Yes" or "No," if based on your review of Veteran information and clinical judgement, the Veteran will require ADL support

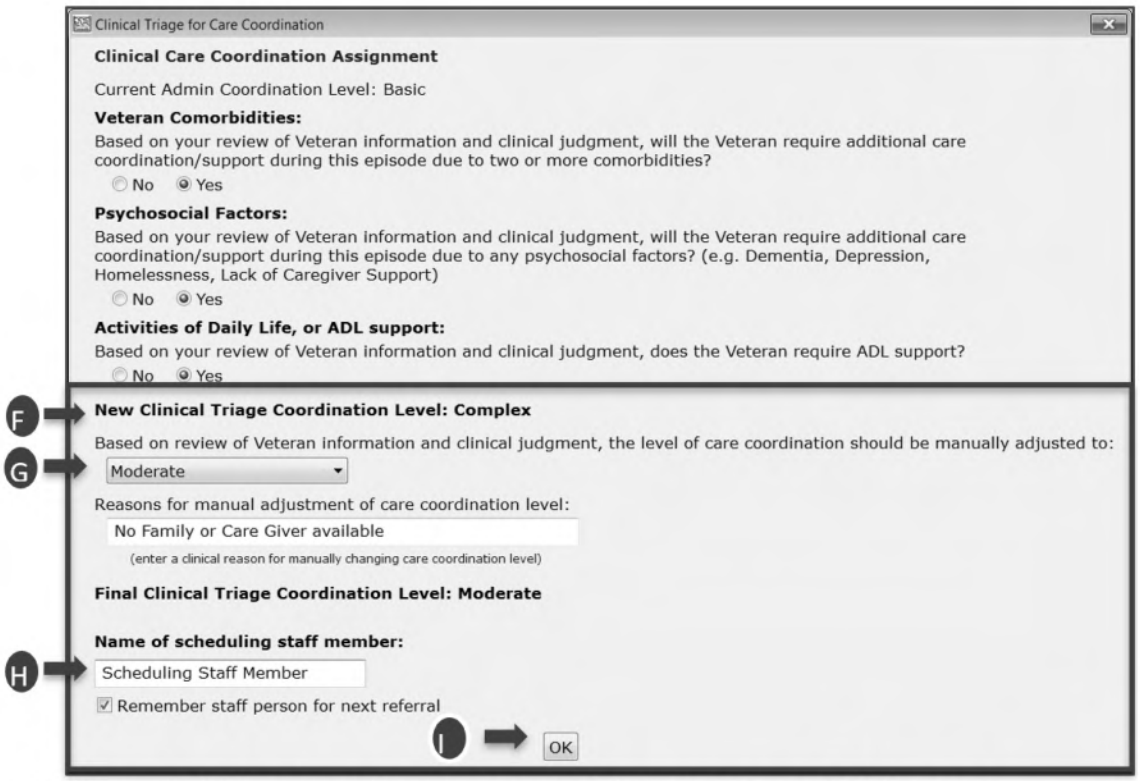
E) Name of scheduling staff should be inserted and sent an alert to schedule the requested services.

Additional information on clinical triage questions:

1) Manual adjustment of care coordination level: At the top of the clinical triage portion of the tool, the care coordination level is displayed as determined by the administrative portion. After completing sections 1-3 of the clinical triage portion of the tool, a care coordination level based on these inputs (1-3) will be displayed. This level may be different from the one determined after the completion of the administration portion of the tool. The clinical staff member should use information in the Veteran's medical record, clinical knowledge, and other relevant information to determine whether the original care coordination level generated by the tool is appropriate.

2) If the clinical staff member makes the determination that the result generated by the tool were not accurate, the level should be manually adjusted. The clinical staff member should select the appropriate level (basic, moderate, chronic/complex, urgent) from the dropdown menu in the clinical section of the tool. The reason for manual adjustment should then be entered in the blank line below the drop-down selection.

Example of Manual Adjustment: A Veteran level of care coordination was previously complex, after reviewing the Veteran's psychosocial factors and noting the Veteran has good family support the clinician reviewing the clinical triage portion of the tool determined the care coordination level should be moderate instead of complex. The clinician would enter a reason for the manual adjustment to the moderate level stating that "The Veteran has strong social support and no concerning psychosocial factors."



F) Clinical staff reviews the newly calculated assessment of the care coordination level

G) The Clinical staff can override the results of the tool (based on clinical expertise and judgment), by selecting a new level from the drop-down menu, and documenting the clinical reason for the change in the comment section. The reason should be brief (no more than 10-12 words). "Final Clinical Triage Coordination Level" auto-populates based on the completion of Clinical Triage questions or manual override.

- Basic
- Moderate
- Complex/Chronic
- Urgent

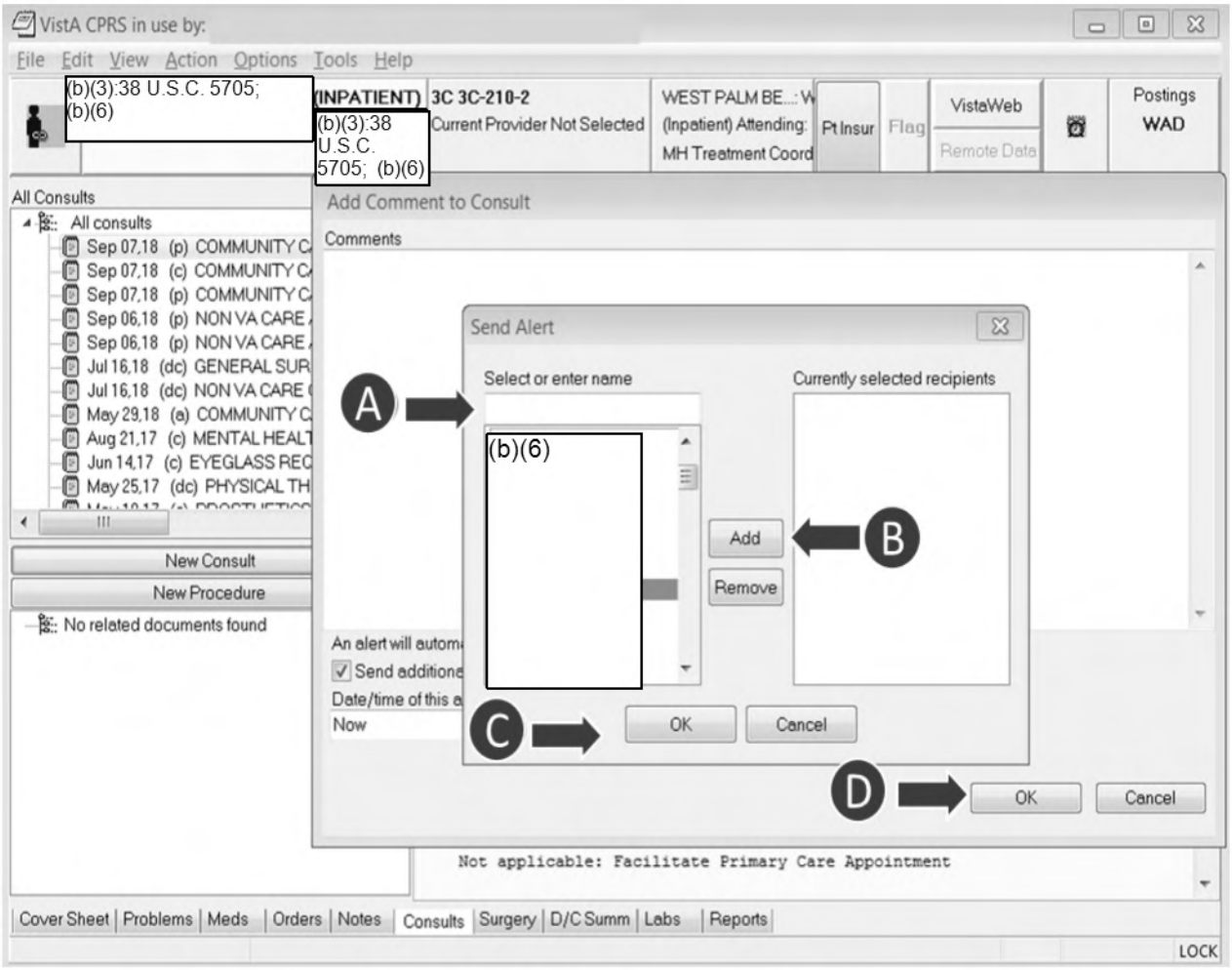
H) Input the full name of the scheduler on the integrated care team
I) Click “OK” to submit the results

6

(CTB Version 2.0)

How do I submit for clinical triage?

Once the “Send additional alerts” box is checked, and the “Send Alert” window opens, the tool will prompt the user to select the appropriate Clinician to complete the clinical portion of the triage review.



E) From the “Send Alert” window, enter the name of the appropriate clinician, or select from the list on the left-hand side.
F) Once a name has been chosen, click “Add” to move the name into the right-hand side titled “Currently selected recipients”. Confirm you have selected the correct recipient.
G) Click “OK” to assign the Clinical Triage portion of the S/T Tool to a facility community care clinical staff.

H) Click “OK” once more on the “Add Comment to Consult” window to complete the process.

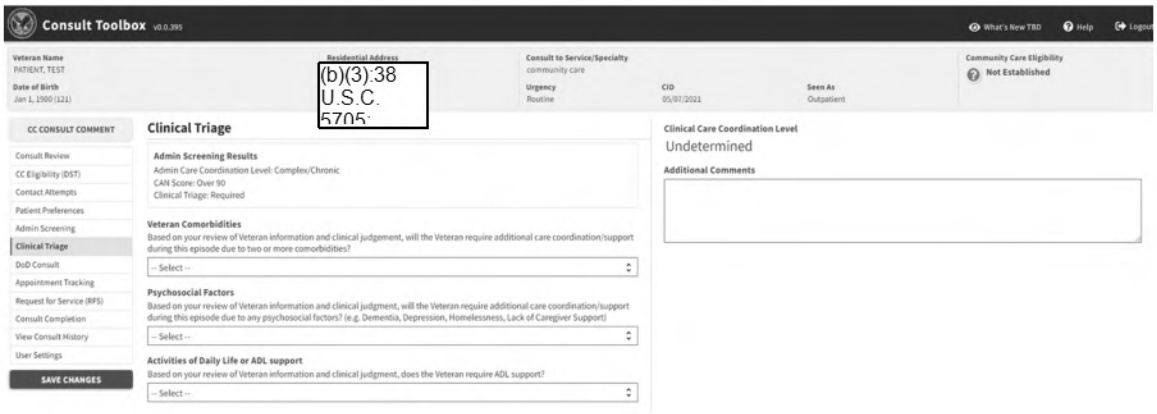
How do I complete clinical triage?

If the level of care coordination determined in the Administrative Screening section is not “basic,” the Administrative staff member will alert a Clinician to complete the Clinical Triage section. The Clinical section consists of questions regarding the Veteran’s comorbidities, social factors, and need for assistance with ADLs. These questions will be **completed based on information in the consult, review of the medical record, and clinical judgment.**

The clinical staff completes the required questions in the ‘Clinical Triage’ tab.

NOTE: The Administrative screening portion will need to be completed prior to beginning the clinical triage process. It is important to check to see if the process has already been completed for that consult.

D) The staff will click on “Clinical Triage” tab:

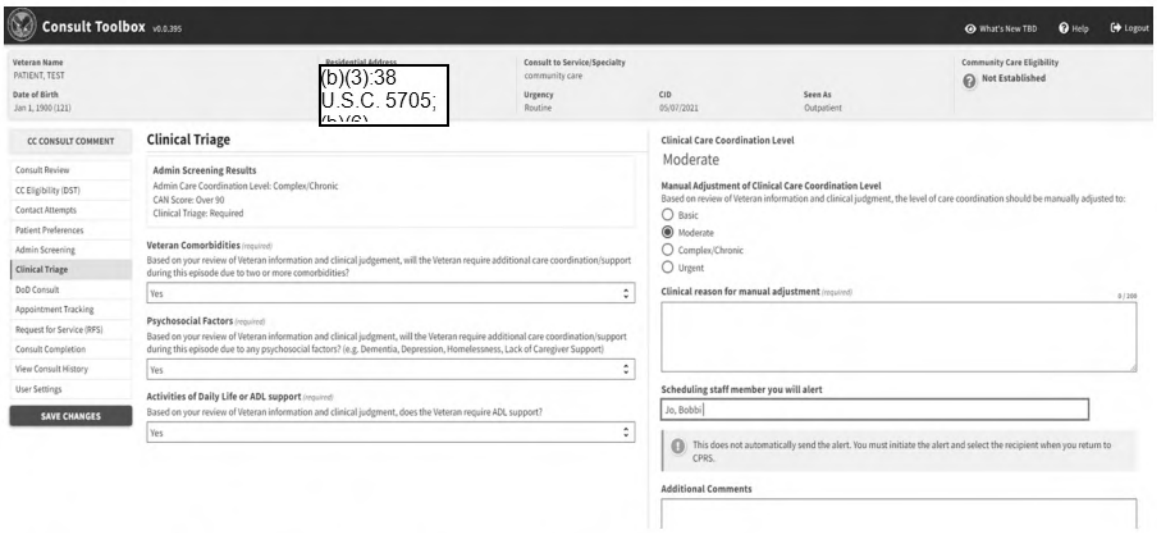


E) The clinical staff can view three fields:

- Veteran Comorbidities: Select “Yes” or “No,” if based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to two or more comorbidities
- Psychosocial Factors: Select “Yes” or “No,” if based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to any psychosocial factors (e.g. Dementia, Depression, Homelessness, Lack of Caregiver Support), etc.
- Activities of Daily Life or ADL Support: Select “Yes” or “No,” if based on your review of Veteran information and clinical judgement, the Veteran will require ADL support
- Clinical staff reviews the care coordination level previously assigned during the Administrative Screening. This level may be different from the one determined after the completion of the administration portion of the

tool. The clinical staff member should use information in the Veteran's medical record, clinical knowledge, and other relevant information to determine whether the original care coordination level generated by the tool is appropriate. If the clinical staff member makes the determination that the result generated by the tool were not accurate, the level should be manually adjusted. The clinical staff member should select the appropriate level (basic, moderate, chronic/complex, urgent) from the menu. The reason for manual adjustment should then be entered in the blank line below the drop-down selection.

F) Name of the scheduling staff should be inserted and sent an alert to schedule the requested services.



G) Click on "Save Changes".

What do I do with the S/T tool result?

At the completion of the S/T tool, the care coordination level should be used by the appropriate personnel (admin or clinical) to create a care coordination plan, which will outline what activities will be facilitated by the integrated team and what care coordination activities are to be completed, with clear roles and responsibilities outlined.

2.26 How to Determine Clinical Service Availability within VAMC or Sister Facility

(Pre/Post CCN)

The Veteran's care coordination needs will be assessed by Facility Community Care Office staff using the Veteran's information and the Screening/Triage process when the clinical review is complete. This assessment identifies the appropriate levels of care coordination and lays the foundation for the Veteran's care coordination plan.

The appropriate community care option is determined by review of the Veteran's clinical need, provider availability, and local leadership guidance for current funding sources. MISSION Act has been activated as of June 6, 2019. Prior to CCN site activation, the PC3 contract, Urgent Care, and Individual Authorizations are the available options. Post MISSION Act (June 6, 2019), the Community Care Network will be the preferred method for obtaining community care for Veterans as Regions and local facilities are activated in a phased approach. Other options (including PC3 contract and Veteran Care Agreements (VCAs) ((VCA 11.2.5) may also be available and potentially more appropriate based on the Veteran's needs. Please remember eligible veterans can and should be sent to the new CCN providers as they will be paid from the CCN fund. Veterans eligible for community care due to services not available, should also preferentially be sent to CCN providers but when appropriate, care can also be authorized using a VCA or local contract. VA Proposed new Eligibility Criteria under the MISSION Act include:

- Services Unavailable
- Residence in a State without a full service VAMC
- 40-mile Legacy/Grandfathered from Choice
- Access Standards
- Best Medical Interest
- Veteran requiring medical service that complies with VA standards for quality and is not available in ordering VAMC

VA has enacted access standards for community care. Average Drive Time and Appointment Wait Times:

- Primary Care, Mental Health, and non-Institutional Extended Care Services: 30-minute Average Drive Time Standard
- Specialty Care: 60-minute Average Drive Time Standard
- Appointment Wait-Times:
  - 20 days for Primary Care, Mental Health, and non-Institutional Extended Care
  - 28 days for specialty care from the date of request with certain exceptions
- Urgent Care
  - Urgent Walk-in Care (provider in VA's CCN)

NOTE: Facility Community Care Office staff should seek guidance from their supervisor on how to assess available funding. Guidance may also come from the Chief of Staff, Medical Center Director, Chief Financial Officer, or other medical center leadership.

Drive Time Calculation Update
Office of Community Care is developing an improvement to DST that will support a more consistent assessment of Veterans' drive time eligibility for community care.

Now that VA has one year's worth of experience, VA identified the need to improve the geographic information system determining drive time eligibility under the Veterans Community Care Program. This was done by introducing a new geographic drive time eligibility information system. DST will receive information on average drive time from a new data source. The data from VA Planning Systems Support Group (PSSG) will replace data from Provider Profile Management System (PPMS).

NOTE: Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web based tool integrated within CPRS. Equivalent of the DST is built directly into the CTB Version 2.0.

When DST begins to connect to the new data source August 28, 2020, DST users will experience the following:

- DST will display all VHA facilities within a 90-minute drive time radius that may offer the selected clinical service
- Average drive time will display as a ten-minute range: 0-10, 10-20, 20-30 minutes, etc.
    - Although the bands appear to overlap, note that the ranges should be interpreted as 0 minutes to exactly 10 minutes, greater than 10 minutes to exactly 20 minutes, greater than 20 minutes to exactly 30 minutes, etc.
- The green "Community Care Eligible based on: Drive Time" banner in DST will continue to identify drive time eligibility when a Veteran's residential address is within a drive time range that exceeds the drive time standards:
    - 30 minutes for primary care, mental health care, and extended care services (GEC)
    - 60 minutes for specialty care services

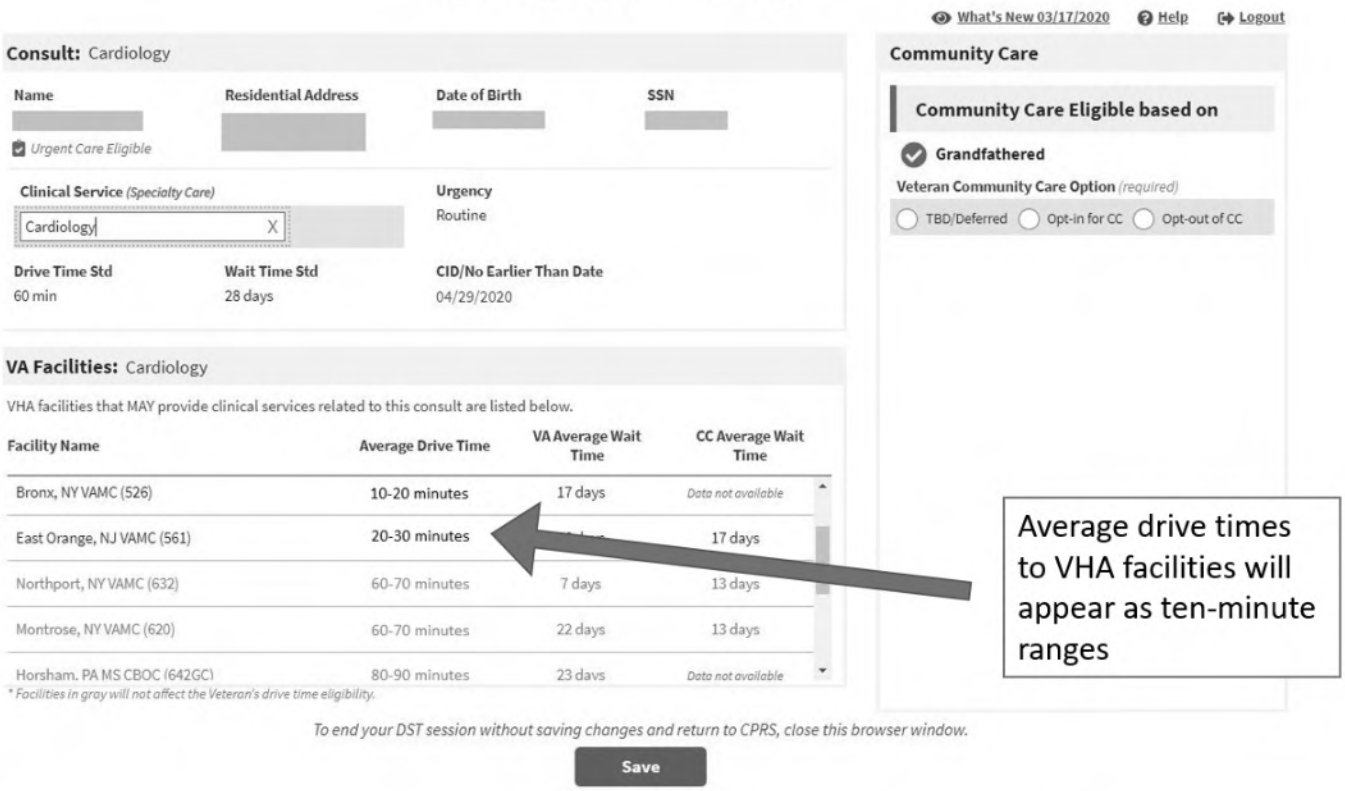
DST will use geographic information data provided by VA Planning Systems Support Group (PSSG) that creates bands around each VHA facility that reflect drive times in ranges of ten-minute increments, starting with 0-10 minutes and going up to 80-90 minutes.
DST will display an estimate of the drive time between the Veteran's residential address, as reflected in the Enrollment System (ES) and the VHA facility in a ten-minute range, instead of a single time estimate as in the current system.
The system will calculate average drive time bands based on historical traffic patterns on Wednesdays at 10:00 a.m. at the Veteran's local time

- This time and day of the week reasonably approximate times that Veterans would be traveling for appointments, while working within the capabilities of the system and the available data

Historical traffic data will be updated two to three times per year to reflect changes in local travel patterns

Last Modified on: Tuesday, August 3, 2021

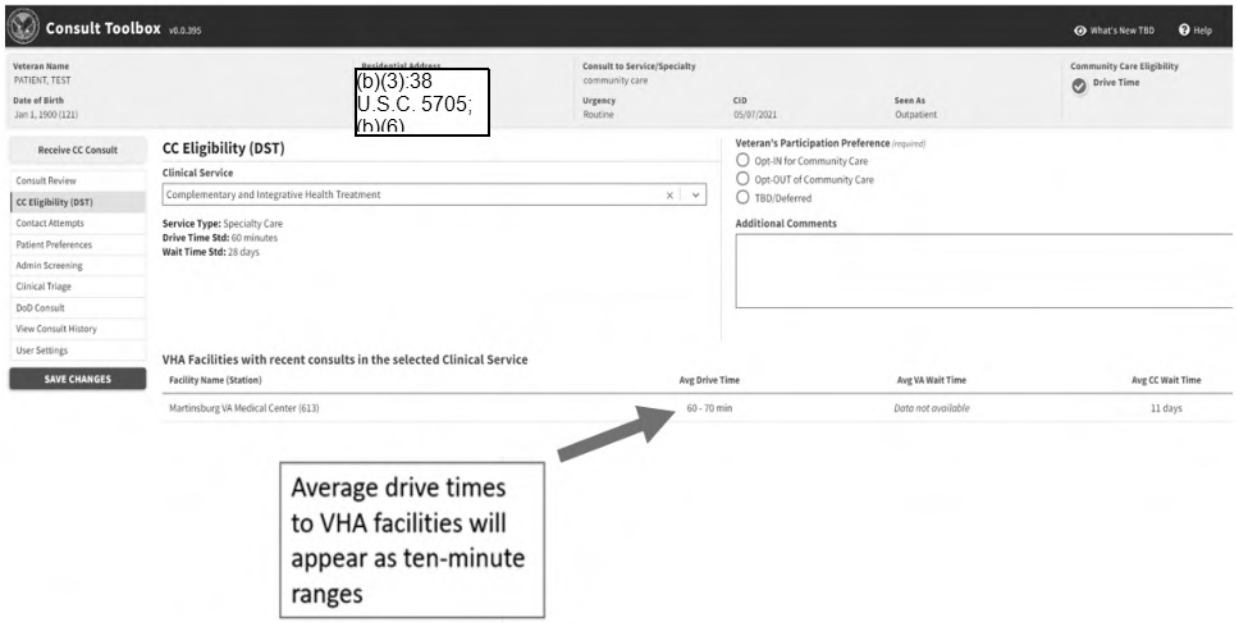
(CTB Version 1.9.0078)



VA staff will continue to use and interpret drive time information in DST in the same way.

CTB Version 2.0)

Last Modified on: Tuesday, August 3, 2021



2.27 How to Assess which Services to Buy

The processes for determining a Veteran's level of complexity and level of care coordination consists of reviewing consults, requested services and clinical information related to the Veteran's Episode of Care (EOC), along with conducting a Screening / Triage process.

Note: The recommended care coordination activities should be taken into consideration when executing the care coordination plan. Use of the Screening/Triage Tool is mandatory and determining the personalized care needs of the Veteran should be done by reviewing the medical record including the most recent notes, consult, problem list, and recent discharge summaries to help inform your determination. GEC consults are exempt from mandatory use of the Screening/Triage Tool. Care coordination and oversight processes for these services are standardized per the relevant handbook, directive, or guidance in the GEC section of the Specialty Program Chapter of the Field Guidebook.

The National Deployment of the Community Care Coordination Model (CCM)10N Memo was released on September 16, 2019 The CCM consolidates various care coordination components through the implementation of , the Screening/Triage (S/T) Tool, use of a Community Care-Coordination Plan (CCP) Note, HealthShare Referral Manager (HSRM) care coordination functionalities, and Case Management (CM) process, if indicated, to assess a Veteran's CM needs. The purpose of implementing a standardized CCM is to provide Veterans with personalized and well-coordinated care across the continuum and help smooth transitions of care between facility community care offices and community providers.

Care Coordination Model Framework

People	Processes	Technologies

• Integrated Team:
  • Facility community care administrative staff (e.g., Medical Support Assistants (MSAs)/Program Support Assistants (PSAs), etc.)
  • Facility community care clinical staff (e.g., Registered Nurse (RN), Social Worker (SW)
• Internal VA care team (Referring Provider, Patient Aligned Care Team (PACT))
	• Integrated Team Model
	• Administrative screening
	• Clinical triage
		• Computerized Patient Record System (CPRS)
		• HealthShare Referral Manager (HSRM)
		• Consult Toolbox
		• Screening/Triage Tool
		• 5-part case management screening and 9- part case management assessment
		• Screening/Triage Tool usage report which shows the usage and percentage of Veterans within each level of care coordination.

Veteran needs assessment overview

A personalized approach to care coordination will facilitate safe, high-quality and timely access to care for Veterans. The Veteran needs assessment step in the care coordination process enables staff to determine each Veteran's unique care coordination needs using the Screening/Triage (S/T) tool.

The purpose of the S/T tool, located in the Consult Toolbox in Computerized Patient Record System (CPRS), is to enable facility community care staff to assess a Veteran's care coordination needs on a consult level basis. The tool is an end-to-end care process which uses a combination of automated and user-input information regarding clinical factors, psychosocial factors, and the Veteran's Care Assessment Need (CAN) score to assess whether a Veteran's care coordination need is basic, moderate, complex/chronic, or urgent. These four levels are intended to provide a level of context and standardization for VA staff that will be coordinating care. Each level demonstrates increasing complexity and, therefore, a greater need for various care coordination services. Consistent use of the tool will give facility community care staff greater insight into the health and care coordination needs of their Veteran population.

The process begins with a receipt of request for community care from a referring provider. After a Veteran's eligibility for community care has been verified, and the Veteran has decided on community care, the S/T tool is used in Step B (above), "Assess Veteran needs," to determine the appropriate level of care coordination for a Veteran. The tool has two portions, an administrative screening portion and a clinical triage portion. While the administrative portion may be completed by any integrated team staff member (Medical Support Assistant (MSA)/Program Support Assistant (PSA), Registered Nurse (RN), or Social Worker (SW), (if applicable), the clinical portion can only be completed by clinical staff members (RN and SW, if applicable). The administrative section consists of questions about the urgency of the Veteran's care coordination needs, the requested services in the consult, and the corresponding Veteran Care Assessment Need (CAN) score. The CAN score is an evidence-

based algorithm that is used to provide a score which is automatically populated on the 'Administrative Screening' page within the S/T tool.

Who is responsible for assessing the Veteran's needs using the Screening/Triage tool?

Based on the answers in the administrative section, the tool will determine whether the clinical triage portion will be necessary. If, based on the administrative portion of the tool, the care coordination level is basic, no further action is needed, and the user should proceed to name a scheduling staff member to schedule the requested services. If the care coordination level is not basic, the clinical triage portion of the tool should be completed by a clinical staff member, then similarly the clinical staff member should send an alert to a scheduler after clinical triage has been completed to notify the scheduler to schedule the requested services. The clinical portion of the tool consists of questions regarding comorbidities, psychosocial factors, activities of daily life (ADL) support, and a manual adjustment option. This option should be used when the clinical staff member believes the care coordination level is not appropriate based on his/her clinical assessment, knowledge and judgement and a clinical justification reason documented.

Services Covered Under CCN

Basic Medical

- Preventative Care
- Outpatient Services
- Inpatient Services
- Hospital Services
- Ancillary Services
- Behavioral Health
- Comprehensive Rehab
- Residential Care
- Home Health
- Hospice
- Geriatrics
- Long Term Acute Care
- Maternity and Women's Health
- Newborn care
- Acupuncture
- Telehealth
- Chronic Dialysis
- Assisted Reproductive Tech

Conditional Benefits

- Pharmacy
- Dental
- Emergent Care
- DME
- Reconstructive Surgery
- Immunizations
- Implants
- Urgent Care
- Skilled Nursing Facility Care
- In Vitro Fertilization (IVF)*

- Walk-In Care*

CIHS
- Bio Feedback
- Hypnotherapy
- Massage Therapy
- Native American Healing
- Relaxation Techniques
- Tai Chi

Non-Covered Services
- Beneficiary Travel
- Prosthetic Device Evaluation
- Nursing Home Care
- Home Deliveries
- Ambulance Services
- Yoga+

Excluded
- Abortion
- Drugs not approved by FDA
- Gender alteration
- Institutionalized Patient care
- Spa/Health club
- Out-of-network Services

Clinical Trial Guidance
Veterans being referred to community care for a clinical trial must still meet community care eligibility criteria. It is important to note that 38 CFR 17.38(3) prevents VA from providing experimental treatment except when part of an approved research project. Clinical trials are traditionally covered by the group conducting the research and a community care consult can be used to cover the associated labs, radiology services and additional ancillary services needed. For Veterans who require a clinical trial and they meet the clinical trial criteria, the local office of community care should still follow the rules to make sure the Clinical Trial is appropriate and part of the Clinicaltrials.gov site with a NCT number.

Last Modified on: Tuesday, August 3, 2021

TMS

Available for access via the Hub

- The Use of Veteran Online Scheduling (VAOS) for Community Care
- Preparing for the National Deployment of the Screening Triage Tool
- Care Coordination Plan Note (CC-CCP Note)
- Decision Support Tool (DST) for Administrative Staff
- Forwarding a Consult to Community Care
- Introduction to Consult Management
- How to Create a Community Care Consult
- Community Care Referral Process for Complementary and Integrative Health
- Capturing Veterans Community Care Scheduling Preferences
- Community Care Veteran Self-Scheduling Process
- VA Community Provider Locator (CPL) Tool
- Consult Toolbox (CTB) 2.0
- Admin Screening and Clinical Triage in CTB 2.0

Additional Training



- **TMS- VA 38471**
  An Overview of Community Care
- **TMS VA 39161**
  An Overview of VCCPE Consult
- **TMS VA 4507398**
  What's New in Community Care
- **TMS VA 38464**
  Decision Support Tool (DST) Complete Overview
- **TMS VA 38465**
  Eligibility 201- Detailed Process Training

Last Modified on: Tuesday, August 3, 2021

- **TMS VA 4541952**
  Community Care Online Scheduling (VAOS) and Scheduling Manager (SM)
- **TMS VA 4557037**
  Module 1- Initiating a Consult and Verifying Veteran Eligibility for Community Care
  Module 2- Locating a Provider and Creating an Authorized Referral
  Module 3- Scheduling a Veteran's Appointment
  Module 4- Generating an Offline Referral
  Module 5- Generating a Letter for a Veteran and Closing a Consult
- **TMS VA 455850** Webinar - Community Care Veteran Self-Scheduling Process
- **TMS VA 4560233**
  Webinar - Capturing Veterans Community Care Scheduling Preferences
- **TMS VA 4562423** VA Community Provider Locator (CPL) Tool
- **TMS VA 4568812** Consult Toolbox (CTB 2.0)
- **TMS VA 4536160** A How to Guide: Completing Consults & Referrals (CTB 2.0)
- **TMS VA 45567333** Consult Toolbox 2.0 Training Demo

- Article: New eligibility criteria a major improvement over existing rules
- Fact Sheet: Eligibility
- Video: Veteran Community Care - Eligibility
- Webpage (Public – Veterans)
- Webpage (Public – Providers)
- Fact Sheet/FAQs
- Video: Emergency Medical Care

Note: The information in the Office of Community Care Field Guidebook (FGB) contains "live" documents that are consistently updated with new and updated information. Please ensure to access the FGB using the link below when printing or saving a copy of the FGB to your local desktop.
https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

VHA Office of Community Care
Field Guidebook
Chapter 3: How to Perform Care Coordination

Care Coordination Model	3.0	The Care Coordination Model (CCM)
	3.1	Coordinating Care Delivery (Pre/Post CCN
	3.2	How to Perform Care Coordination (Pre/Post CCN
	3.3	Standardized Episodes of Care (SEOC)
How to Coordinate Pre-Authorized Care	3.4	How to Coordinate Authorized Care (Pre CCN
	3.5	Understanding Pharmacy, Durable Medical Equipment (DME) and Medical Device Benefits under CCN
	3.6	Managing Care Coordination for Veterans through the Community Care Emergency Treatment Process
	3.7	Urgent Care Benefit
	3.8	Transplantation Care Process (Pre/Post CCN)
How to Schedule	3.9	How to Review Community Care Programs and Determine Community Care Purchasing Authorities
	3.10	How to Review Available Community Care Options
	3.11	Initiating Community Care Under Selected Option (Pre/Post CCN)
	3.12	How to Continue Care Initiation Using the Selected Community Care Option
	3.13	Contact Veteran and Fulfill Minimum Contact Requirements
	3.14	How to Schedule Care Under Community Care Network (CCN)

	3.15	How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran
How to Schedule Care Under CCN	3.16	Community Care Veteran Self-Scheduling Process
	3.17	How to Schedule Under CCN When the Community Provider Contacts the Veteran to Schedule
	3.18	How to Schedule Under CCN When Veteran Requests Appointments via VA Online Scheduling
	3.19	Optional Task #1 - Appointment Scheduling and Comprehensive Care Coordination under CCN
	3.20	How to Perform Clinical Review of Documentation and Coordinate Follow Up Care
	3.21	How to Manage Clinical Documentation from Community Providers
	3.22	How to Verify the Veteran Attended the Appointment
Completing the Follow up on an Episode of Care	3.23	How to Search for Clinical Documents
	3.24	How to Save Documents to the Shared Folder Location
	3.25	Roles and Responsibilities for Importing Clinical Documentation
	3.26	Release of Information (ROI) and Accounting of Disclosure
	3.27	How to Use Available Clinical Document Exchange Tools
	3.28	Requesting Clinical Documentation from the Community Providers
How to Use Available Clinical Document Exchange Tools	3.29	Receiving Documents via TriWest Portal (TPA)
	3.30	Receiving Documents via Azure Rights Management Service (RMS)
	3.31	Receiving Documents via VHIE Direct Secure Messaging (DSM)
	3.32	Receiving Documents via Joint Legacy Viewer (JLV)

	3.33	Receiving Documents via eFax (StreemFax/RightFax)
	3.34	Receiving Documents via Traditional Fax
	3.35	Receiving Documents via US Mail
	3.36	How to Use FBCS to Receive and Upload Clinical Documentation
	3.37	Receiving Documents via HSRM
	3.38	How to Perform Quality Assurance and Upload Clinical Documentation
	3.39	Performing Quality Assurance on Clinical Documentation Received from Community Providers
How to Perform Quality Assurance and Upload Clinical Documentation	3.40	Saving Clinical Documentation to a Shared Location
	3.41	Recording the Documentation Exchange Method
	3.42	Request for Service (RFS)
Request for Service	3.43	Management of Community Provider Request for Services
Community Provider Orders	3.44	Community Provider Orders

3.0 The Care Coordination Model (CCM)

The Care Coordination Model follows five principles to ensure that Veterans receive high quality, personalized care:

- Personalized Care Coordination Plan: A care coordination plan is developed to meet the care coordination needs of Veterans
- Seamless Transmission of Information: Health information is available when needed
- Collaborative Relationships: The Veteran, VA, and community partners are aligned on the care coordination plan and communicate actively
- High Quality and Timely Care: Clinical and administrative decisions are evidence-based, timely, and follow consistent protocols
- Clear Governance Structure and Roles and Responsibilities: Decision making follows established governance processes. Roles and responsibilities are clearly defined and understood by all stakeholders

3.1 Coordinating Care Delivery (Pre/Post CCN)

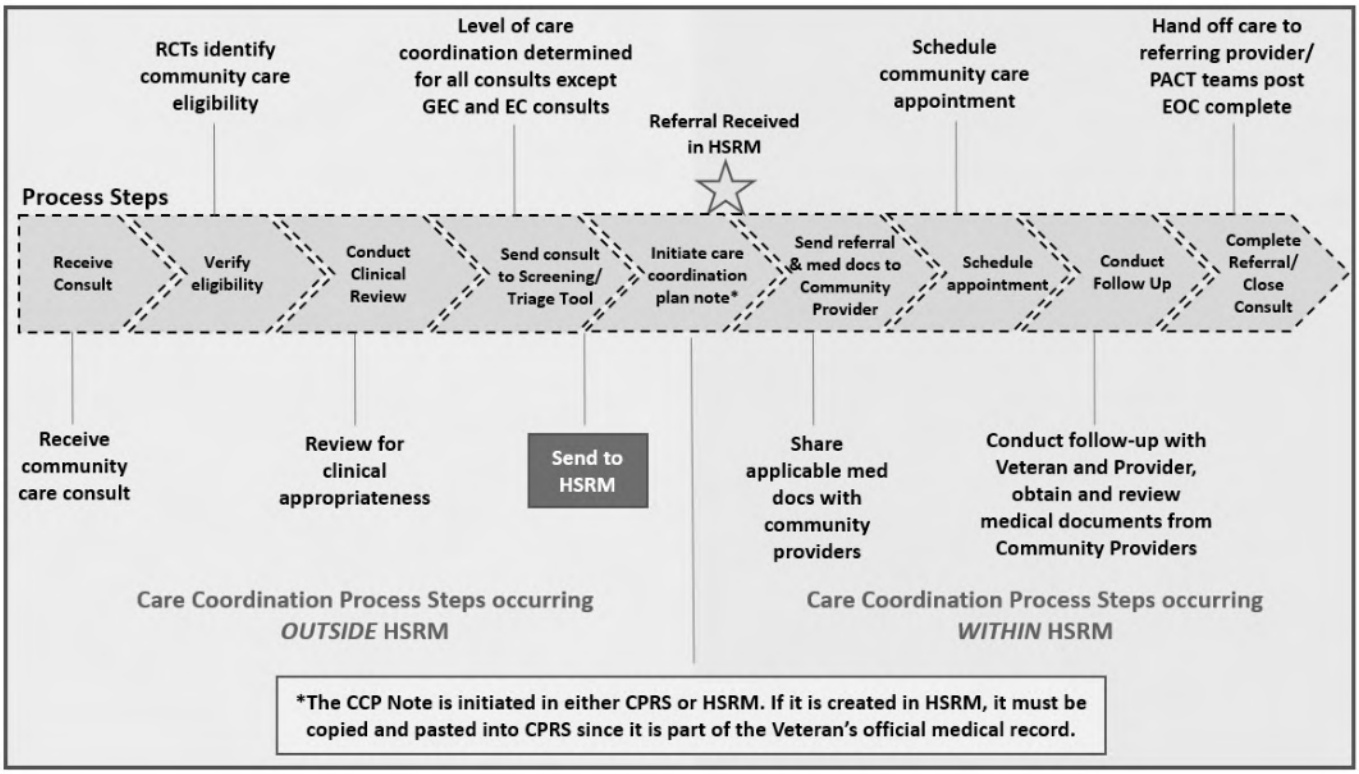
Care coordination is defined as a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services. It can include, but is not limited to, care management and case management. Within the VHA levels of care coordination framework, care coordination falls within the basic level. This includes several key process steps occurring outside of and within HSRM for each episode of care, as demonstrated below in Figure 1. HSRM supports clinical and administrative processses for care coordination by:

- Providing Veterans with timely in-network community care referrals.
- Providing community providers with referrals and authorizations which are consistent with industry standards.
- Decreasing the administrative burden on facility community care staff
- Facilitating communication between facility community care staff, third-party administrators, and community providers (who use HSRM).

Within HSRM, VA facility community care staff will be able to complete appropriate care coordination activities, such as sharing referral and medical documentation, scheduling community care appointments, conducting care coordination follow-up and closing referrals when episodes of care are complete.

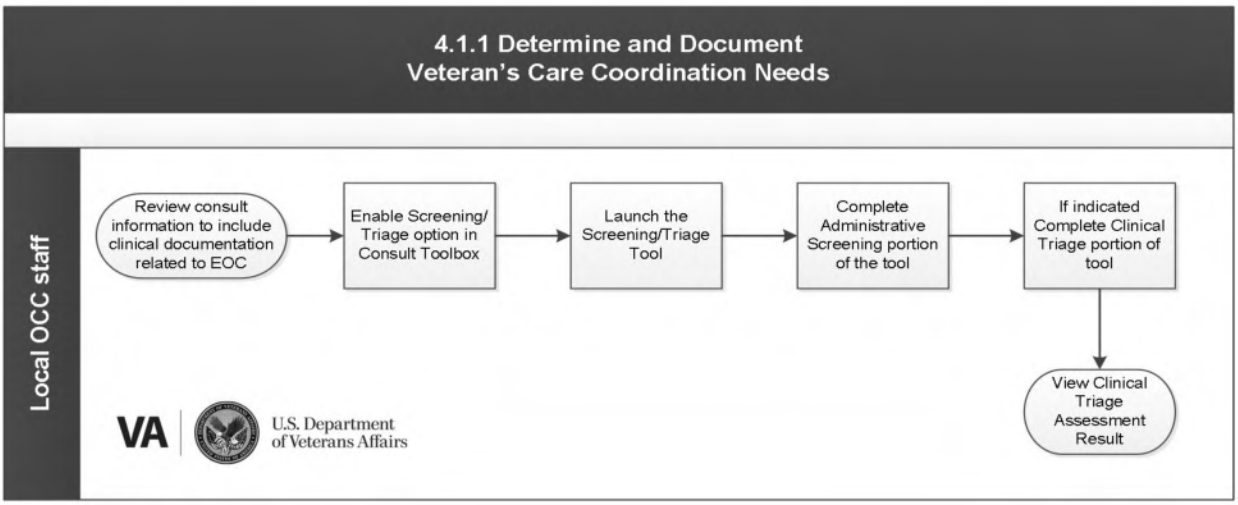
Note: The National Deployment of the Community Care Coordination Model 10N Memo dated September 19, 2019 states that once all HSRM care coordination functionality is fully deployed, sites will be required to use the templated Community Care-Coordination Plan Note and staff must use HSRM for advanced care coordination functionalities including reviewing tasks, tracking documentation transfers, statuses, setting reminders and alerts.

Care Coordination Process



Screening/Triage Tool SOP (Department of Veterans Affairs Screening Triage Tool SOP)

How to Determine and Document Veteran's Care Coordination Needs



PROCEDURES

General Considerations:

Facility Community Care Administrative Clinical staff will assess a Veteran's care coordination needs using the Screening Triage (S/T) tool within the CTB. The S/T Tool will provide a care coordination level (basic, moderate, complex/chronic, or urgent) with recommended care coordination activities for the Veteran.

The S/T Tool ultimately assigns the Veteran to one of four care coordination levels, which are reflective of the intensity, frequency, duration and care coordination services required. The table below depicts the four care coordination levels along with services corresponding to that level and the recommended frequency of contact.

Care Coordination Level	Care Coordination Services	Recommended Frequency of Contact with Veteran
Basic	• Navigation • Scheduling • Post-Appointment Follow-Up • E-Communication to referring provider	As needed
Moderate	All Basic Care Coordination Services, plus: • Monitoring and coordination of Rehab/PT services • Direct communication to referring provider • Chronic disease management, if appropriate	Monthly to Quarterly
Complex/Chronic	All Moderate Care Coordination Services, plus: • Case Management if appropriate • Direct communication with interdisciplinary team • Chronic disease management, if appropriate	Weekly to Monthly
Urgent	• Immediate facilitation of requested services and direct communication with the Veteran providers	Hourly to Daily

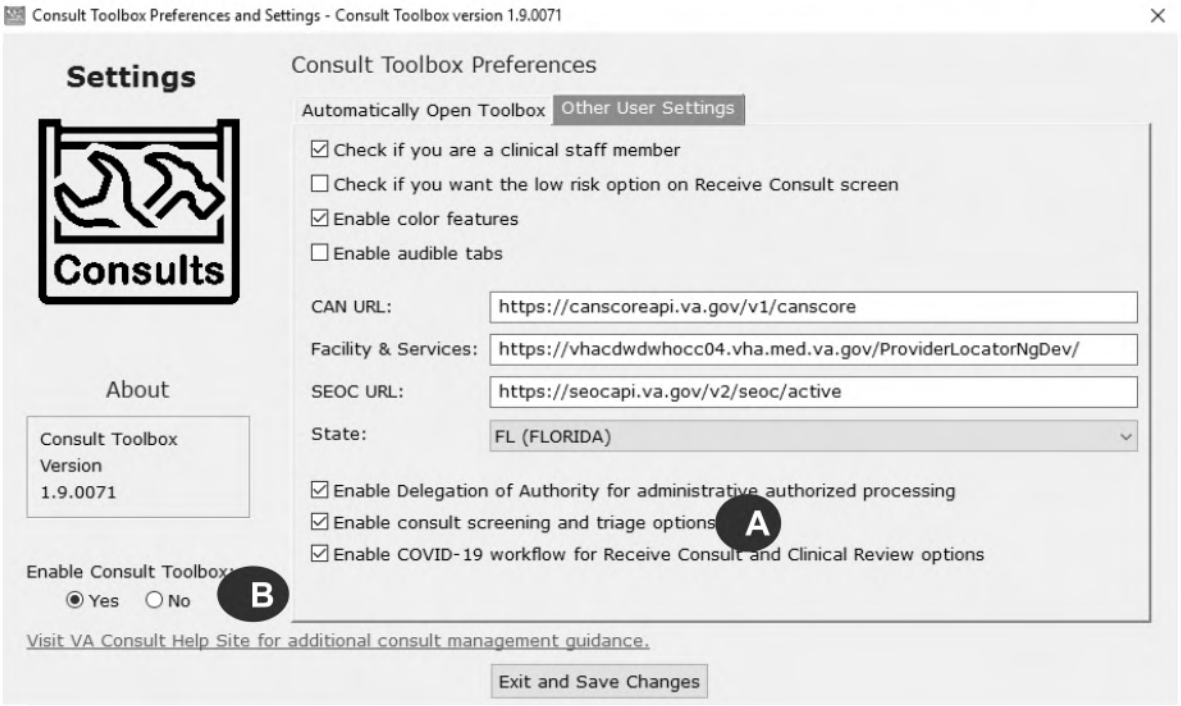
A Veteran's care coordination needs depend on urgency, psychosocial, clinical and episode-specific factors. For example, a relatively healthy Veteran obtaining community care for a routine eye exam will require less resources to coordinate his care than a Veteran with several comorbidities, lack of social support and a need for inpatient surgery.

To assess the Veteran’s care coordination needs, the integrated team should review the Veteran’s social situation and pertinent documentation. This documentation can include the

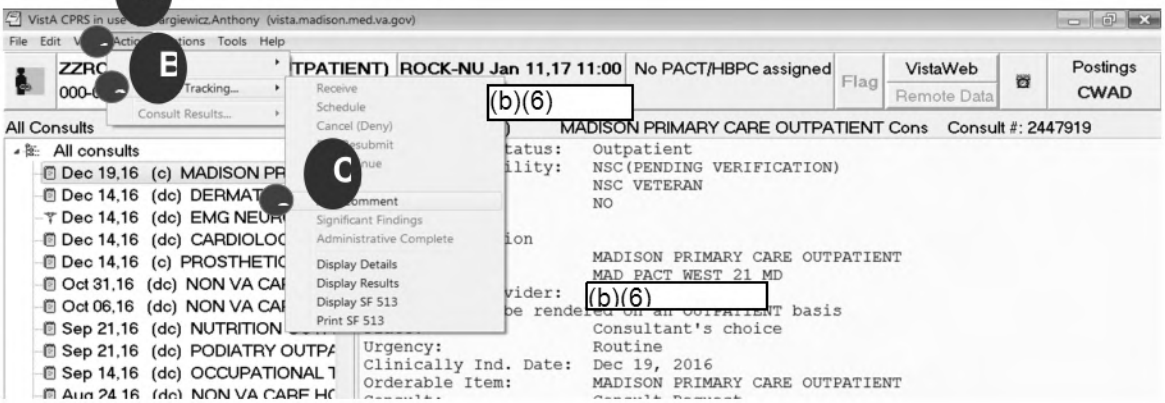
referral request, authorization information, medical records, doctor orders, supporting imaging/lab and other supporting information.

Clinical Staff will then have to answer a specific set of questions based on their understanding of the Veteran's clinical and psychosocial status. The S/T Tool will record and score these responses and assign a care coordination level based on an evidence-based algorithm. Refer to the Screening/Triage Tool Training and Consult Toolbox User Guide for more details.

Steps	Activity
1	**Review Consult Information to include clinical documentation** related to this EOC. Administrative documents can include: • Referral request • Billing information • EOCs/Authorizations (a clinician will perform the authorization review) These administrative documents can be obtained by using the S/T Tool. For additional instructions on how to do so, please refer to the Screening/Triage Tool SOP. Clinical documents can include: • Medical records • Doctor orders • Supporting imaging/lab

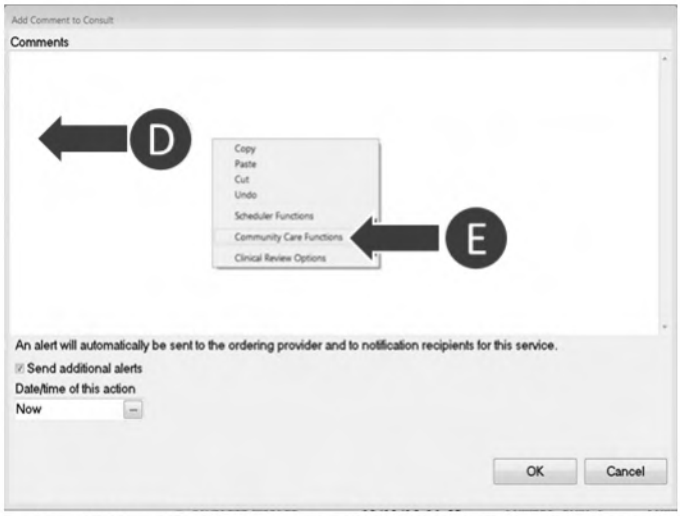
2	CTB Version 1.9.0078 **Enable the S/T option in the CTB** If the S/T tool is not enabled in CTB; navigate to the Preferences and Settings section.  To enable the S/T tool: A. Click the checkbox for "Enable consult screening and triage options" B. Check "Yes" for "Enable Consult Toolbox" prompt in the lower left
3	**Launch the S/T tool**

After the Screening and Triage options have been enabled, the S/T Tool is launched via the Community Care Functions section of the CTB. NOTE: Need to open the community care co lt on the consult tab.



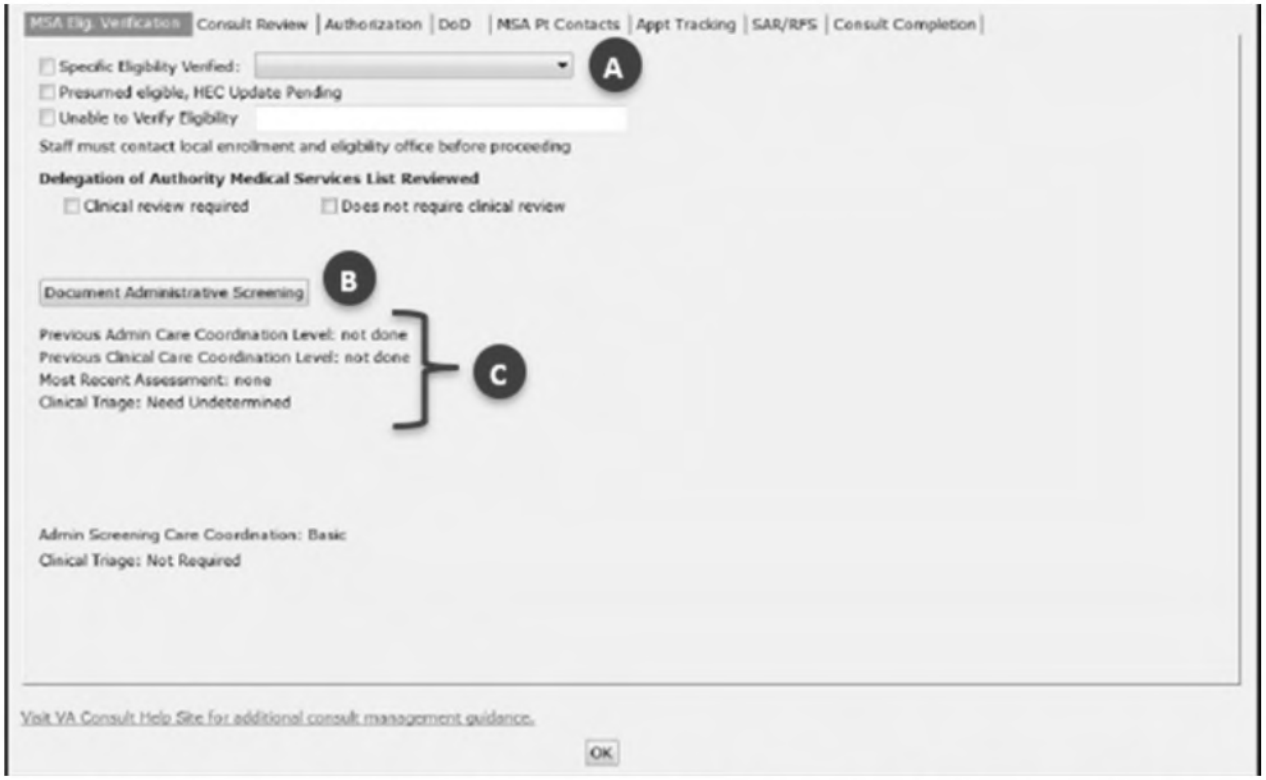
To launch the S/T Tool in CTB, the comment window should be opened via the following steps:

A. Click on "Action" in the top toolbar
B. Hover over "Consult Tracking"
C. Select "Add Comment" from the menu

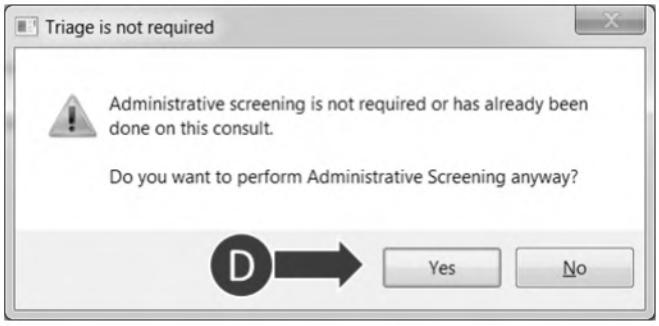


D. If the CTB does not open automatically, right-click anywhere in the white space of the Comments section.
E. Click on “Community Care Functions” to open the CTB.

4	**Complete the Administrative Screening Portion of the S/T Tool** The first step is to begin the Administrative Screening process. The first tab that the administrative staff should begin with is the “CC MSA Eligibility Verification”.



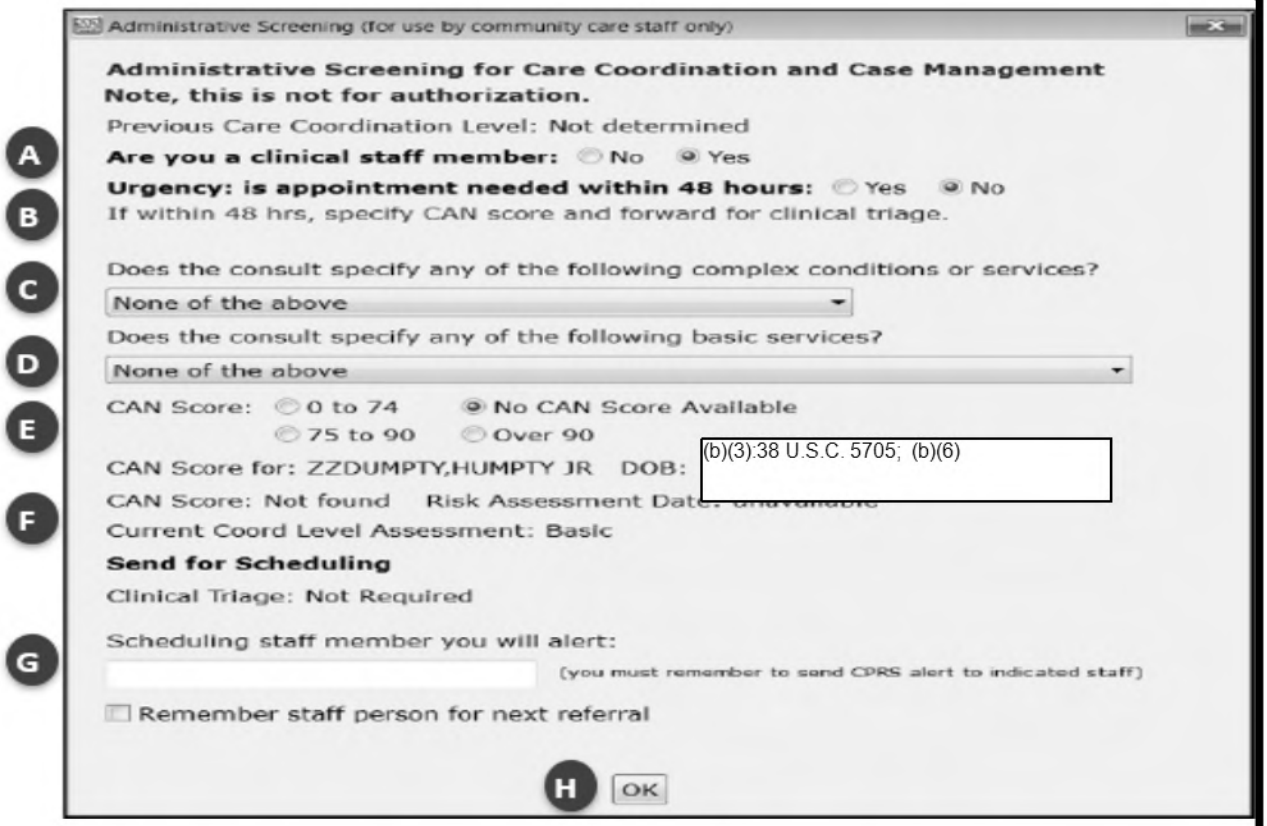
A. The “MSA Eligibility Verification” tab will open a checkbox for the administrative staff to check-off eligibility verifications and pending items.
B. Once Administrative Staff clicks on the button “Document Administrative Screening” and in instances when Administrative Screening has already been completed, a window will appear (Label D, as shown below) asking staff if they would like to repeat the screening. Administrative Screening is required for every consult. If a patient has an extended EOC, the level of care coordination may be updated by the integrated team managing the care.
C. This section will indicate to the administrative staff or clinical staff whether this consult has gone through care coordination or a recent assessment. It will also determine whether clinical triage is needed. Refer to Section 5 for more information.



D. When Administrative Screening has already been performed, staff can either:
   - Click “Yes” to replace previous entry with new information. Only click “Yes” if a significant change has occurred during the EOC
   - Click “No” to keep the current results

How to initiate the administrative screening portion of the S/T tool
The Administrative Screening portion helps determine if administrative staff should hand off the EOC to clinical staff. Depending on the local facility workflow, the person receiving the consult (one member from the facility community care integrated team) will complete the administrative portion of the S/T Tool.

An Integrated Team (Admin or Clinical) member will complete the required questions in the 'Administrative Screening' window.



The Administrative Screening section includes the following questions:

A) Are you a Clinical Staff Member?
- Confirm the identity of the type of staff completing the Administrative Screening
- This question will screen to see if clinical staff need to review an alert, which would not be needed if the user is clinical staff (e.g., RN, SW, if indicated)

B) Urgency: is appointment needed within 48 hours:
- If "Yes," skip remaining questions and forward for clinical triage
- If "No," continue answering the questions from the Administrative Screening

C) Does the consult specify any of the following complex conditions or services?

- If the consult specifies any of the listed complex conditions or services, select it from the following drop-down menu, or select "none of the above":
    - New Cancer diagnosis
    - Coronary Artery Bypass Grafting (CABG)
    - Chronic Heart Failure
    - Chronic Obstructive Pulmonary Disease/Pneumonia
    - Inpatient Hospitalization (any cause)
    - Outpatient Surgery
    - None of the above

D) Does the consult specify any of the following basic services?

- If the consult specifies any of the listed basic services, select the applicable service from the following drop-down menu, or select "none of the above":
    - Routine Follow-up Therapeutics (Pre-scheduled services Dialysis, OT, PT, RT)
    - Routine Mammography
    - Direct Scheduling
    - Cervical Ca Screening (PAP Test)
    - Complementary and integrated medicine
    - Routine Screening Colonoscopy
    - Low Dose CT Scans
    - None of the above

E) Care Assessment Need (CAN) Score:

- The CAN score reflects the estimated probability of hospital admission or death within a specified time frame (90 days or 1 year). The CAN score that is auto-populated in the S/T Tool is the 1-year time frame indicator. The score is expressed as a percentile, ranging from 0 (lowest risk) to 99 (highest risk) and indicates how a given patient compares with other VA patients in terms of likelihood of hospitalization or death. Patients with a very high score (e.g., 99) have a risk of admission or death that approaches 74 percent in the next year, while for those with a low score (e.g., 5) that risk is only about 2 percent. The CAN score is generated using sophisticated statistical prediction models that utilize demographic data (e.g., age, gender) and clinical information (e.g., medical conditions, use of VA health care, vital signs, medications and laboratory tests) from VHA administrative data. The model also considers social-economic status based on patient residence and census tract level data obtain from the U.S. Census Bureau. The goal is to identify groups of patients at high risk for whom care coordination may be valuable.

F) Current Coordination Level Assessment:

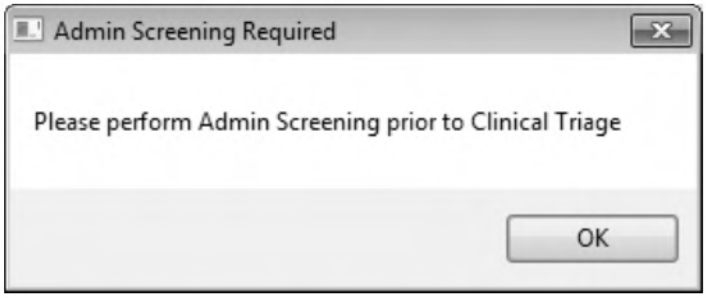
- The care coordination level of the Veteran will appear once the CAN score is auto populated. The result will be one of the four levels: basic, moderate, complex/chronic, or urgent. Refer to care coordination levels in the Overview section.

- If the "Current Coordination Level Assessment" is not "basic," a box will appear to input the name of the RN/SW responsible for completing the clinical triage portion of the S/T Tool.
- The box will not appear for Clinical Staff if the level is "basic."

G) Select the "remember staff person for next referral" check box if you would like the CTB to remember your selection for the next referral.

H) Click OK to complete the Administrative Screening portion

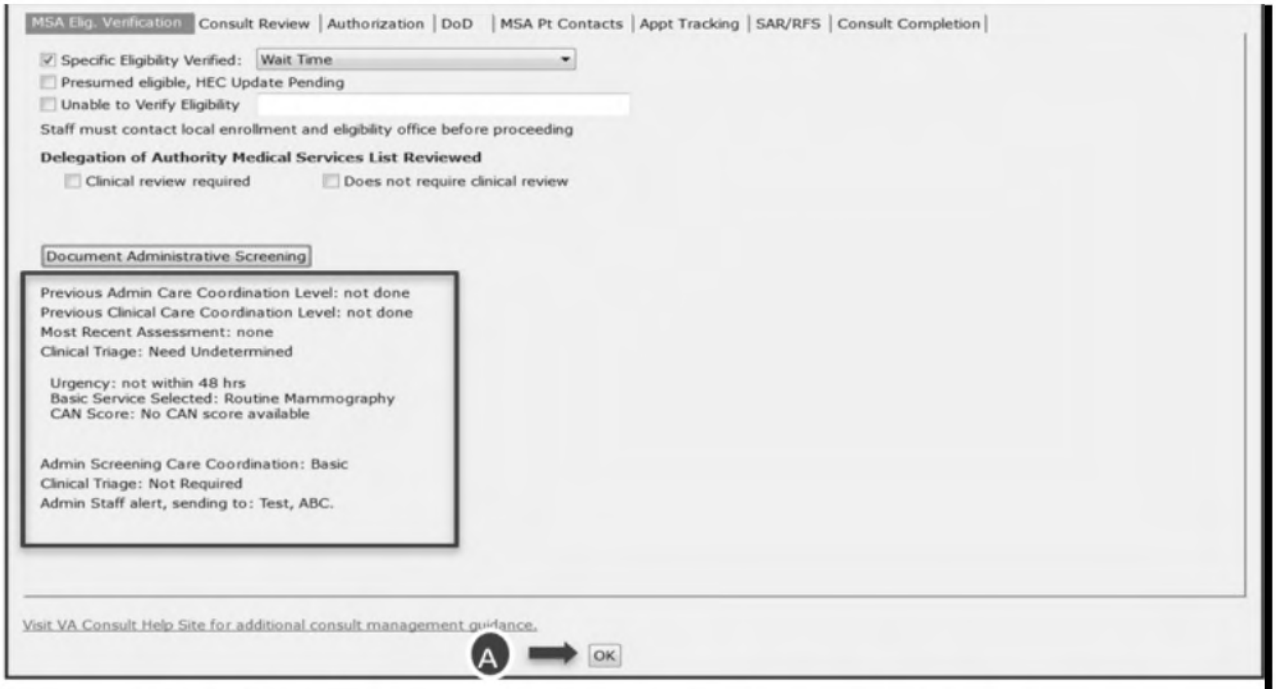
Note: Please ensure that the CAN score is for the correct Veteran as noted above. An error notification will pop-up if staff try to skip the Administrative Screening portion



How to complete the administrative screening portion of the S/T tool

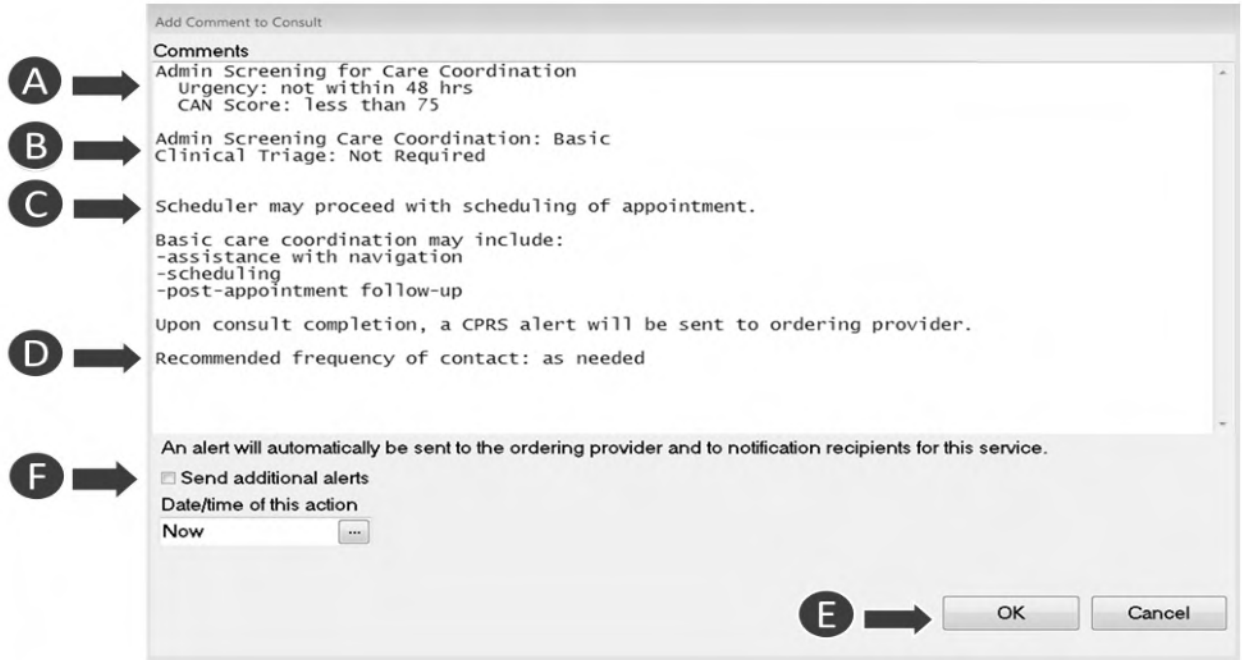
Once the Administrative Screening is complete, the results will populate within the "MSA Elig. Verification" tab of the CTB.

- If the level of care coordination is "basic," an administrative member of the integrated team may proceed to coordinate the appointment.
- If the level is NOT "basic," a clinical member of the team will be required to assist in coordinating the EOC and establishing a CCP or the administrative staff member should notify Clinical Staff to complete the Clinical Section of the assessment.

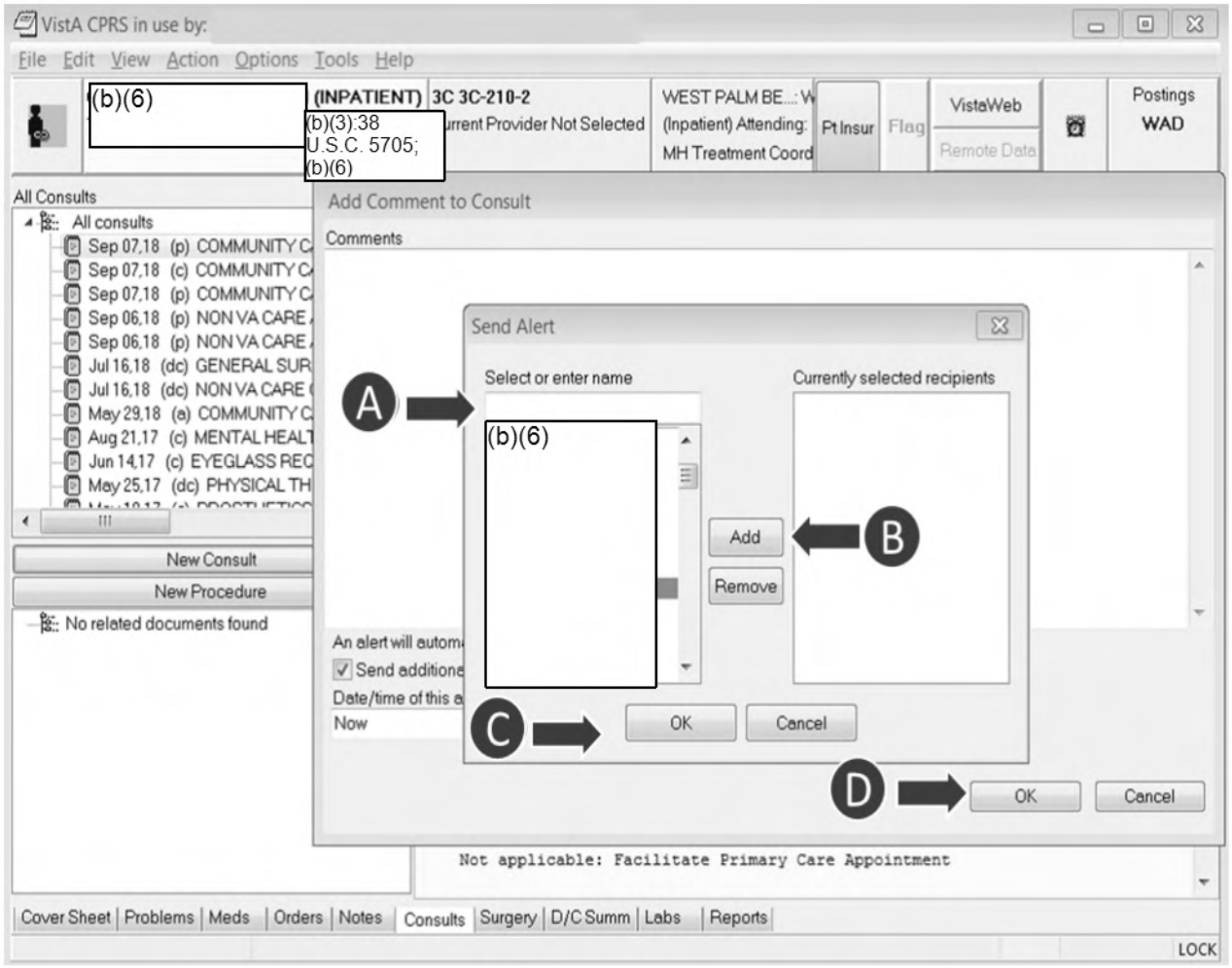


A) Click OK to submit the results and the window will close automatically

Once the S/T is complete, the S/T Tool will populate comments in the body of the consult detailing the level of care coordination, directions for proceeding with care coordination, and a list of required care coordination services for the Veteran. The comments will also provide guidance on the frequency of contact and need for warm handoff, if necessary. Results will be displayed in the “Comments” section.



	Note: Do not manually adjust the format or delete any content in the comment box; as it will affect the data resulting in inaccurate reports and incorrect workflow data reporting. **A)** The first item in the "Comments" section will be a summary of the Administrative Screening responses. It provides information regarding the Urgency and CAN Score of the Veteran. **B)** The second item addresses the established care coordination level of the consult and whether Clinical Triage is required. **C)** The third item indicates directions for the scheduler and guidance on what the care coordination activities may entail for that level. **D)** The fourth item indicates the recommended frequency of contact **E)** If the care coordination level is "basic" and the results have been reviewed, click "OK." This will record results in the consult. **F)** If the care coordination level is anything other than "basic," a box will open to input the name of the clinical staff member responsible for completing the clinical triage portion of the tool. This is not shown for clinical staff and the scheduler will need to select the appropriate Clinician to assess the Veteran based on the triage tool by checking the box "Send additional alerts." By checking the box, the "Send Alert" window will open.
53.	**Submit and Complete Clinical Triage in the S/T Tool** Once the "Send additional alerts" box is checked, and the "Send Alert" window opens, the S/T Tool will prompt the user to select the appropriate Clinician to complete the clinical portion of the triage review.



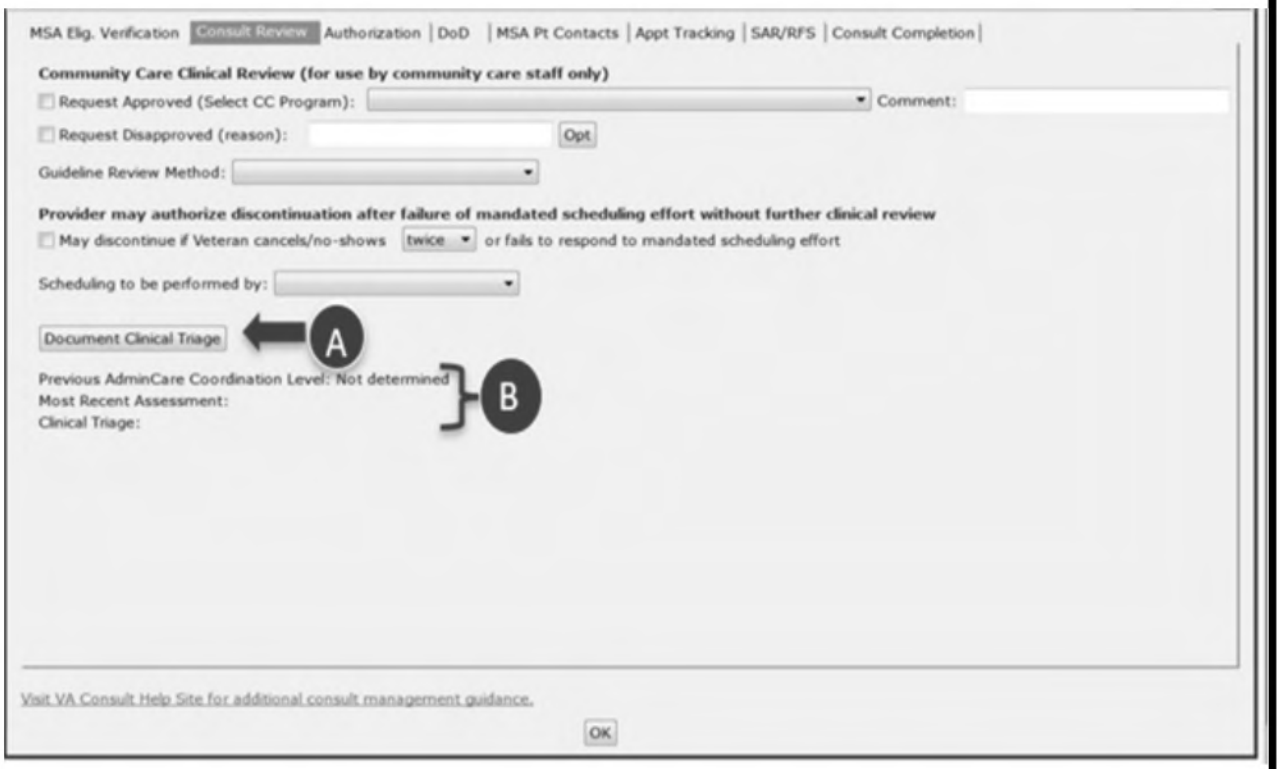
A) From the “Send Alert” window, enter the name of the appropriate clinician, or select from the list on the left-hand side.
B) Once a name has been chosen, click “Add” to move the name into the right-hand side titled “Currently selected recipients”. Confirm you have selected the correct recipient.
C) Click “OK” to assign the Clinical Triage portion of the S/T Tool to a facility community care clinical staff member.
D) Click “OK” once more on the “Add Comment to Consult” window to complete the process.

How to Complete clinical triage

If the level of care coordination determined in the Administrative Screening section is not “basic,” the Administrative staff member will alert a Clinician to complete the Clinical Triage section. The Clinical section consists of questions regarding the Veteran’s comorbidities, social factors, and need for assistance with activities of daily living (ADLs). These questions will be completed based on information in the consult, review of the medical record, and clinical judgment.

The clinical staff completes the required questions in the ‘Clinical Care Coordination Assignment’ window.

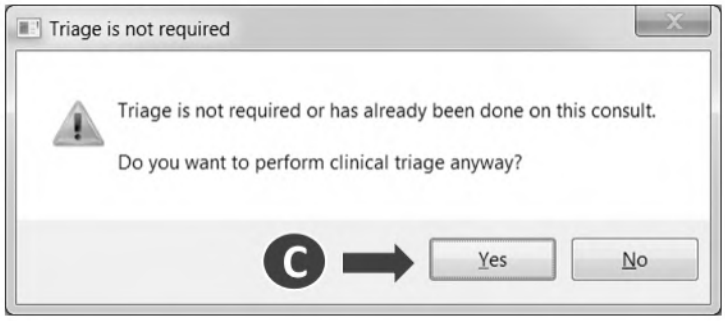
NOTE: The Administrative screening portion will need to be completed prior to beginning the clinical triage process. It is important to ensure the administrative screening process has already been completed for the consult prior to initiating clinical triage. If clinical triage has not been performed or needs to be updated, the Clinical staff should click on the “CC Consult Review” tab in the Consult Toolbox to view three indicators which are found below the “Document Clinical Triage” button.



A) The staff will click on “Document Clinical Triage” button

B) The clinical staff can view three fields:

- Prior Admin Screening Care Coordination: Specifies the previous care coordination level assigned during the Administrative Screening, please note the S/T Tool must be performed for each consult (regardless of the number of consults for a Veteran).
- Most Recent Assessment: Indicates the most recent type of assessment (Administrative or Clinical)
- Clinical Triage: Indicates whether Clinical Triage is required

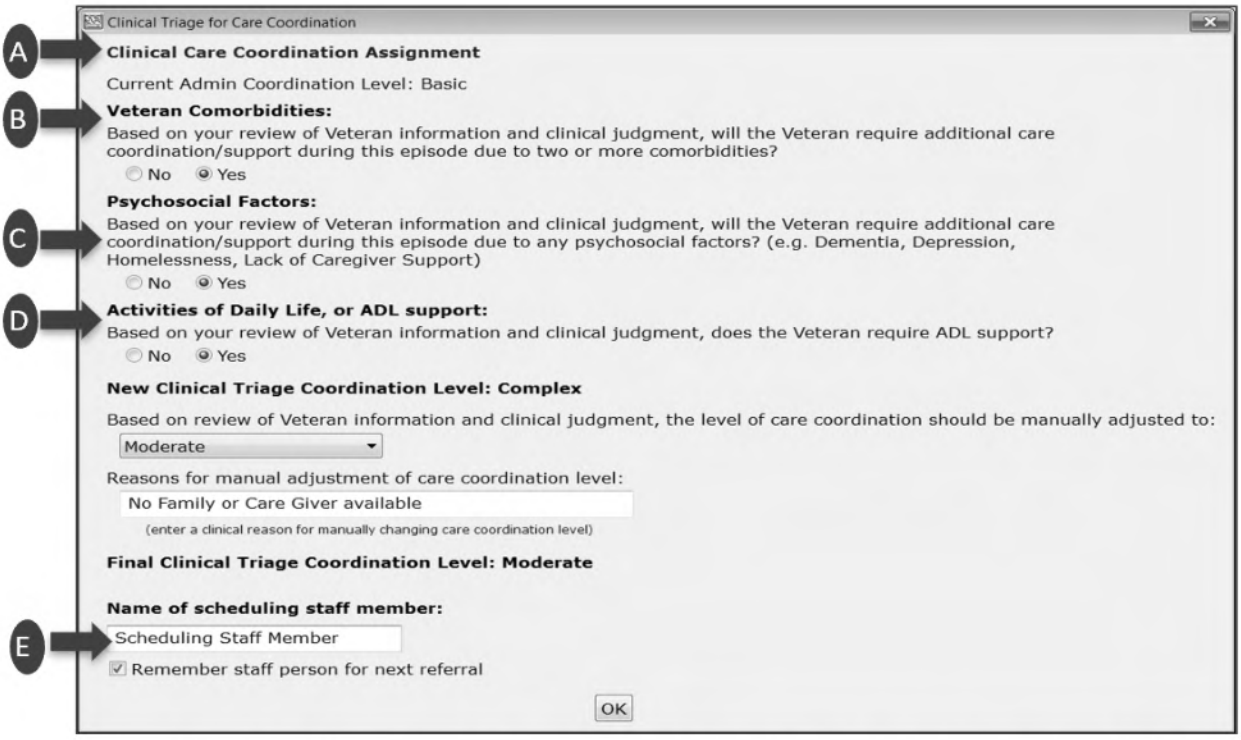


Note: The warning pop-up will appear if:

- Triage is not required — the consult was assessed at a Basic level of care coordination during Administrative Screening
- Triage has already been done — someone has already performed clinical triage on the consult

C) If a Clinical Triage has already been completed, a small window will appear to ask if you want to repeat the triage. If it has not been completed, the Clinical Triage portion will appear.

- Clicking “Yes” will enable the previous entry to be replaced with new information (Only click “Yes” if you believe that a significant change has occurred to the factors in the clinical triage section for that consult).
- Clicking “No” will maintain current results



A) Clinical staff reviews the care coordination level previously assigned during the Administrative Screening

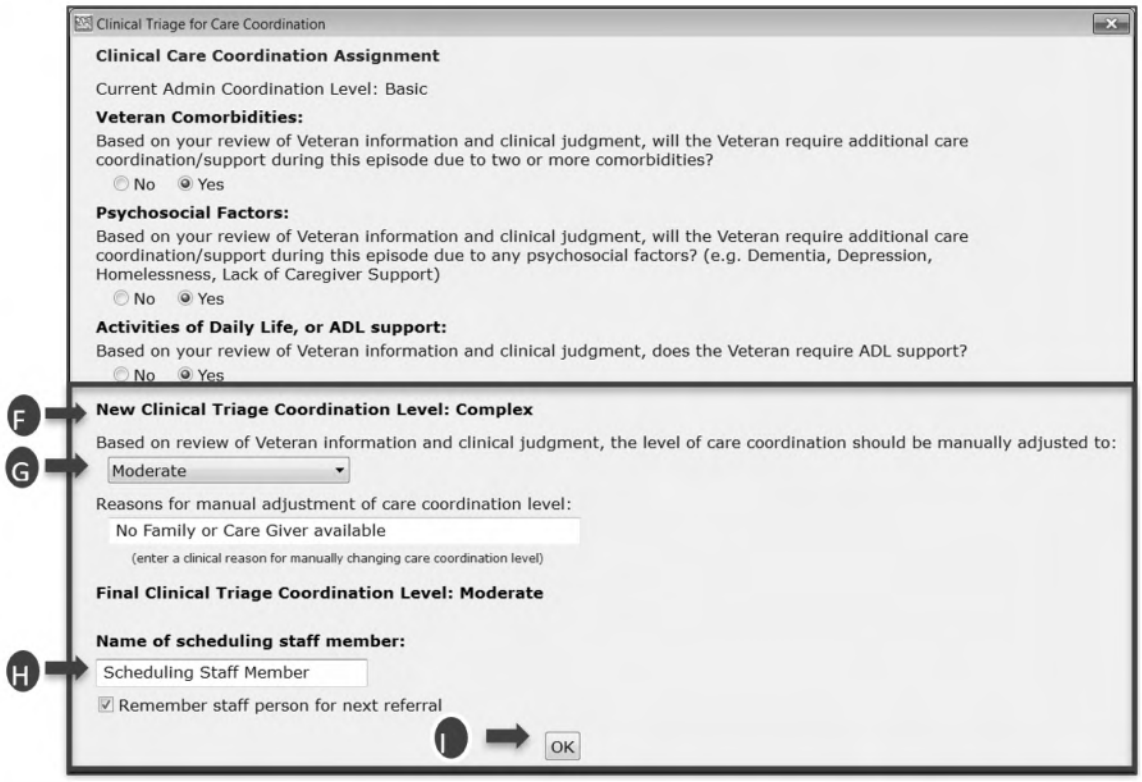
B) Veteran Comorbidities:
- Select "Yes" or "No," if, based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to two or more comorbidities

C) Psychosocial Factors
- Select "Yes" or "No," if, based on your review of Veteran information and clinical judgement, the Veteran will require additional care coordination/support during this EOC due to any psychosocial factors (e.g., Dementia, Depression, Homelessness, Lack of Caregiver Support), etc.

D) Activities of Daily Life, or ADL Support:
- Select "Yes" or "No," if, based on your review of Veteran information and clinical judgement, the Veteran will require ADL support

E) Name of scheduling staff should be inserted and an alert will be sent to schedule the requested services.

Example of Manual Adjustment: A Veteran level of care coordination was previously complex, after reviewing the Veteran's psychosocial factors and noting the Veteran has good family support, the clinician reviewing the clinical triage portion of the tool determined the care coordination level should be moderate instead of complex. The clinician would enter a reason for the manual adjustment to the moderate level stating that "The Veteran has strong social support and no concerning psychosocial factors."



F) Clinical staff reviews the newly calculated assessment of the care coordination level

G) After completing sections 1-3 of the clinical triage portion of the tool, a care coordination level based on these inputs (1-3) will be displayed. This level may be different from the one determined after the completion of the administration portion of the S/T Tool. The clinical staff member should use information in the Veteran's medical record, clinical knowledge, and other relevant information to determine whether the original care coordination level generated by the S/T Tool is appropriate. If the clinical staff member makes the determination that the result generated by the S/T Tool was not accurate, the level should be manually adjusted. The clinical staff member should select the appropriate care coordination level (basic, moderate, chronic/complex, urgent) from the dropdown menu in the clinical section of the S/T Tool. The reason for manual adjustment should then be entered in the blank line below the drop-down selection. By selecting a new level from the drop-down menu, and documenting the clinical reason for the change in the comment section. The reason should be brief (no more than 10-12 words). "Final Clinical Triage Coordination Level" auto-populates based on the completion of Clinical Triage questions or manual override.

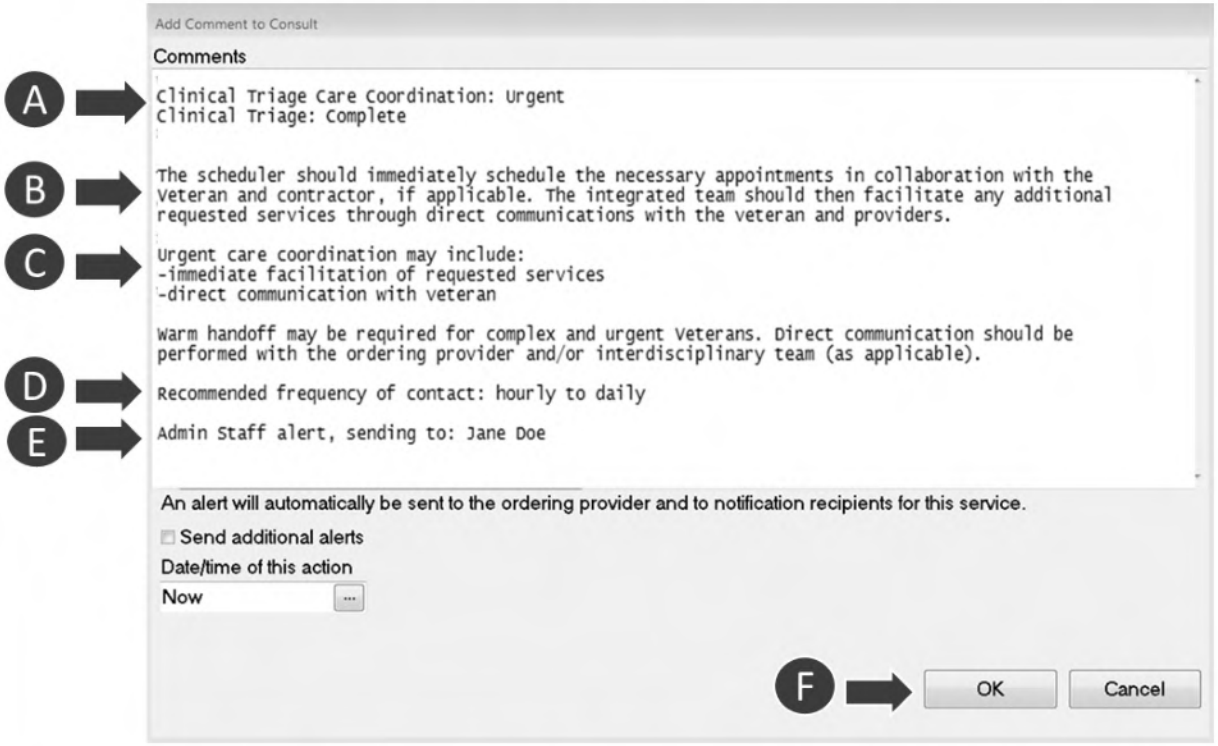
- Basic
- Moderate
- Complex/Chronic
- Urgent

H) Input the full name of the scheduler on the integrated care team

I) Click "OK" to submit the results

6 **View the Clinical Triage Assessment Result**

After clicking "OK," the S/T is complete; the S/T Tool will populate a comment in the body of the consult detailing the level of care coordination, directions for proceeding with care coordination, and a brief sample of care coordination services for the Veteran. The comments will also provide guidance on the frequency of contact and need for warm handoff. The results will be displayed in the 'Comments' Screen:



- **A)** The first comment will display the care coordination level and the status of the clinical triage
- **B)** This comment will indicate instructions for the scheduler to coordinate schedules and any necessary appointments, if applicable. It will also advise the integrated team to work with the Veteran and providers to streamline any requested services.
- **C)** With the care coordination level calculated from the clinical triage, any relevant care coordination activities that entail for the level of care coordination will be summarized here in a list format
- **D)** Indicates the recommended frequency of contact
- **E)** Identifies appropriate staff to alert and schedule the requested services
- **F)** Click "OK" to close

Note: Once clinical triage has been performed on a consult, subsequent users who attempt to perform triage will receive a following message to ensure that there is no duplication of efforts

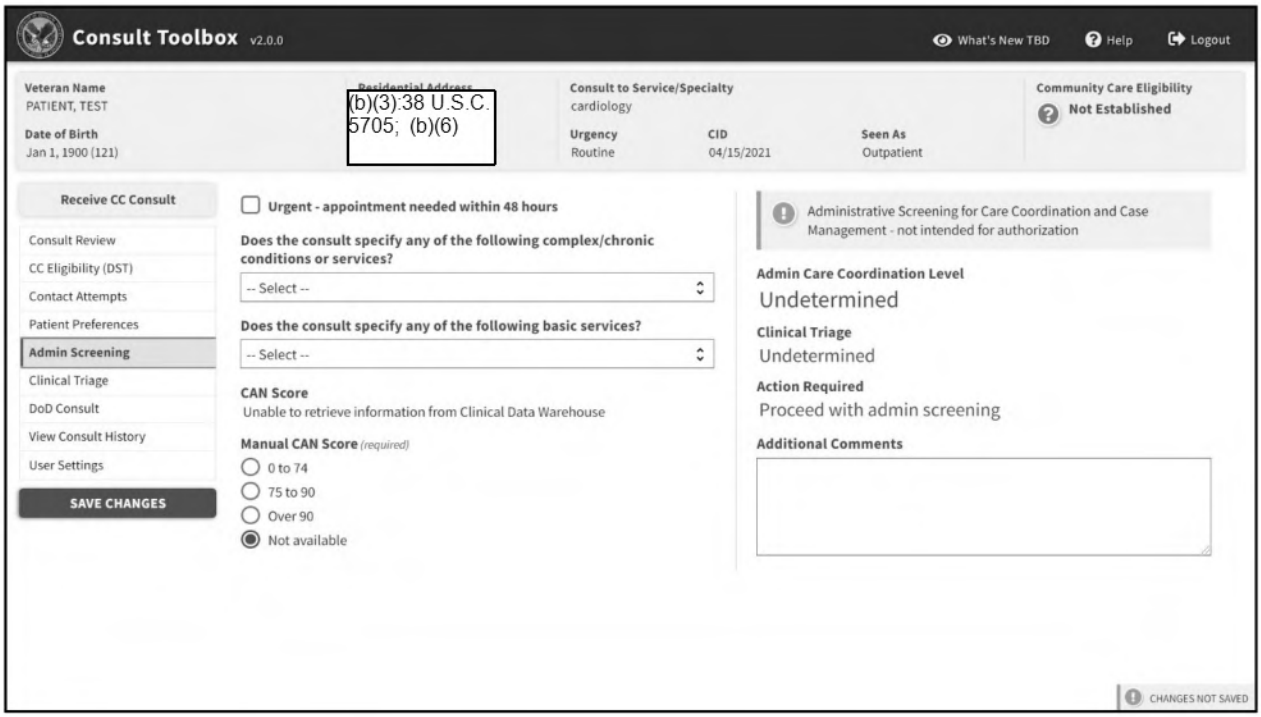
How to Use the S/T Tool Result

At the completion of the S/T tool, the care coordination level should be used by the appropriate personnel (admin or clinical) to create a cCCP, which will outline what activities will be facilitated by the integrated team and what care coordination activities are to be completed, with clear roles and responsibilities outlined.

CTB Version 2.0

The Screening Triage Tool is now part of CTB 2.0.

Receiving Community Care Admin Screening



- Prior Admin Screening
- **Urgent: appointment needed within 48 hours**—if urgent care coordination is required, forward immediately for clinical triage. (If within 48 hours, skip remaining questions and forward for clinical triage.)
- Does the consult specify any of the following complex/chronic conditions or services? — if the consult specifies any complex conditions or services, select one of the following options from the drop-down menu.
    - Chronic Heart Failure
    - **Chronic Obstructive Pulmonary Disease/Pneumonia**
    - Coronary Artery Bypass (CABG)

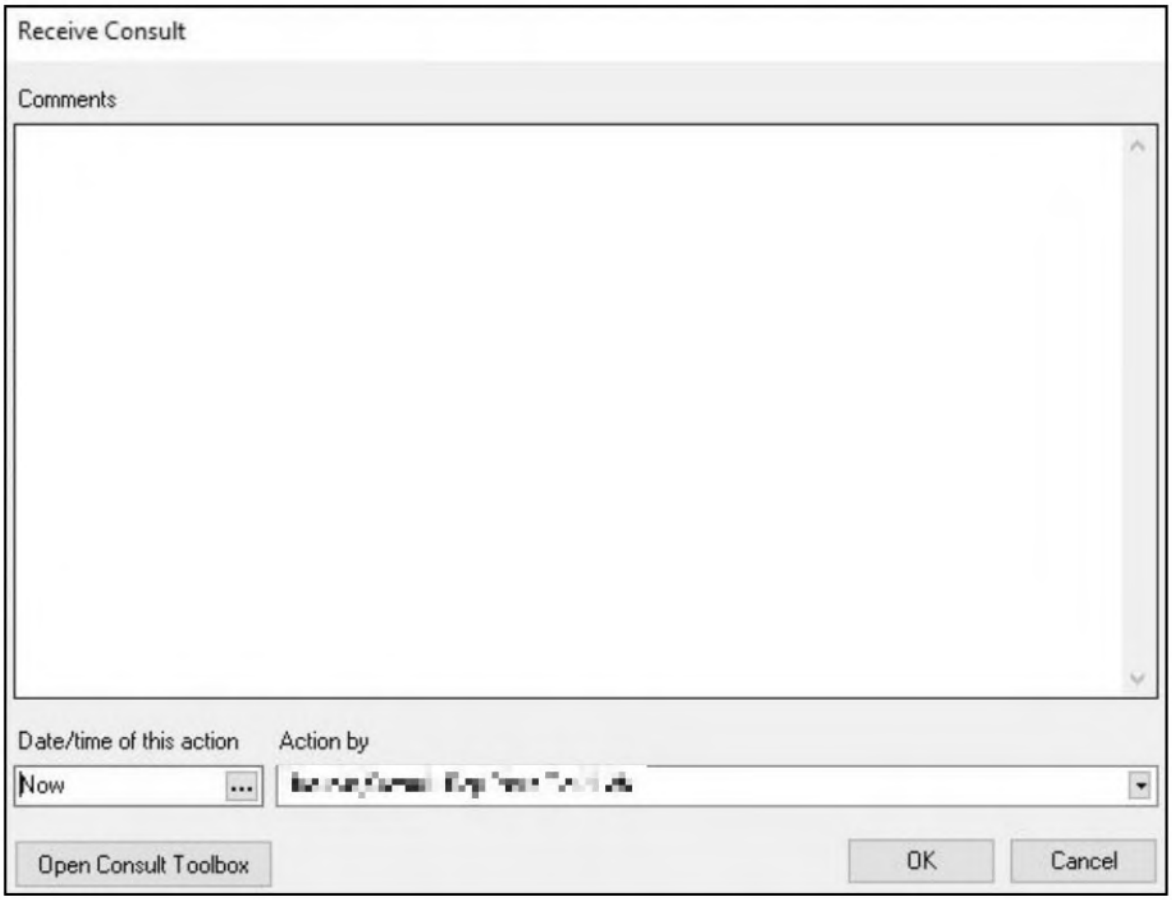
  - **Inpatient Hospitalization (any cause)**
  - New Cancer Diagnosis
  - **Outpatient Surgery**
  - None of the above
- **Does the consult specify any of the following basic services?** — if the consult specifiesbasic services, select the applicable service from the drop-down menu.
  - Cervical cancer screening (PAP Test)
  - **Complimentary and integrated medicine**
  - Direct scheduling
  - **Low dose CT scans**
  - Routine laboratory and/or radiological service
  - **Routine mammography**
  - Routine screening colonoscopy
  - **Routine therapeutic services (Dialysis, OT, PT, RT)**
  - None of the above
- **CAN Score** — Care Assessment Needs (CAN) Scores is an important component to theScreening/Triage process providing a standardized evidence-based measure of Veteran risk. CAN Scores measure the probability of inpatient admission or death within a specified period of time (1 year) in percentage form. CTB automatically retrieves the CAN Score for a patient from the CDW via the CAN Score service.

  If the CAN Score service is unavailable or does not exist for a patient, manual entry ofthe CAN Score is enabled.
- **Manual CAN Score (required)** - *This option is not available for the MSA/Clerk user role.* To access a Veteran's CAN Score manually, the staff are required to access VHA Support Service Center (VSSC). If CAN Score is known, make the appropriate selection,or if not available, select **No CAN Score Available** from the following choices:
  - 0 to 74
  - **75 to 90**
  - Over 90
  - **Not available**
- Admin Care Coordination Level
- **Clinical Triage**
- Action Required
- **Scheduling Staff Member You Will Alert**
- Clinical Staff Member You Will Alert
- **Additional Comments** – Field to enter additional comments.

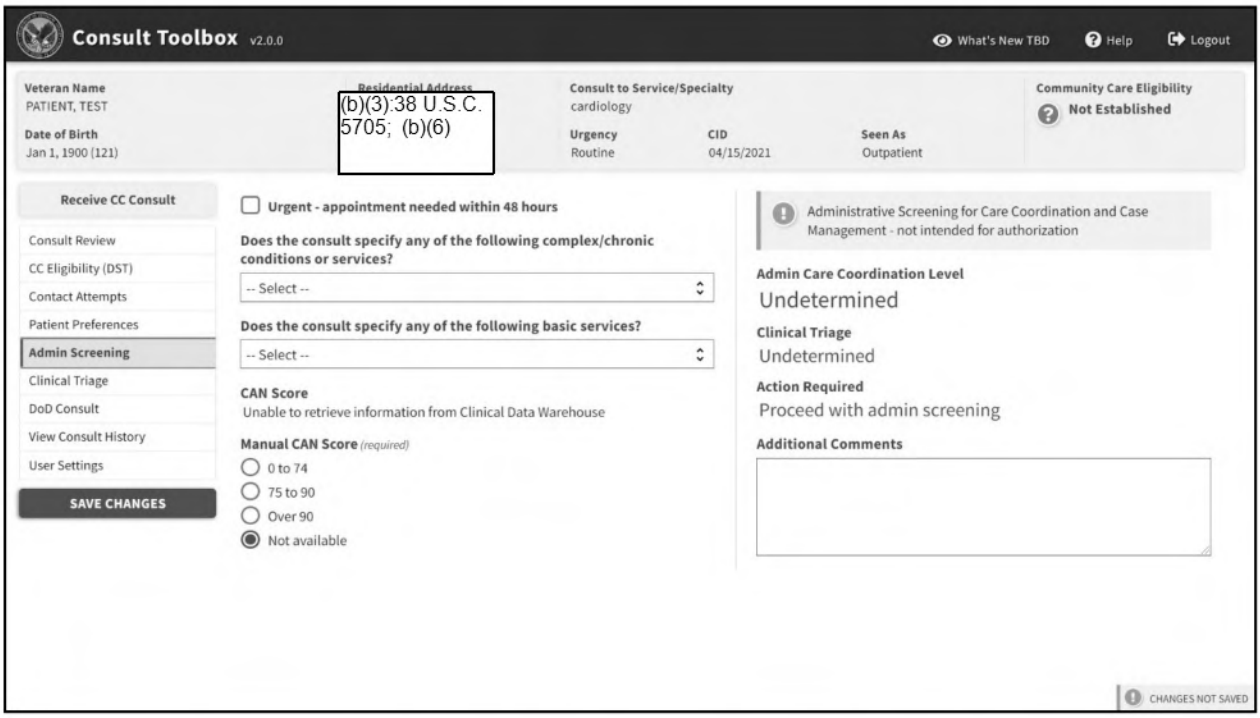
Receiving Community Care Admin Screening Steps

1. From the **Action** menu, select **Consult Tracking…**, and then select **Receive**. The **Receive Consult** dialog box opens.

2. From the **Action** menu, select **Consult Tracking…**, and then select **Receive**. The **Receive Consult** dialog box opens.



3. Click **Open Consult Toolbox**. The **Receive CC Consult** dashboard opens.



4. From the workflow menu, select **Admin Screening tab. T**he **Receive Community CareAdmin Screening Dashboard Screen** displays.
5. Select the **Urgent: appointment needed within 48 hours** check box if urgent care coordination is required, this should be forwarded immediately for clinical triage. (Ifwithin 48 hours, skip remaining questions and forward for clinical triage.)
6. From the **Does the consult specify any of the following complex/chronic conditions orservices**? drop-down menu, select if the consult specifies any complex conditions or services.
7. From the **Does the consult specify any of the following basic services?** drop-downmenu, select if the consult specifies basic services.
8. If the CAN Score service is unavailable or a CAN Score does not exist for a patient, manual entry of the CAN Score is enabled. From the **Manual CAN Score (required)** section, select the CAN Score. *This option is not available for the MSA/Clerk user role.***Admin Care Coordination Level**
9. If it is determined that Clinical Triage is not required, enter the staff member name in the Scheduling Staff Member You Will Alert field.
10. In the **Additional Comments** section, enter any comments pertaining to the consult.
11. Click **SAVE CHANGES**.

Community Care-Coordination Plan (CCP) Note

- The HSRM system is the primary platform
  that facility community care staff will use for implementing, assessing and updating the CC-CCP Note. HSRM may also be used by community providers but is not, currently, mandatory. HSRM's task

management system enables staff to view Veteran and consult information, create, assign, and track care coordination tasks, as well as set reminders and alerts for each EOC. The system allows staff to sort and filter tasks by patient, consult and other factors.

- The CC-CCP Note is developed based on the Veteran's level of care coordination identified by the Screening/Triage (S/T) Tool and contains Veteran, consult, and task-level information necessary to coordinate community care. The plan can include both administrative and clinical care coordination activities and ensures that the integrated team actively involves the Veteran in planning. Thus, the process of developing and implementing a CC-CCP Note is highly collaborative, requiring participation from each staff member involved in care coordination activities for a specific EOC, as well as the Veteran and/or their family/caregiver. A complete CC-CCP Note details the assigned roles, responsibilities and ownership for tasks related to care coordination activities, when applicable, such as:

    - Navigation and scheduling
    - Veteran/family education
    - Case management
    - Disease management
    - Social services (e.g., transportation)
    - Lifestyle modification
    - Post-appointment follow-up*

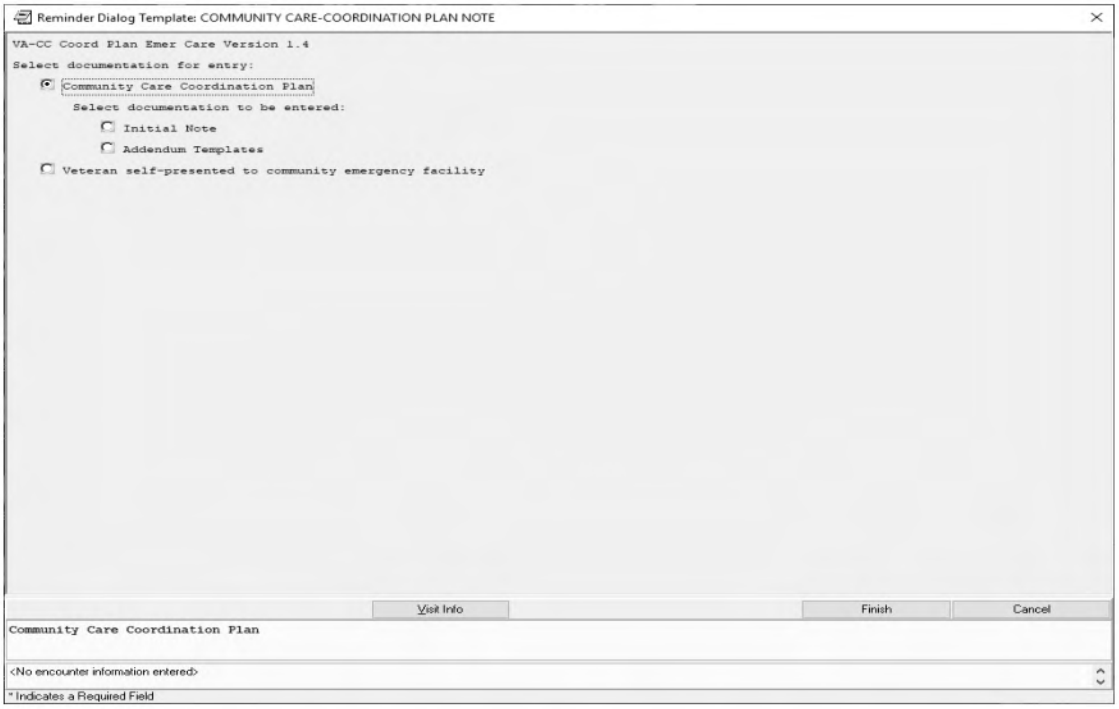
    *Refers to communication to the Veteran and/or his or her caregiver to determine if the care met the Veteran's need – and what next steps may be, to close the consult.

- It is important to note that the development of the CCP and its execution is not always linear in nature and may occur concurrently. For example, an administrative staff member may be working to schedule the appointment listed in the referral, while case management activities are being planned by clinical staff. Efficient care coordination should never result in a delay of care. Staff should use appropriate judgement when deciding on the applicable care coordination services to ensure quality, safety, and timeliness.

When is a Community Care-Coordination Plan Note necessary?

- A Community Care-Coordination Plan Note should be created for every new community care referral (excluding direct scheduling, Emergency Treatment (self-presented) and GEC consults).
- The CC-CCP note is required for all community care consults (except for Geriatrics Extended Care, Direct Scheduling, and Emergency Care). The note can be entered after clinical staff have completed the clinical portion of the Screening/Triage (S/T) tool within Consult Toolbox (CTB) or after the Veteran has already been scheduled for community care appointments.
- If the HSRM Community Care – Coordination Plan note template is used, this note will not be included within the Veteran's official medical record. Thus, the CC-CCP note must be copied and pasted in CPRS or must be completed in CPRS.

- However, Emergency Care documentation should be entered directly into CPRS, by opening the Community Care – Coordination Plan note template and selecting the second note titled Veteran Self-presented to Community Emergency facility
- For Emergency Treatment (self-presented care) a new progress note template has been added to the CC-CCP Note landing page. (See image below)
- The new progress note, the VA-COMMUNITY CARE COORDINATION PLAN EMER CARE should be utilized for all new notifications received as of June 8th, 2020 and moving forward.
- The initiation of the note will use the information obtained from the Emergency Care Authorization Tool (ECAT) SharePoint site.
- When initiating the Community Care Emergency Treatment section, open the Community Care - Coordination Plan note and first select “Veteran self-presented to community emergency facility”. Then, select “Emergency Notification Intake” and transcribe information from the ECAT SharePoint site into the intake section of the note.
- Once care coordination begins, reload boilerplate, and select “Emergency Treatment Care Coordination”. Then, go back to “Emergency Treatment Care Coordination” section.
- This section allows the clinical staff to conduct timely continued stay reviews and document appropriate care coordination activity during Veteran’s community facility admission, assisting with discharge planning or transfer to the VA. Provide the information necessary by the prompts. Add Notification ID in the Additional Notes free-text section of the Emergency Treatment Coordination Plan note for future reference. Utilize the Notification ID to reference the record in the ECAT SharePoint and obtain visibility into decision of care. In the future, an enhancement will be added to the ECAT SharePoint site that will provide a field within the intake note for the Notification ID.



- While the Veteran-level information (e.g., demographics, social support, etc.) may remain consistent across different referrals, the consult-level information may change.

Who is Responsible for Developing a Community Care-Coordination Plan?

- If the care coordination level assigned by the Screening/Triage (S/T) Tool is "basic,", the administrative staff member (e.g., MSA or PSA) on the integrated team is assigned as the owner of the community care-coordination plan. For levels other than "basic" (e.g., "moderate," "complex/chronic," and "urgent") the clinical staff member (e.g., RN or SW) on the integrated team is responsible for developing the plan. Regardless of the level of care coordination, the plan can include both administrative and clinically driven care coordination activities. Thus, it is the responsibility of the staff member assigned to coordinate the care for the Veteran to ensure that stakeholders are collaborating on the plan within the CC-CCP Note and assigning appropriate roles.
- For example, throughout the care coordination process, the administrative team will be responsible for verification of eligibility, scheduling, documentation exchange while the clinical team will be responsible for ensuring appropriate care and facilitation/oversight of care coordination activities.

Open CPRS and select the CC-CCP Note title:

A reminder dialog template will load with two template options.

Choose "VA Facility Care Coordination Plan Note (INITIAL NOTE)" (must be completed to attach addendum).

- Click to see list of consults- the 10 most recent consults will then be displayed below.
- Search the consult for which CC-CCP Note is being entered (type into the blank field to the right of “Community Care Consult” to find the consult).
- Enter Veteran’s chief complaint.
- Record any clinical or biopsychosocial risks for the Veteran that have been identified.
- Select the level of care coordination.

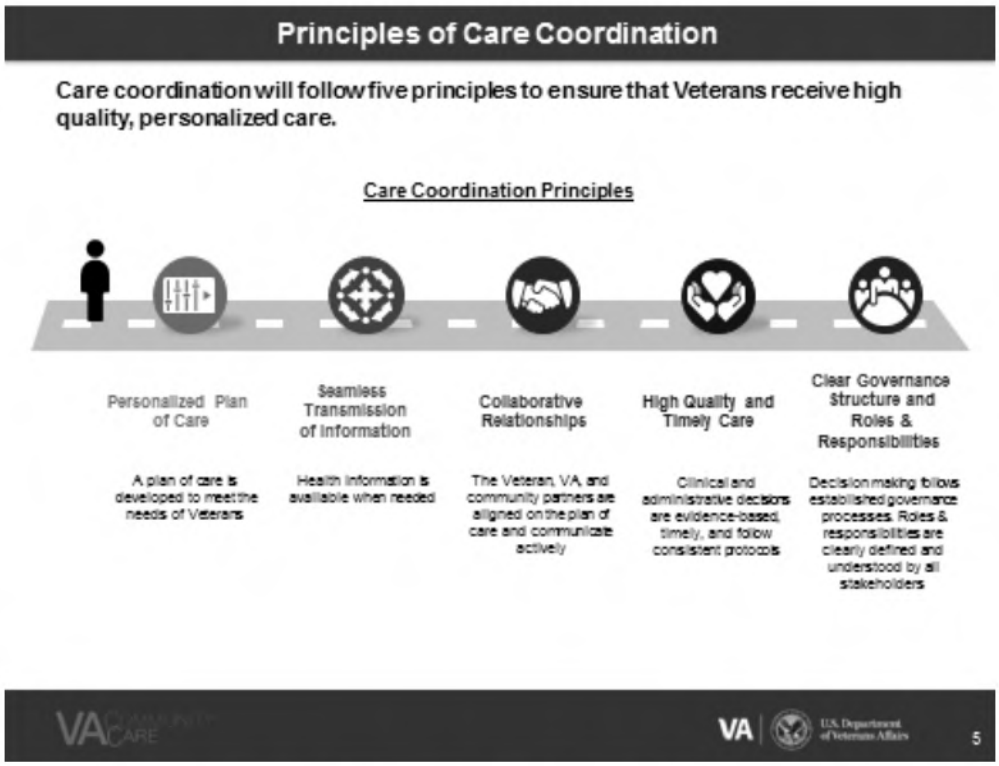
Note: The level of care coordination (basic, moderate, complex/chronic, or urgent) will determine if the note will be initiated and/or completed by an administrative staff member or by a RN/SW. Administrative staff will be responsible for a “basic” level CC-CCP note, whereas RN/SW will complete the CC-CCP note for all other levels of care coordination (moderate, complex/chronic, urgent).

Screening/Triage Tool SOP (Department of Veterans Affairs Screening Triage Tool SOP)

3.2 How to Perform Care Coordination (Pre/Post CCN)

Care coordination initially involves determining the complexity of care needs of Veterans who receive community care, followed by the subsequent coordination of care delivery and transition back to the VA. Care coordination also includes appropriate and timely transfer of information, medical documentation, and addressing potential gaps in meeting a Veteran's interrelated clinical and non-clinical needs.

Efficient care coordination is based on the following principles: a personalized care coordination plan, seamless transmission of information, collaborative relationships, high quality and timely care, and clear delineation of governance & staff roles/responsibilities.



- **Personalized Community Care-Coordination Plan**: A care coordination plan for community care should be personalized based on an individual Veteran's needs. Creation of the Community Care-Coordination Plan is a key step in effective care coordination.

- **Seamless Transmission of Information**: In order for staff, community providers, and Veterans to be fully informed in the care coordination process, information should flow smoothly between systems and different points of care.

  Note: Upcoming HSRM Release 13.0 will feature Clinical Viewer as a replacement to community viewer. Clinical Viewer will allow community providers and staff the ability to securely view a Veterans' encounter-level VistA electronic health record (EHR)when they have been allocated to a referral.

- **Collaborative Relationships**: Facilitating collaborative relationships transcends all aspects of the care coordination process; existing systems should be leveraged to ensure that staff within the Facility Community Care Office have active relationships with VA Medical Center (VAMC) providers, call centers, Community Care Network (CCN) Third-Party Administrators (TPAs), and community providers. This helps to streamline the flow of information and provide every Veteran with the right care, at the right time, and at the right place.

- **High-Quality and Timely Care**: All Veterans deserve prompt and high-quality care. This principle should be used to ensure that Veterans have a voice in

sharing their preferences and goals, as well as ensuring accountability in the timeliness of the transmission of information and scheduling of care.

- **Clear Governance Structure**, Roles, and Responsibilities: For every step-in care coordination, clear guidance and local oversight regarding what type of staff can perform each task or aspect of the model is necessary to facilitate high quality care coordination for Veterans.

3.3 Standardized Episodes of Care (SEOC)

SEOC is a VA health policy made up of pre-approved bundled services and procedures that relate to a specific category of care or sub-specialty and comprised of a clinical and coding profile. SEOCs have been developed through collaboration with National Clinical Program Offices across Veterans Health Administration (VHA), Veterans Affairs Chief Medical Officers (CMO), Chiefs of Staff (COS), Office of Clinical Integration leadership (OCI), to and Third-Party Administrators (TPAs) improve the quality and timeliness of care provided in the community.

The goal is to reduce the administrative burden on VA staff and Community Providers, increase consistency in the authorization process, improve the ability to measure utilization by the VA, and streamline the experience for the Veteran when referred into the community for medical care. Additionally, application of SEOCs will greatly reduce the frequency of Request for Services (RFS), formerly Secondary Authorization Requests (SAR). By grouping medical services for authorization and payment, the administrative burden on VA staff and Community Providers is significantly decreased.

Under CCN guidelines, VA medical centers will issue referrals directly to community providers and Third-Party Administrators (TPAs). All referrals will include a consult order accompanied by a single clinically appropriate SEOC that outlines approved visits or services related to a specialty or category of care. Each SEOC defines a specific duration of care. It is important to note, there is not a limit on the number of visits within a year for the Veteran, per episode of care. Additional care may be requested for approval by submitting an RFS to the facility community care office for clinical review if the care is unrelated to the original referral, or if it falls outside of the care customary to the specialty noted in the SEOC or approved services.

Special Note:

- **For inpatient care instances** where the care continues beyond the 30-day duration of the SEOC, the end date may be extended to the date of discharge. VA supervisors and POM staff with the assigned key can adjust the end dates for inpatient episodes of care only.
- **For instances when the Veteran reaches a point of stabilization**, determine if the Veteran is eligible for transfer back to the VA.
    - If the Veteran declines transfer to the VA, the expiration date will be the date of refusal. VA supervisors with the assigned key can adjust the referral end date to the date of refusal to transfer.
    - Only inpatient Episodes of Care end dates can be changed.

For every referral, there will be one consult order and one SEOC attached. The SEOC is selected by choosing the specialty/Category of Care that matches the care requested on the consult order. If the specific SEOC does not appear to be available in the SEOC drop down of Consult Toolbox/Decision Support Tool, the Clinical Reviewer can identify the closest SEOC within the same COC and Provider Type for the requested service(s). VA staff may refer to the SEOC Database to search for SEOCs. SEOC FAQ and other additional supporting documents can be found on the SEOC Solutions Page.

Note: *The consult order is what guides all scheduling and care coordination. It is not expected that all services on the SEOC are to be performed.*

Scenario 1: When a new consult/SEOC/referral **is** needed
The SEOCs are assigned by specialty and what is customary to the specialist on the SEOC. When a Veteran is referred to an oncologist, an Oncology Comprehensive SEOC is attached to the Oncology consult order. The consult and SEOC is then packaged as a referral and sent out to the oncologist utilizing HSRM as described in Chapter 3.11 or using the HealthShare Referral Manager (HSRM) User Information Site. If the oncologist refers the patient to another specialty (i.e. radiation therapy, general surgery for a resection or tumor removal, or interventional radiology for an evaluation and development of a next steps plan) then a new consult order with a clinically appropriate SEOC is needed as this is a referral to a new specialty.

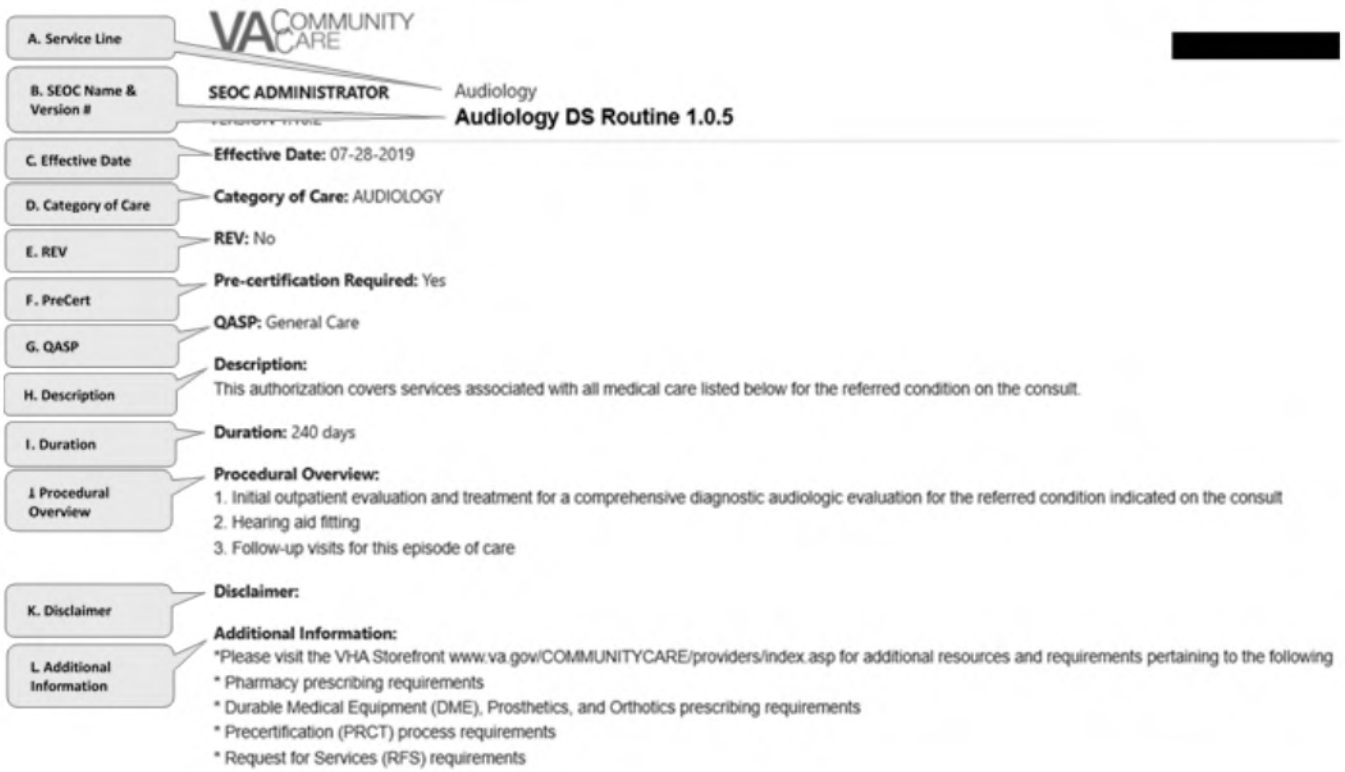
Scenario 2: When a new consult/SEOC/referral is **NOT** needed
When a Veteran is referred out to an orthopedist for knee pain, an Orthopedics General SEOC is selected and attached to the Orthopedic consult order. During the visit, the orthopedist identifies that the knee pain is caused by radiating hip pain, and a treatment plan is already established within consult order for the hip pathology. The orthopedist is following the intent of the referral. Thus, a new consult order is not required. The orthopedist will be able to treat the hip under the authorization and be paid appropriately.
However, when the same Veteran with the hip issue injures their shoulder 3 weeks later, a new consult order, SEOC, and referral as this was not the original intent of the consult order and not directly related to the original Episode of Care.

Note: *A Veteran may have two episodes of care concurrently to the same specialty, within the same window of time (i.e. two Orthopedic consult/SEOC/referral).*

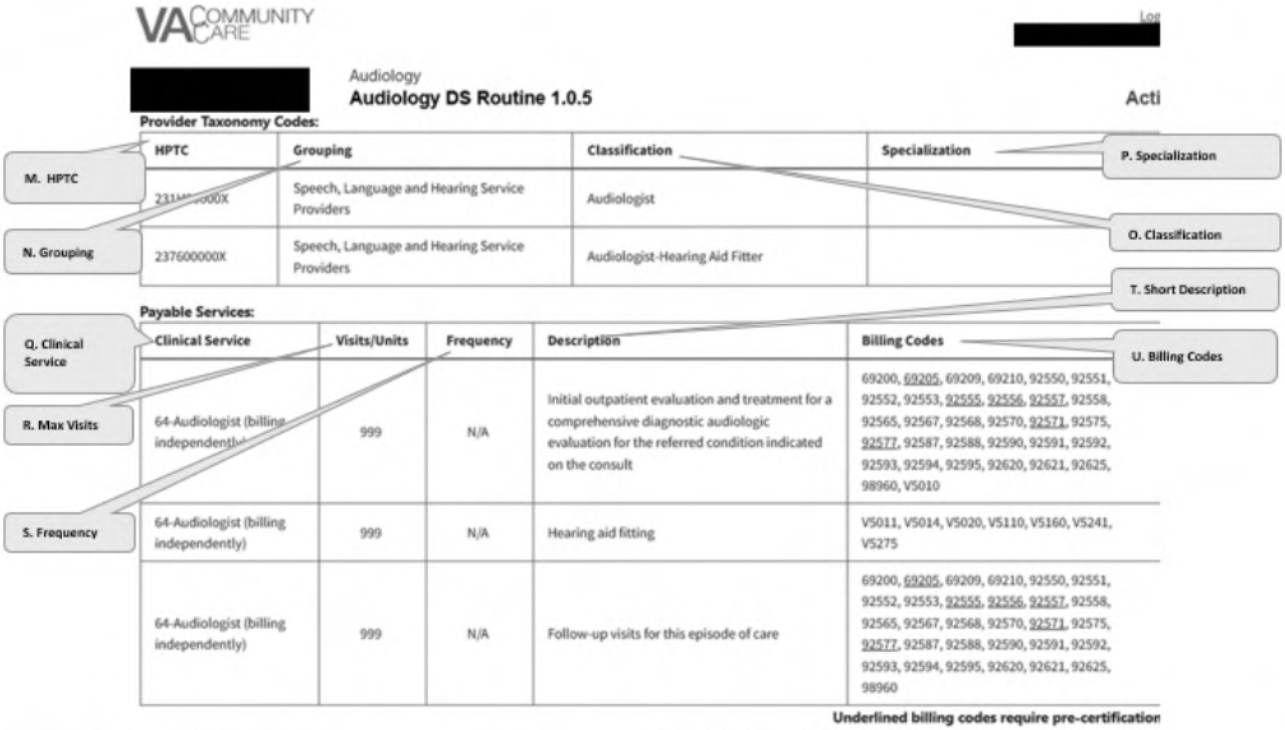
SEOC Components

SEOCs are broad in clinical scope and VA providers must note requested services in the consult order. Each SEOC is comprised of two main components: the clinical profile and the coding profile. Definitions for each section are provided after the profile samples.

1) The clinical profile of the SEOC



2) Coding profile of the SEOC:



Section	Section Title	Detailed Description
A	Service Line	A high level SEOC category for the services and procedures included which is intended to be used to categorize and filter SEOCs for easier accessibility. A standardized 3-letter abbreviation of the service line is included at the beginning of the SEOC ID.
B	SEOC Name & Version Number	A unique title that categorizes a SEOC by specialty/subspecialty or area of clinical practice. ***Note:*** *Certain SEOCs may contain a PRCT REV flag within the referral information sent by HSRM. These designations are based on complexity of care from both a clinical and coding perspective and require Third Party Payer prior authorization for certain services listed on the SEOC. As such they will require an additional layer of review by the appropriate clinical or revenue-based stakeholders prior to distribution.*
C	Effective Date	The date the SEOC status was made Active within the SEOC Database. This transition occurs at midnight after the status has been marked
D	Category of Care	The clinical category associated with the primary service(s) within the SEOC
E	Revenue (REV)	Flag to Revenue to begin precertification process for Veterans with Other Health Insurance and care is non-service connected.
F	Pre-Certification Required	The Precert Required column specifies whether a pre-certification is required for the associated code. Codes that require this flag are identified by the Revenue team. ***Note:*** *Once a code is marked as requiring precertification, it is still subject to change based on legislation, coding updates, etc.*
G	QASP	Quality Assurance Surveillance Plan category (5 total categories)
H	Description	A broad description of what the SEOC authorizes.

I	Duration	The number of days the SEOC is approved for, or the "lifetime of the SEOC", with a maximum limit of 365 days. All SEOCs must include a duration to specify the timeframe within which care can be provided under the referral.
J	Procedural Overview	A list that includes broad descriptions of the clinical services and procedures providers are authorized to render to the Veteran as clinically appropriate. Numerical frequencies will apply to individual payable services within the SEOC. Clinicians should refer to the information contained within the consult to develop an appropriate plan of care utilizing the services contained within the SEOC. All services falling outside the parameters of the SEOC will require an RFS for authorization and payment. ***Note:*** *Frequency limits are not applicable for all SEOCs and will only pertain to those containing singular or rehabilitative services (i.e. Physical Therapy, MRI-MRA etc.)*
K	Disclaimer	
L	Additional Information	Important pieces of communication regarding additional information or resources including specifics about administrative steps, medication requirements, law references, or VA regulations.
M	HPTC	High Performance Technical Computing code is used to filter the type of provider to perform the service(s) on the SEOC. Coding is based on National CMS Taxonomy to support pathing information into associated systems. ***Note:*** *It is understood that CMS does not have appropriate taxonomy for all specialties such as Complementary and Integrative Health. CMS Taxonomy cannot be altered at this time thus VA has applied codes that allow pathing of the information in support of smooth referral processes.*
N	Grouping	High level type of service or clinical specialty based on the HPTC code
O	Classification	Type of provider clinically appropriate to perform the service
P	Specialization	Sub-specialty type of provider clinically appropriate to perform the service
Q	Clinical Service	A nationally recognized classification system that is used by billing and payment to associate fee schedules. ***Note:*** *Not all services have a fitting clinical service such as Complimentary and Integrated Health Services.*
R	Max Visits	The number of visits provider is approved to treat their patient for the duration of the SEOC. If the visits are denoted as '999', this indicates that there is no limitation of visits for the duration of the SEOC. ***Note:*** *If the allowable number of visits on the SEOC or duration has been met, a new consult order, SEOC, and referral will need to be created.*
S	Frequency	The number of times within a certain time period the service or treatment has been approved to be performed (X per week, X per month, or X per year)
T	Short Description	A short description that provides specific detail around what is covered under each billing code. This field can also be found on the clinical profile of the SEOC under Procedural Overview.
U	Billing Codes	A unique code that aligns to a specific service contained in the SEOC and is used for billing purposes to settle payment. Different types of Billing codes can be included in a SEOC. (E.g. CPT, HCPCS, HIPPS etc.) ***Note:*** *SEOCs are designed by Category of Care or specialty. It is not expected there will be a 1:1 code match for all care that is customary for the specialty designated on the SEOC may provide (i.e.* ancillary services,

		medications administered in the clinical setting and supplies utilized during the visit).

Changing the SEOC after the Consult is sent to HSRM

Scenario 1:

If the consult has been sent to HSRM and the referral is in an **approved status** only ***and* network affiliation has *not* been chosen**, the SEOC may be changed in Consult Toolbox which will update the referral in HSRM. The referral will only update in HSRM as it has not been sent downstream to the Third-Party Administrator (TPA) yet.

Scenario 2:

If the consult has been sent to HSRM, is in an **approved status *and* network affiliation has been chosen** or **the referral is in "Sent" or "First Appointment Made" status** (appointment hasn't been attended or is set in the future), to change the SEOC the user **must** get a new consult. The previous consult should be **discontinued,** which will cancel the referral in HSRM. Upon receipt of new consult, ensure the correct SEOC is chosen and send to HSRM. The community provider should be provided with the new referral number for billing purposes to avoid denials.

Scenario 3:
If the consult has been sent to HSRM and the **appointment has already occurred** (could be in "First Appointment Made", "Initial Care Given" or "EOC Complete status"), the user **should not change the SEOC nor cancel the consult** as the care has already been provided and the referral will need to proceed to claims as is. Referral should be end-dated (change the expiration date) and not cancelled (or else could be issues with any claims that already went through). A new consult with the correct SEOC should be entered, sent to HSRM, adjusting validity period (start and expiration date) in HSRM as necessary and send to TPA.

ADDITIONAL RESOURCES

Access the Office of Community Care (OCC) Training Catalog to find training opportunities to include but not limited to:

- **TMS VA 4551407 Care Coordination Model–Standard Episodes of Care (SEOCs) for Admin Staff**
  - This course will provide an overview of the Care Coordination Model in the Community Care Network, focusing on standardized episodes of care (SEOC). this course will focus on the role of the Administrative staff.
- **TMS VA 4557773 GEC SEOC Refresher Training**
  - The Geriatrics and Extended Care (GEC) Purchased Long Term Services and Supports (LTSS) Standardized Episodes of Care

(SEOCs) Refresher training focuses on a range of topics including an overview of SEOCs, the Consult Toolbox, Community Care Purchasing Authorities, Skilled Home Care Services SEOCs, Personal Care Services SEOCs, and Community Nursing Home SEOCs.

SEOC Billing Code Information and Precertification Requirements for Community Providers

The VA Provider Storefront is a public domain on the VA Webpage that is accessible by community providers and VA staff to easily look up SEOC billing codes and precertification codes. Please review the "SEOC Billing Code Information and Precertification Requirements for Community Providers" guidance that provides the step-by-step instructions on how community providers can access the VA SEOC Billing Code list and Precertification requirements.

3.4 How to Coordinate Authorized Care

Authorized Care is defined as: VA approved care, initiated by a VA provider requesting services in the community and associated care is coordinated by the Facility Community Care Office staff by entering a consult for such services. Such requests for care should be coordinated by using the VA Community Care-Coordination Plan Note (CCP) in Computerized Patient Record System (CPRS) and in Health Share Referral Manager (HSRM).

At the completion of the Screening/Triage Tool, the care coordination level should be used by the appropriate personnel (admin or clinical) to create a Community Care-Coordination Plan Note. The level of care coordination (basic, moderate, complex/chronic, urgent) will determine which staff (e.g., admin or clinical) should initiate the CC-CCP Note.

Screening/Triage Tool SOP (Department of Veterans Affairs Screening Triage Tool SOP)

Community Care-Coordination Plan Overview

- After assessing a Veteran's care coordination needs, a Community Care-Coordination Plan should be created to structure the necessary activities and approach for a specific episode of care (EOC). A Community Care-Coordination Plan includes Veteran information, brief clinical history, risk factors and appointment/referral management information.
- A Community Care-Coordination Plan aligns Veteran needs and preferences to care coordination activities and services that properly address those needs. Additionally, the Community Care-Coordination Plan provides the facility community care office and the integrated team with a means to document activities, coordinate care and manage related tasks. The plan reduces

duplicative efforts and enables a transparent and collaborative approach to coordinating a Veteran's community care.

- The HealthShare Referral Management (HSRM) system is the primary platform that facility community care staff will use for implementing, assessing and updating the Community Care-Coordination Plan (CCP) Note. HSRM may also be used by community providers but is not, currently, mandatory. HSRM's task management system enables staff to view Veteran and consult information, create, assign and track care coordination tasks, as well as set reminders and alerts for each EOC. The system allows staff to sort and filter tasks by patient, consult and other factors.

- The Community Care-Coordination Plan Note is developed based on the Veteran's level of care coordination identified by the Screening/Triage Tool and contains Veteran, consult, and task-level information necessary to coordinate community care. The plan can include both administrative and clinical care coordination activities and ensures that the integrated team actively involves the Veteran in planning. Thus, the process of developing and implementing a Community Care-Coordination Plan Note is highly collaborative, requiring participation from each staff member involved in care coordination activities for a specific EOC, as well as the Veteran and/or their family/caregiver. A complete CC-CCP Note details the assigned roles, responsibilities and ownership for tasks related to care coordination activities, when applicable, such as:

  1. Navigation and scheduling
  2. Veteran/family education
  3. Case management
  4. Disease management
  5. Social services (e.g., transportation)
  6. Lifestyle modification
  7. Post-appointment follow-up*

  * Refers to communication to the Veteran and/or his or her caregiver to determine if the care met the Veteran's need – and what next steps may be, to close the consult.

- It is important to note that the development of the Community Care-Coordination Plan and its execution is not always linear in nature and may occur concurrently. For example, an administrative staff member may be working to schedule the appointment listed in the referral, while case management activities are being planned by clinical staff. Efficient care coordination should never result in a delay of care. Staff should use appropriate judgement when deciding on the applicable care coordination services to ensure quality, safety and timeliness.

C.2 **When is a Community Care-Coordination Plan Note necessary?**

- A Community Care-Coordination Plan Note should be created for every new community care referral (excluding direct scheduling, Emergency Treatment-(self-presented) and GEC consults).

- While the Veteran-level information (e.g., demographics, social support, etc.) may remain consistent across different referrals, consult-level information may change.

C.3 **Who is Responsible for Developing a Community Care-Coordination Plan?**

- If the care coordination level assigned by the Screening/Triage (S/T) Tool is "basic,", the administrative staff member (e.g., MSA or PSA) on the integrated team is assigned as the owner of the community care-coordination plan. For levels other than "basic" (e.g., "moderate," "complex/chronic," and "urgent") the clinical staff member (e.g., RN or SW) on the integrated team is responsible for developing the plan. Regardless of the level of care coordination, the plan can include both administrative and clinically driven care coordination activities. Thus, it is the responsibility of the staff member assigned to coordinate the care for the Veteran to ensure that stakeholders are collaborating on the plan within the CC-CCP Note and assigning appropriate roles.
- For example, throughout the care coordination process, the administrative team will be responsible for verification of eligibility, scheduling, documentation exchange while the clinical team will be responsible for ensuring appropriate care and facilitation/oversight of care coordination activities.

Open CPRS and select the CC-CCP Note title:

- A reminder dialog template will load with two template options.
- Choose "VA Facility Care Coordination Plan Note (INITIAL NOTE)" (must be completed to attach addendum).
- Click to see list of consults- the 10 most recent consults will then be displayed below.
- Search the consult for which CC-CCP Note is being entered (type into the blank field to the right of "Community Care Consult" to find the consult).
- Enter Veteran's chief complaint.
- Record any clinical or biopsychosocial risks for the Veteran that have been identified.
- Select the level of care coordination.

NOTE: The level of care coordination (basic, moderate, complex/chronic, or urgent) will determine if the note will be initiated and/or completed by an administrative staff member or by a RN/SW. Administrative staff will be responsible for a "basic" level CC-CCP Note, whereas RN/SW will complete the CC-CCP Note for all other levels of care coordination (moderate, complex/chronic, urgent).

General Considerations:

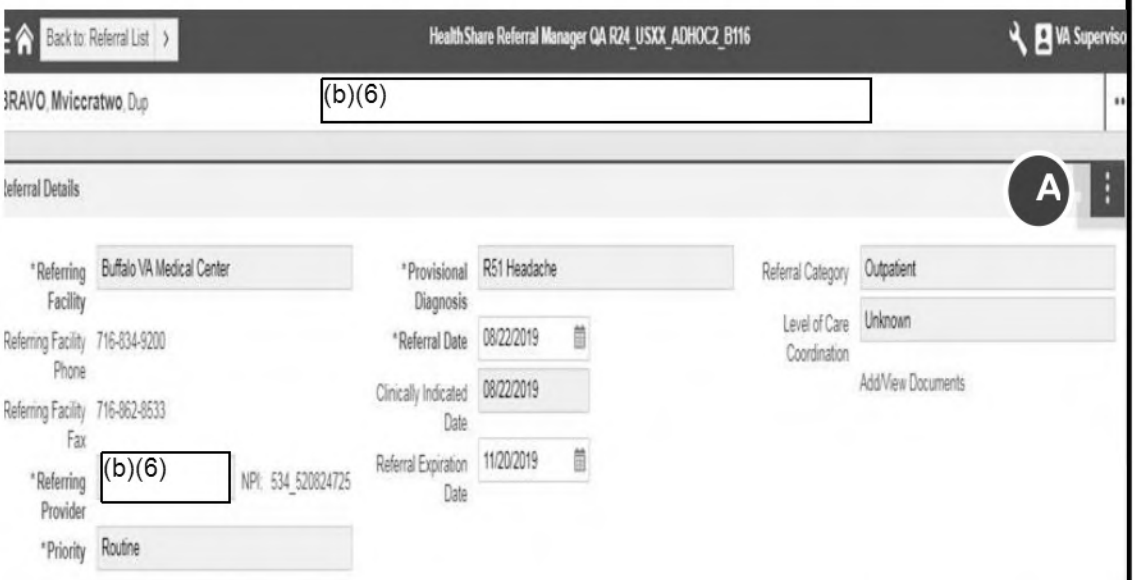
In general, the process for authorized care includes the following steps. For detailed guidance on the processes for Community Care-Coordination Plan Note review the following here:

- VA Community Care-Coordination Plan Note Reference Sheet
- Screening/Triage Tool SOP (Department of Veterans Affairs Screening Triage Tool SOP)

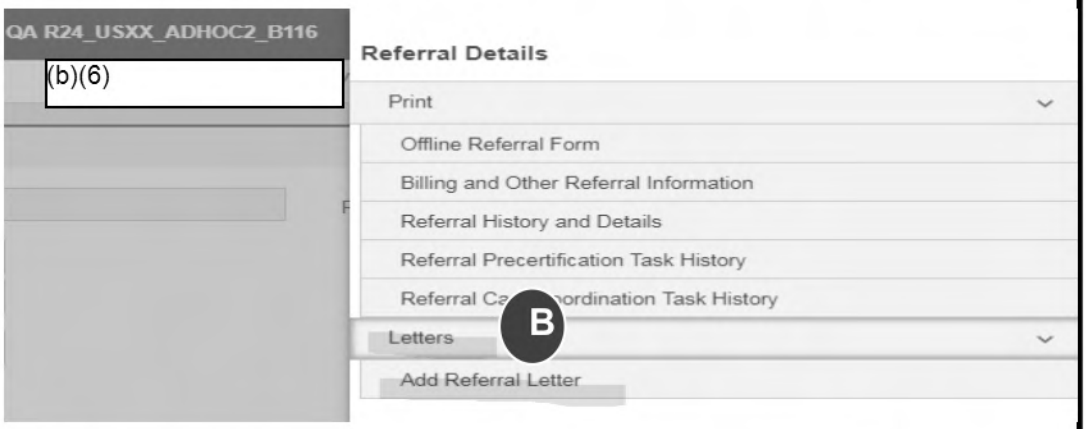
STEP	ACTIVITY
1	Obtain Planned Procedure, Appointment, or Admission Information • Identify the community provider based on Veteran preferences, (including ED referrals): • Consult with Facility Community Care Office management for further guidance related to DoD processes if your facility has a sharing agreement with the DoD **Note:** Facility Community Care Office staff may also contact the Veteran directly to understand if the admission date is still unknown and if assistance is required for completing pre-op testing or labs.
2	Identify the responsible staff/interdisciplinary team that will coordinate services needed by the Veteran based on the level of care coordination required. Guidance on how to use the Screening/Triage (S/T) Tool is located in the Office of Community Care Field Guidebook, chapter 2, section 3.1 “Coordinating Care Delivery”. Identify level of care coordination populated on the consult. Each Veteran will be assigned to one of the following levels of care coordination: • Basic • Moderate • Complex/Chronic • Urgent Basic care coordination is intended to be managed solely by administrative staff, who would be responsible for initiating the CC-CCP Note. The administrative note can be updated throughout the episode of

	care as the Veteran may require navigation, scheduling, and other related activities. For all other levels of care coordination (moderate, complex/chronic, urgent), clinical staff such as Registered Nurse (RN), Social Worker (SW), Interdisciplinary team (IDT) will lead care coordination in conjunction with administrative staff to manage the Veteran's care and would be responsible for initiating the CC-CCP Note. The CC-CCP Note is updated as needed by the admin and/or clinical staff as appropriate.
3	Create Community Care-Coordination Plan (CCP) Note in CPRS and include required information. The Community Care-Coordination Plan Note is created for each community care referral by reviewing the clinically indicated services requested in the consult, a Veteran's psychosocial needs and his or her preferences and goals. **NOTE:** The CC-CCP Note is not required for use with Direct Scheduling or GEC consults. In addition, the care coordination level, indicated by the Screening/Triage Tool, should guide the decision for potential care coordination services to be included in the community care-coordination plan (e.g., navigation, scheduling or disease management services). Clinical judgment should also be used to determine the most appropriate care coordination activities for a Veteran's consult, if an RN or SW is leading the Veteran's care coordination. All the required information on the Community Care-Coordination Plan Note needs to be completed by those editing the note, as it is not automated. Include required interdisciplinary needs (i.e. Transportation, SW, Pharmacy, etc.). Include additional information if known, as applicable: • Appointment date and time • Provider Instructions on creating the CC-CCP Note in CPRS can be found in the VA (Community Care-Coordination Plan (CCP) Note Overview). Additional information is available in the Department of Veterans Affairs Community Care-Coordination Plan Note Standard Operating Procedure. Pre-CCN: The care coordination note can be used to identify individuals in the care team by annotating them as "additional signers" and to request actions that need to be taken in the coordination process. As a best practice, use IM/F2F communications with team members to resolve urgent, time sensitive or high-risk issues. **Post CCN process:** The Community Care-Coordination Plan (CCP) Note includes separate admin and clinical sections to align with the day-to-day functions of the Facility Community Care Office staff members. The Facility Community Care Office staff will also be able to use Health

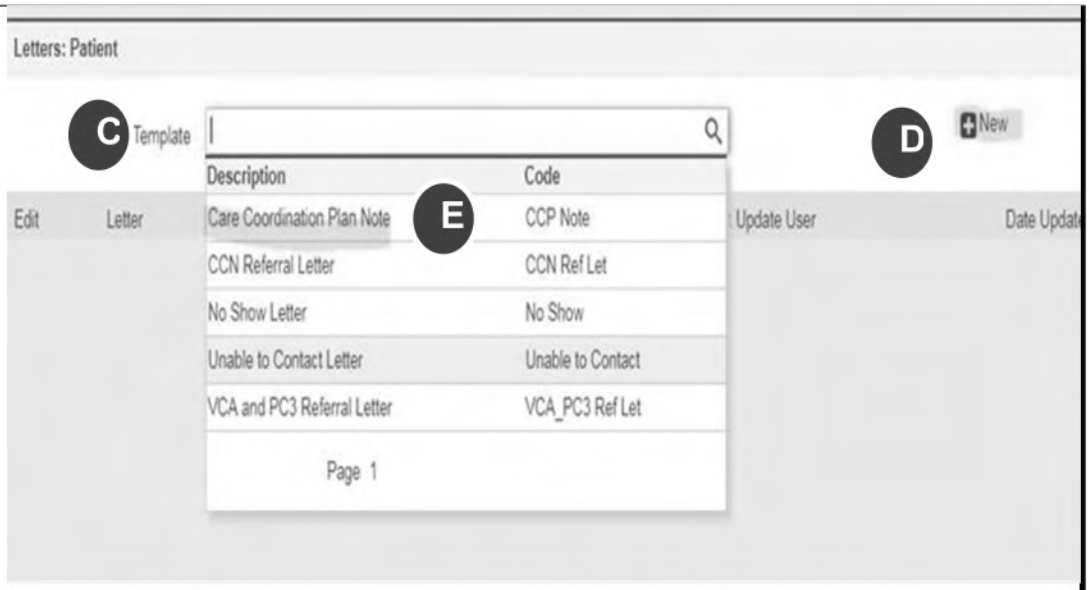
Share Referral Manager (HSRM) for all care coordination functions once the tool and functionality is deployed.



A. After accessing the referral details screen, click the three vertical dots found on the right of the screen.



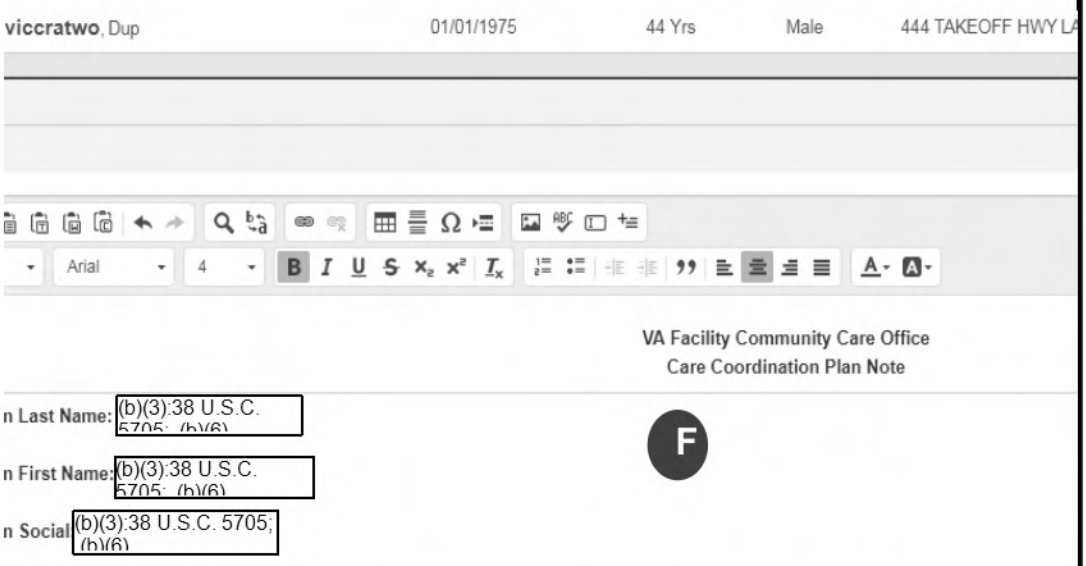
B. Click on the menu item of Letters. Click the down arrow to expand the Letters section and select Add Referral Letter, then the Letters - Patient screen appears.



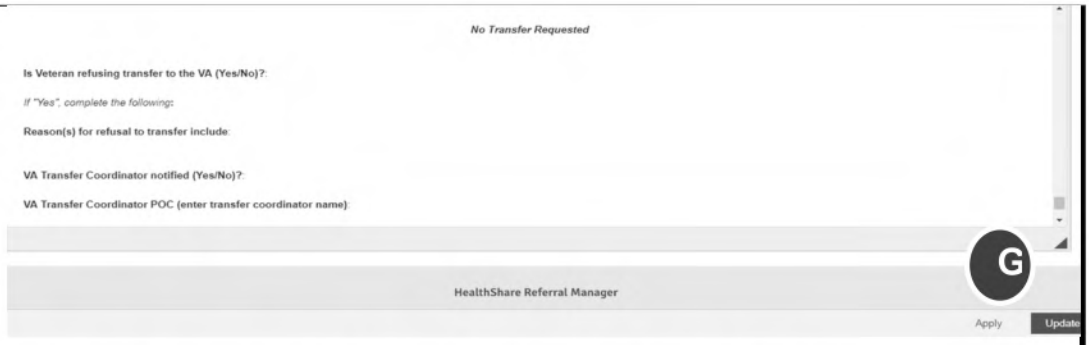
C. Select "**Template**" from the drop-down list in the Template field.

D. Click the **New button** to create a new letter based on the template selected.

E. Choose the **Care Coordination Plan Note template** from the dropdown.



F. The CC-CCP Note will then populate for you to begin filling out.



G. Once the user is finished, select "**Apply/Update**" to save changes.

4 Sign the note.

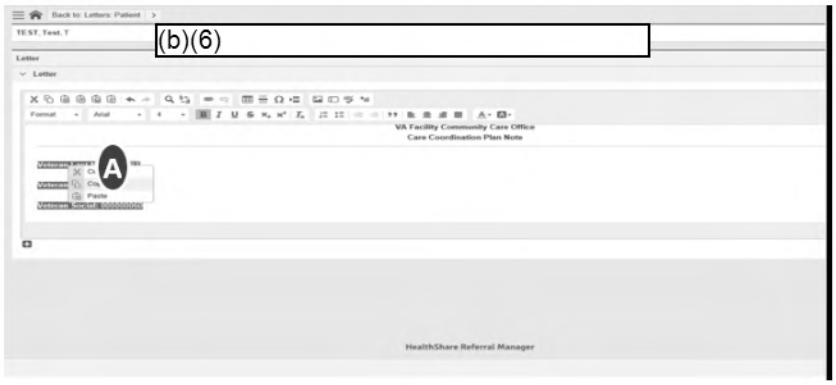
You will then be able to print the note to upload to CPRS or copy/paste the note.

NOTE: *Must copy & paste CC-CCP Note from HSRM back to CPRS until full functionality within HSRM is implemented. This has been approved by HIMS.

NOTE: As a shortcut, with your cursor inside of the letter, click CTRL+A (for all), then CTRL+C (for copy). This will copy everything in the note.

To paste the HSRM CC-CCP Note back to CPRS:

A. Once the information has been entered into HSRM Care Coordination Plan template.
   1) Use mouse to highlight and select information entered.
   2) Right mouse click and select Copy from dropdown.



B. Locate the note for the referral in CPRS and paste the HSRM CC-CCP Note into the existing CC-CCP Note for the referral.

C. Select Patient record in CPRS, select Community Care Coordination Plan note. When template appears –click "X" in the upper right corner to close

D. Left mouse click in progress note window. Then right mouse click and select Paste from Dropdown.

Review note text copied to CPRS for accuracy and edit as appropriate. Then sign note as any other documentation in CPRS.

5	Clearly indicate the role of Additional Signers, as needed (i.e., indicate if signer is added as an FYI or if it's a required task). Identify appropriate tasks and document responsibilities of each additional signer. This can include members of Veteran's IDT, Transportation, Pharmacy needs etc.
6	Communicate the VA's plan of care to Veteran or Caregiver, Providers and Care teams, as needed, throughout the EOC. Coordinate Veteran needs throughout the episode of care by sharing relevant information and/or obtaining appropriate authorizations, referrals and status, as needed, from: Veteran and/or family: Staff is expected to communicate proactively with the Veteran or Veteran's representative to discuss timely access to care, scheduling, ADL Support etc. Providers: Staff is expected to have an open line of communication with providers managing Veteran's care. Communication should include discussing the plan of care, managing transitions, etc. **Pre-CCN:** Staff should communicate proactively with CCN partners to discuss authorization of services, coordination of care in the community, initiating Veteran engagement etc. **Post-CCN:** Under CCN the staff should work with the Community Providers for coordinating the Veteran's care in the community. If the Veteran is admitted to the hospital, the staff will work with the hospital discharge planner and CCN assigned discharge planner to coordinate transition of that preauthorized inpatient visit **NOTE:** Under CCN there is a requirement that the community provider have an assigned discharge planner that supports VAMCs to coordinate discharges. After care has been communicated, review Chapter 3, Sections 3.22-3.27 "Completing the Follow Up of an Episode of Care".

3.5 Understanding Pharmacy, Durable Medical Equipment (DME) and Medical Device Benefits under CCN

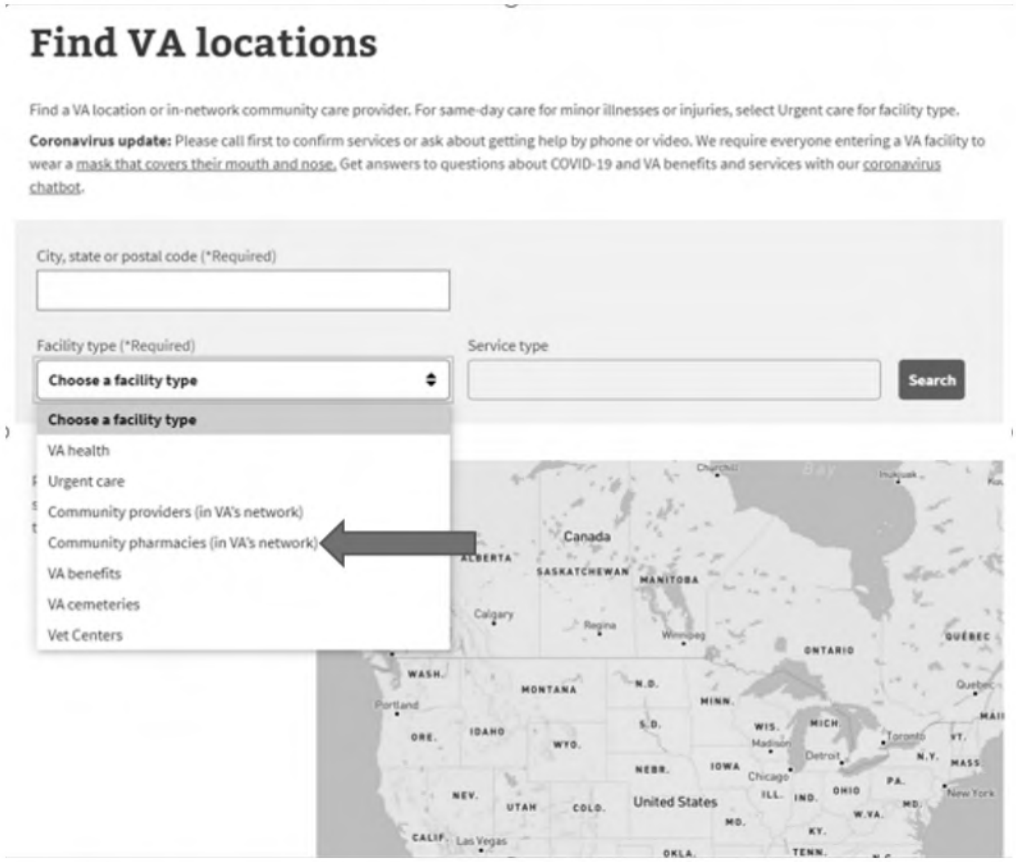
Pharmacy Benefits

(Post CCN)

VA healthcare benefits include providing Veterans with prescription medications, medical/surgical supplies, and nutritional products. The CCN contract requires all routine/maintenance prescriptions to be forwarded to VA pharmacy for processing and fulfillment. Veterans who are authorized CCN care through VA can now also get their prescriptions filled through the CCN retail pharmacy network in addition to the VA network.

Under the CCN contract, there are no out-of-pocket expenses for up to a fourteen (14) day urgent/emergent care prescriptions filled at local retail in-network pharmacies. Please see the OCC Veteran Urgent/Emergent Prescription Reimbursement SOP for guidance on the process and criteria for Urgent/Emergent prescription reimbursement for authorized episodes of care in the community.

Veterans/VA staff can find in-network pharmacies for filling medically urgent/emergent prescriptions at: Find VA Locations | Veterans Affairs.



Should a Veteran require continued medications beyond the urgent / emergent fourteen (14)-day supply, CCN providers must generate a second prescription to be delivered to and filled at a VA Pharmacy.

Note: This can occur through a fax, hand carry, or E-prescription. These options are to be communicated to the Veteran via a letter/email and the community provider HSRM generated referral package.

For routine/maintenance prescriptions for Wait-Time and/or Drive-Time Eligible Veterans, the prescription must be sent to and processed by the Veterans enrolled VAMC Pharmacy only.

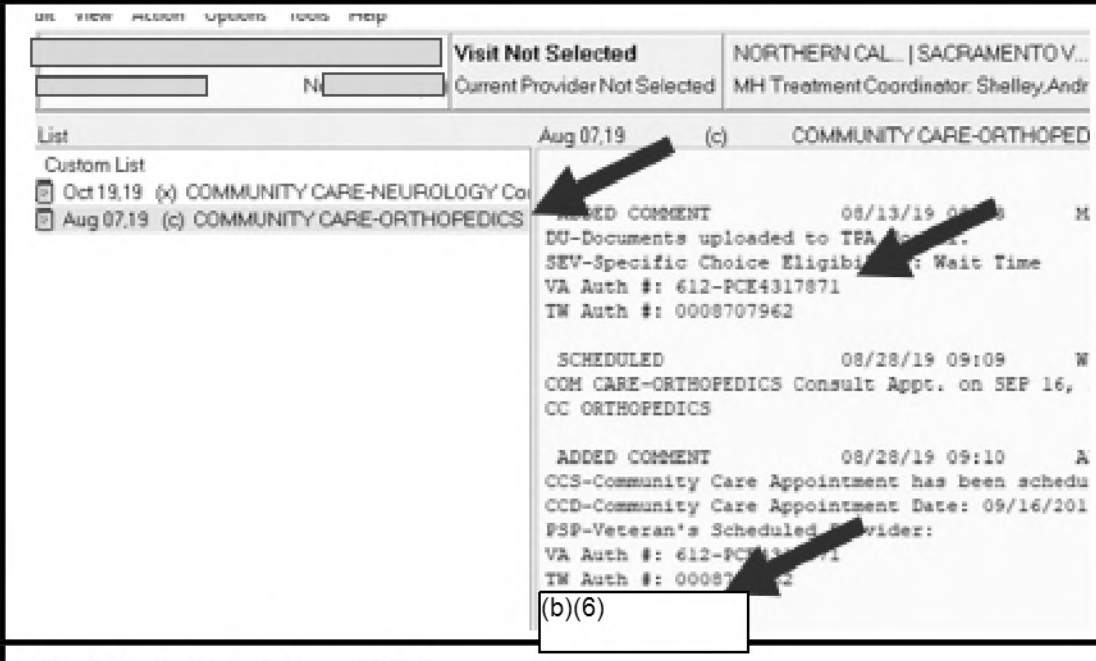
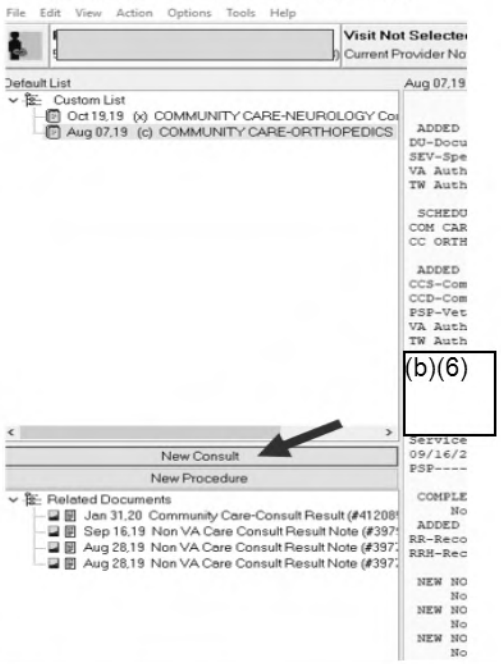
DME and Medical Devices

(Post CCN)

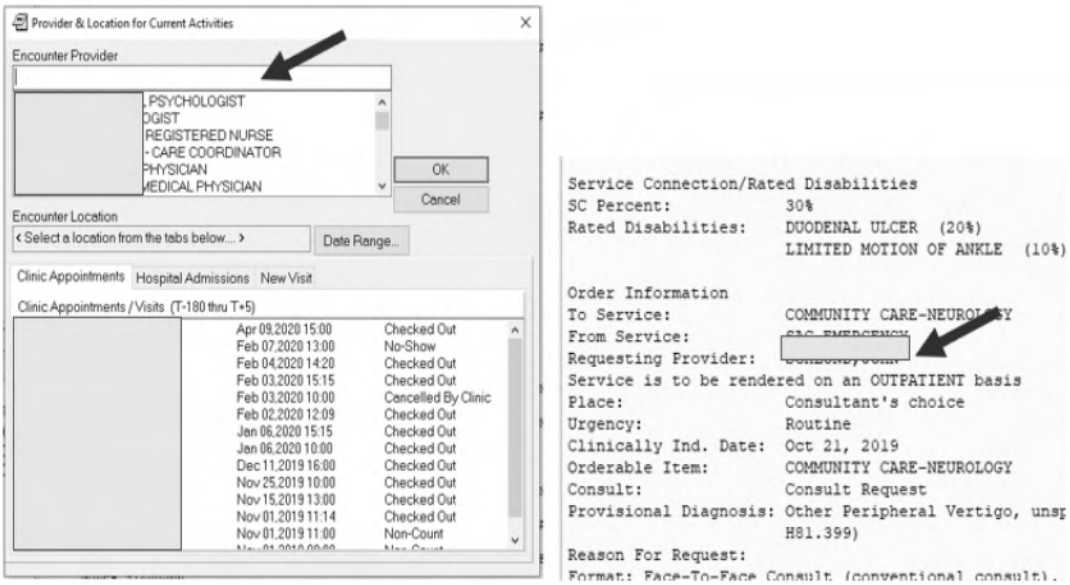
All DME and Medical Device prescription requests must be submitted by the community provider using VA-provided Request for Services (RFS) form 10-10172 within twenty-four (24) hours or the next business day after completion of healthcare services from which the prescription was generated. As urgent/emergent DME are covered under the CCN contract, the Community Provider will also ensure that eligible Veterans are provided with urgent and emergent DME/Medical Devices prior to leaving the appointment/hospital. More information can also be found on the Prosthetic & Sensory Aids Service SharePoint.

PROCEDURES	
General Considerations: • Request for Services forms may be received by fax, secure e-fax, HSRM, TPA Portal (for PC3), and email from an internal clinic or prosthetics department that initially received the request. • Below is step-by step guidance on how to enter a consult for a Durable Medical Equipment Request. • Guidance may vary based on local protocols, please work with facility community care management and prosthetics department leadership to establish best local procedures.	
	How to Enter a Community Care Prosthetics Consult
1	Locate the consult in which the DME request belongs to by matching identifiers such as: Category of Care, Community Care Provider, Authorization Number, etc., to the information on the RFS form.

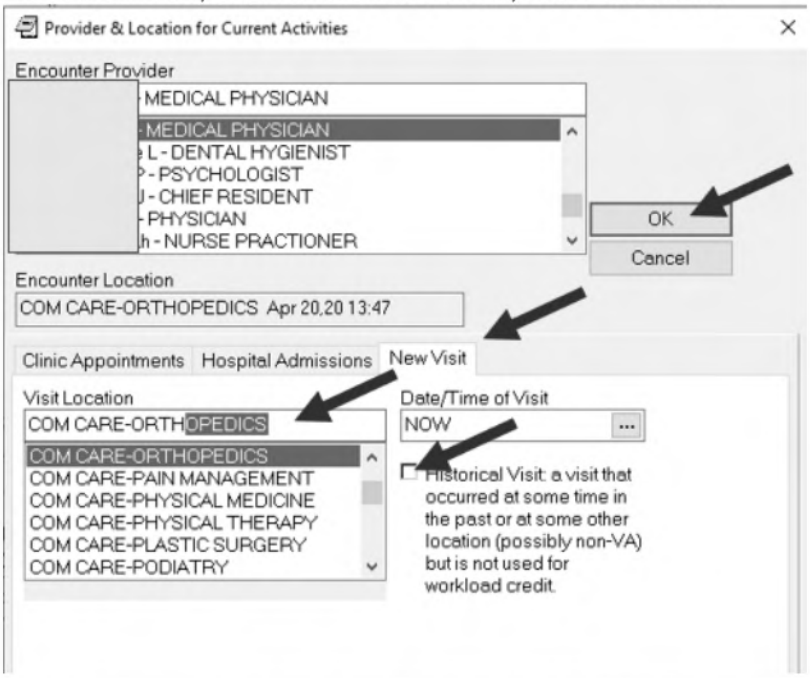
PROCEDURES

	
2	Click **New Consult** in CPRS. 
3	In the **Encounter Provider** box, Enter the requesting provider from the consult in CPRS.

PROCEDURES

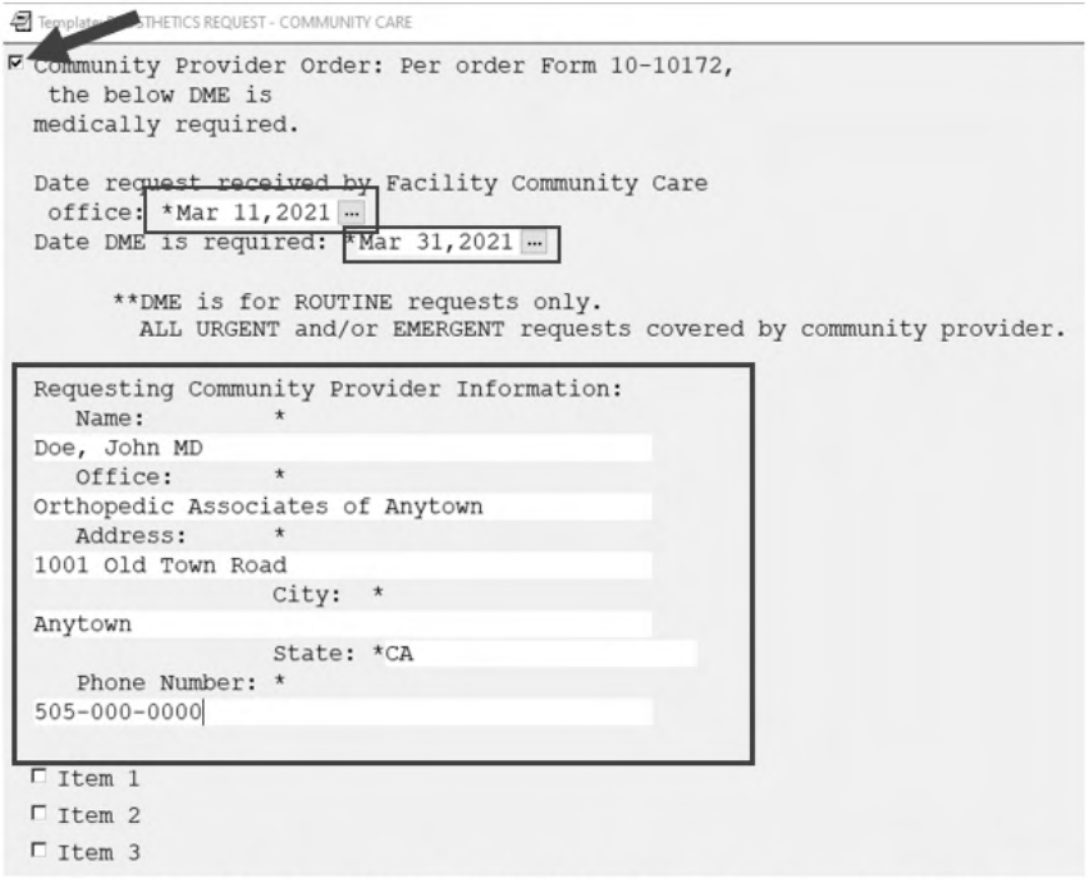


4	Click **New Visit** and type in **Com Care-(COC or correct local clinic name)** in the **Visit Location** box, click **Historical Visit**, then click **OK**.



5	Select the community care prosthetics consult from local consult menu.
6	When the consult template pops up, click the box in the top left of the window. **Note**: if the boxes aren't checked, you will not be able to more forwards with filling out the template.

PROCEDURES



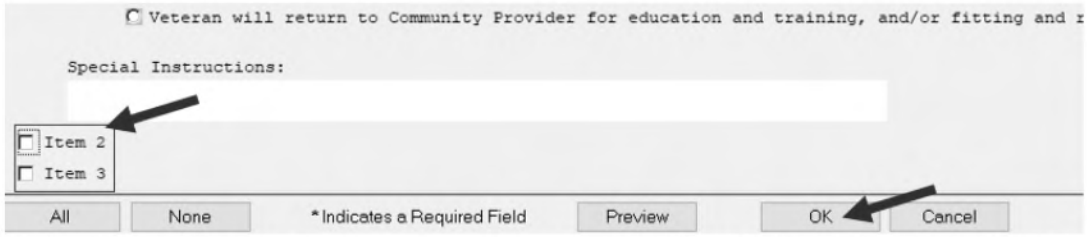
Then fill out the fields using the information on the DME request form:
Date request received: Date request was received by you
Date DME required: Date on the DME request
Community Provider Information: Community care provider's information (From consult or DME request) and put NPI number next to provider name if listed.

7

Enter the item information for items using the information given on the RFS form.
Item requested: Name of the item(s).
Vendor: (If given ex: Precision).
Brand: (If given).
Part of Model number: (If given).
Measurements: (If given).
Other Factors for customization: (size, price etc. if given).
Quantity: 1 if not given.
HCPC (Healthcare Common Procedures Code): (if given).
Open text: VA and TPA authorization numbers (from consult).
Medical Justification: Diagnosis and ICD-10 (from the consult), procedure, etc.

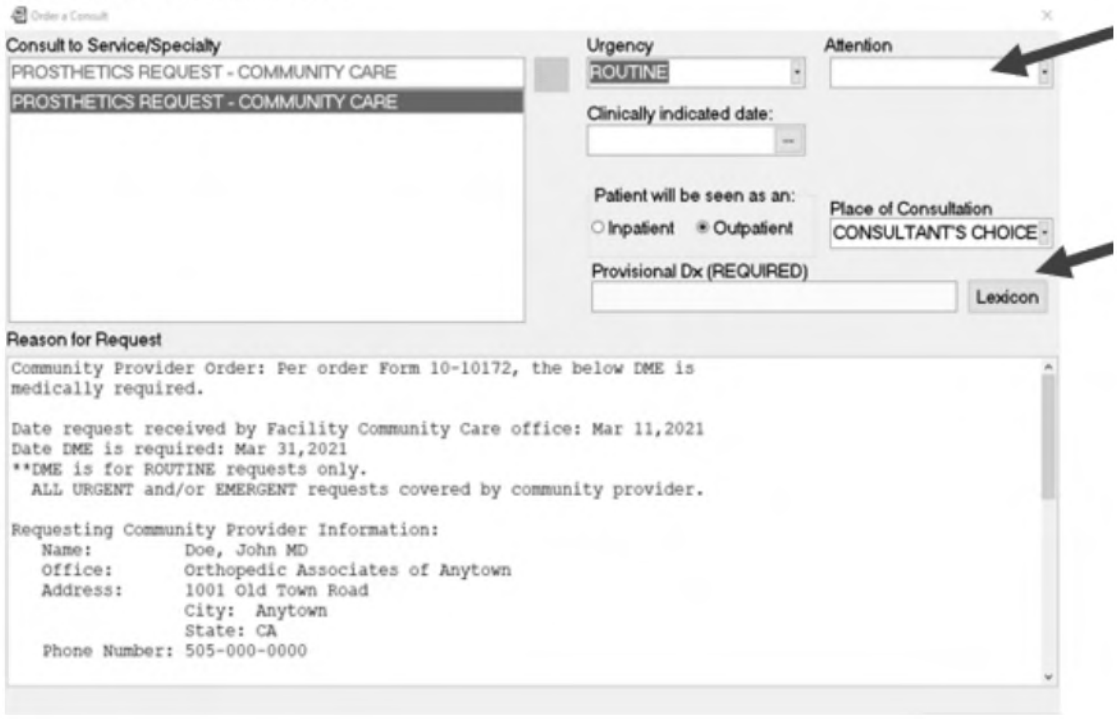
PROCEDURES	
	☑ Item 1 ☑ Item(s) requested (Nomenclature): * DVT Prophylaxis Compression Device Vendor: Precision Brand: Part or Model number: Measurements: Other factors for customization: Quantity: 1 HCPC: Open text: VA auth: 612-[redacted] TW auth: XXXXXXXXXX Medical Justification for all items prescribed: * Pain in left knee M17.12 **Note:** Not all requested factors will have a response on the RFS form, please fill in those with an asterisk *, and any other that information has been provided for.
8	Select **'Completed'** under '**Education, Training, and/ or fitting'** unless otherwise specified. Select '**Veteran's Home'** under '**Deliver to'** unless otherwise specified. TW auth: XXXXXXXXXX Medical Justification for all items prescribed: * Pain in left knee M17.12 Education, Training and/or Fitting: * ◉ Completed ○ Veteran to return to community provider to receive education/training and/or fitting Deliver to: * ◉ Veteran's Home ○ Veteran will pick up at VAMC ○ Veteran will return to Community Provider for education and training, and/or fitting and receive DME. Special Instructions: *Note: if vet is inpatient and DME needs to be delivered to him/her at the facility, enter the delivery instructions(location, floor, room) in '**Special Instructions'** box. If not, leave blank.
9	Click on the box for **items 2** and **3** if needed, repeat **steps 9-11** for each item and click **'OK'.**

PROCEDURES



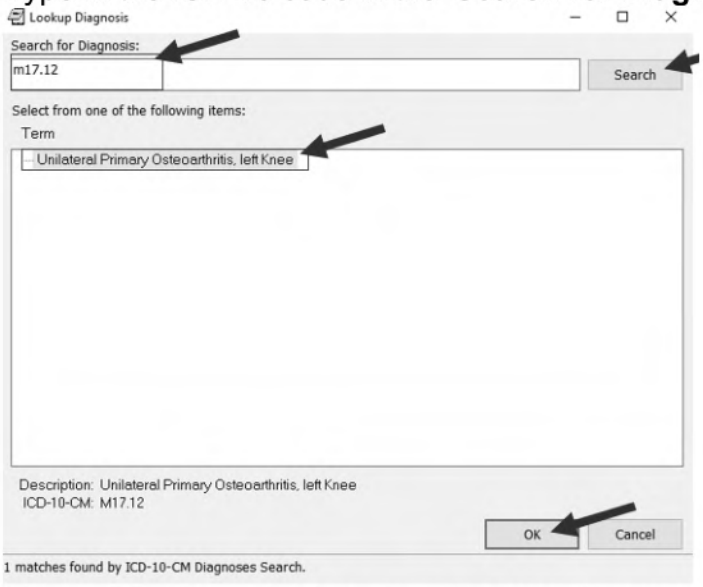
Note: if there are more than 3 items, you can click 'Ok' and free type them into the order manually. Please work with your facility prosthetic department to determine best process. Some may request all on same order, some may require multiple, some may only require multiple for different vendors.

10 Type in the requesting providers name in the '**Attention**' box. (From consult) Then click on **'Lexicon'**.

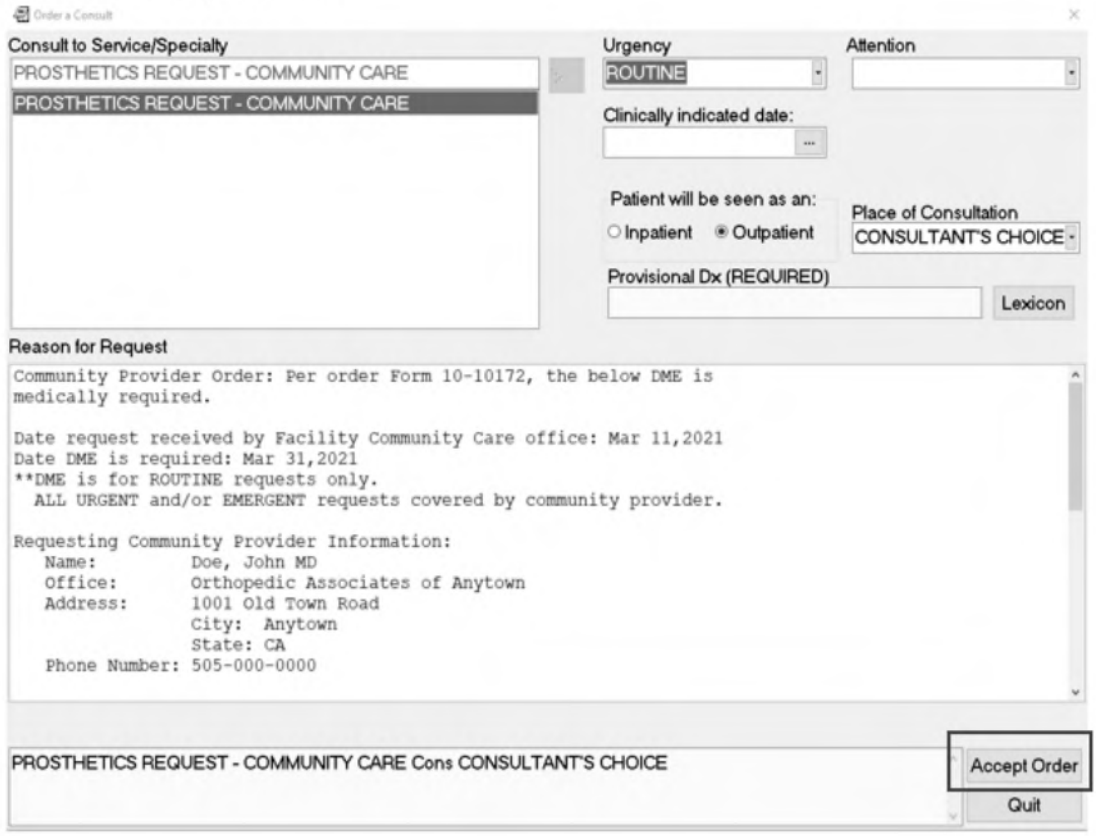


PROCEDURES

Type in the ICD-10 code in the '**Search for Diagnosis'** box and click '**Search'.**



Note: ICD-10 can be found on the consult and sometimes on the DME request, but the Lexicon must be used on every consult.
Select the correct Diagnosis and click '**Ok'**.
Click on 'Accept Order'.



PROCEDURES	
11	Follow established Community Care Process for the RFS form. Once the order is signed, the consult will be sent to the local VA Prosthetics department.

Hearing Aids

(Pre/Post CCN)

All hearing aid prescriptions must be reviewed by the VA before approval. Hearing aids cannot be purchased or provided under this contract by the Contractor or the CCN providers and instead must be provided through the VA Centralized Audiology Team. The VA will provide information about the hearing aid manufacturers that have current contracts with VA. The VA Audiology Toolkit and Hearing Aid Fitting Visit Template are available for VA community care staff to send with Audiology authorizations.
VA Audiology Toolkit for Community Care Providers
Hearing Aid Fitting Visit Template and Follow Up
Please see VA Directive 1034 Prescribing and Provider Eyeglasses, Contact lenses and Hearing Aids for more information.

Eyeglasses and Contact Lens

(Pre/Post CCN)

Eyeglasses (to include approved frames and lenses) may be prescribed by a community provider and will be supplied by the VA

Contact lens may be provided by VA when prescribed based on medical necessity and eligibility for contacts rather than glasses. They are not provided as a customer preference versus eyeglasses.

Please see VA Directive 1034 Prescribing and Provider Eyeglasses, Contact lenses and Hearing Aid for more information.

Home Oxygen:

(Pre/Post CCN)

Home oxygen equipment or supplies cannot be purchased or provided by CCN Contractors or CCN providers. VA staff should follow-up and ensure that the CCN providers have considered the need for home oxygen for the Veteran well in advance of procedure or discharge to avoid delay in fulfilling the prescription (follow local policy).

3.6 Managing Care Coordination for Veterans through the Community Care

Beginning June 8, 2020, Community Care staff will no longer be responsible for eligibility determination or payment approvals/denials, nor will they be responsible for consult management of self-presenting emergency care. The referral process and eligibility determination has been automated and a Centralized Call Center has been created to accept Notification for Community Care Emergency Treatment.

The new process decreases the workload of VA facility community care staff and allows VA facility community care staff to focus their efforts in providing care coordination for Veterans. VA clinical and administrative staff will continue to collaborate to ensure high-level care coordination. The facility community care staff will continue to have oversight of the Veteran during their stay in the community. It is important to maintain open communication between administrative and clinical staff for the success of the care coordination.

The SOP, backlog process, FAQ document and Emergency Care Coordination and Centralized Notification Provider Fact Sheet, and other additional supporting documents can found in the CAEC Emergency Treatment SharePoint site. The Community Care Emergency Treatment Notification Process (National Training) webinar can be found in TMS.

Emergency Treatment Notification Process

(Pre/Post CCN)

1. **Policy**

38 CFR 17.4020(c) Authorized emergency treatment

Authorizing emergency treatment. This section applies only to emergency treatment furnished to a covered veteran by an eligible entity or provider when such treatment was due to VA, and other federal facilities with which VA has an agreement, not being feasibly available. This paragraph does not affect eligibility for or create any new rules or conditions affecting reimbursement for emergency treatment under section 1725 or 1728 of title 38, United States Code.

Notification for Emergency Care in the community will be centralized; notification information can be provided via the Emergency Care Reporting Portal or by calling the Centralized Call Center. Critical data elements will be entered in the Emergency Care Authorization Tool (ECAT) SharePoint site that houses eligibility criteria, an approved emergency diagnosis list, and an associated crosswalk with presenting signs and symptoms. Once determination is made for 38 CFR 17.4020(c) eligibility, an approval or denial correspondence will be sent by the Centralized Call Center staff. If determination decision cannot be made using the automated criteria, then Payment Operations and Management (POM) staff will review to make a final determination.

2. **Purpose**

The purpose of this guide is to provide instructions for managing the Community Care Emergency Treatment process as part of the Centralized Authorization of Emergency Care, including activities related to centralized notification, intake, and associated care coordination.

3. **Scope**

VA provides authorization for emergency treatment for eligible Veterans based on 38 CFR 17.4020(c) and 38 Code of Federal Regulations (CFR) 17.4000-17.4040. These services can be authorized under 38 CFR 17.4020(c) when: a Veteran is referred from the VAMC to an in-network facility or when a Veteran self-presents to an in-network facility; proper notification is received timely; and the Veteran meets administrative and clinical eligibility criteria. The Veteran must be followed with continued stay reviews until transferred to VA once stabilized, discharged, or the Veteran refuses information sharing with the VA.

4. **Acronyms**

   a. AOD: Administrative Officer of the Day

   b. CFR: Code of Federal Regulations

   c. CAEC: Centralized Authorization of Emergency Care

   d. CPRS: Computerized Patient Record System

   e. eCAMS: Electronic Claims Adjudication Management System

   f. ECAT: Emergency Care Authorization Tool

g. ED: Emergency Department

h. EOC: Episode of Care

i. HSRM: HealthShare Referral Manager

j. IDT: Interdisciplinary Team

k. POC: Point of Contact

l. POM: Payment Operations and Management

m. PPMS: Provider Profile Management System

n. RN: Registered Nurse

o. U.S.C.: U.S. Code

p. VAF: VA Form

q. VAMC: VA Medical Center

r. VHA: Veterans Health Administration

s. VistA: Veterans Information Systems and Technology Architecture

5. **Overview**

This topic contains information for VA Medical Centers when referring emergency care to an in-network community facility and processing emergency treatment notification from a community facility. VA facilities can refer care to in-network hospitals for emergent care when it cannot be provided within VA.

Note: To identify in-network community hospitals, utilize the "Provider Locator" in PPMS and search by the Veteran's desired address. Choose code POS 20-Urgent Care Clinics and, if desired, select specific Provider Networks.

Notification of a Veteran self-presenting for emergency care in a community facility can be made by the Veteran, Veteran's representative, or the community emergency care facility within 72 hours of the services being provided via the following options:

- Emergency Care Reporting Portal

  https://emergencycarereporting.communitycare.va.gov/

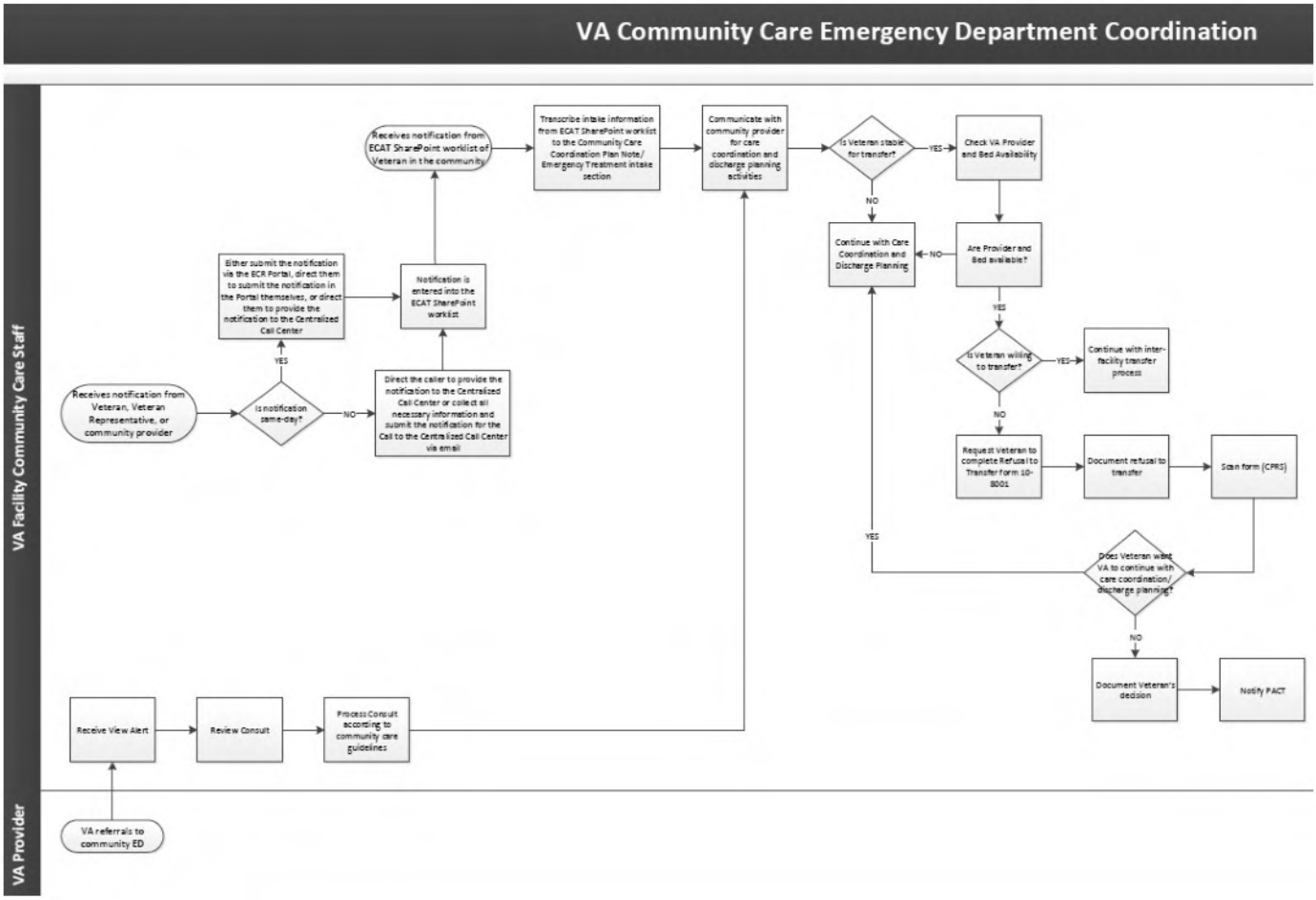
- Centralized Call Center Telephone: 844.72HRVHA (844.724.7842)
- Appropriate VA Official at the nearest VA Facility

Guidance on submitting notifications via the Emergency Care Reporting Portal is outlined in the ECAT section of the SOP. If a notification is submitted to the Centralized Call Center, the Centralized Call Center Staff will be responsible for gathering specific information related to the

notification of a Veteran who self-presents to a community Emergency Department (ED) facility. The community provider storefront will display the Centralized Call Center telephone number, the Emergency Care Reporting Portal domain, and local VA facility community care contacts, to allow community hospitals a point of contact for care coordination and/or Veteran transfer needs.

https://www.va.gov/COMMUNITYCARE/docs/providers/Care-Coordination_Facility-Contacts.pdf#

See the below workflow for an overview of the process that will be reviewed in more detail throughout the SOP:



Responsibilities

The Centralized Call Center staff are responsible for entry to and management of notification information within the ECAT SharePoint site. These staff are also responsible for managing notification submissions received via the Emergency Care Reporting Portal. When all required information has been received, automated logic determines eligibility and payment authority. If submission eligibility and payment authority determination cannot be made through automated logic, the submission will be routed to POM staff for review and further action.

VA facility community care staff are responsible for transcribing the intake information from the ECAT SharePoint worklist to the Community Care Coordination Plan note in CPRS and continue with care coordination of Veteran's emergency episode of care in the community.

If VA facility community care staff receive a notification via a telephone call or a voicemail, they have the following options to ensure that the notification is submitted:

- If a telephone call is received, gather appropriate care coordination information and transfer the telephone call to the Centralized Call Center
- Direct the caller to submit the notification via the Emergency Care Reporting Portal
- Obtain the necessary notification information and submit via the Emergency Care Reporting Portal on behalf of the caller
- If unable to submit the notification via the Emergency Care Reporting Portal, contact the Centralized Call Center
- If a voicemail is received, return the call and ensure that the notification is submitted via one of the options outlined above

Note: When transferring the call to the Centralized Call Center telephone number, press the transfer button on your phone system, press "9" or the number your system uses to transfer outside numbers, enter the Centralized Call Center staff telephone # 844.72HRVHA (844.724.7842). When the call center staff answers, provide a warm handoff and complete the transfer of the call. If the call center staff is not immediately available, direct the caller to leave a voice message with the emergency care notification information. If your facility's phone system does not allow for this process, please contact your local leadership for guidance on how to access outside lines.

VA Referring Veteran for Emergency Care to In-Network Facility

Requirements for referring care to the community originating in a VAMC ED, Community Based Outpatient Clinics (CBOC), VA Inpatient, or VA Outpatient location:

In instances where VA cannot provide the appropriate level of care or the referring VA facility does not have sufficient inpatient capacity or capability for subsequent care, and federal facilities with which VA has agreements with were unavailable, the Veteran can be referred to an in-network ED or inpatient services for further evaluation and treatment when clinically indicated for transfer. Referrals originating from a VA Facility to a Community Care in-network ED, will be considered authorized and must be accompanied by a VA referral. Sites will use the current process of entering the Community Care Coordination Plan note, Consult, and Referral in HSRM.

Note: Telephone triage guidance to seek emergency care to the closest community ED does not constitute pre-authorized care. Care must be reviewed for reimbursement under 38 U.S.C. 1728 and 1725 as applicable.

VA facility community care staff will continue with care coordination efforts throughout the episode of care (EOC) with continued stay reviews and managing discharge planning activities.

Veterans Who Self-Present to Community Facility

Handoff to the VA facility community care staff occurs when the VA facility receives notification from the ECAT SharePoint site that a Veteran has self-presented to a Community ED or has inpatient status resulting from an ED visit. As such, VA facility community care staff are responsible for viewing the ECAT SharePoint worklist daily to capture all new notification intake information and begin care coordination activities of assigned notifications. VA facility community care staff are also responsible for identifying the appropriate staff by adding as an additional signer for ongoing follow up (i.e., Transfer Coordinators, Bed Control Staff, Social Workers, etc.).

If the Veteran is not registered in your local CPRS system, provide your local Eligibility and Enrollment department the Veteran's demographics obtained from the VA ECAT SharePoint site worklist. Eligibility and Enrollment staff will enter the Veteran's demographics into VistA and verify the Veteran's benefit eligibility status. Once the Veteran's information is loaded in the local VistA system, and if eligible for VA care, continue with care coordination. If the Veteran is not eligible, provide that information either in the ECAT SharePoint site by utilizing the corrections request function or via email at VHAEmergencyNotification@va.gov

Note: Approved SEOCs are intended for scheduled admissions or urgent admissions that occur as a result of a Veteran being seen by a provider or due to test results warranting direct admission. Approved SEOCs do not include unplanned Emergency Room presentations, such as in cases where a Veteran has a referral for cardiology and presents to an Emergency Room for chest pain during the duration of the SEOC approval. The Veteran's presentation for chest pain would need to follow the emergency notification process and would not fall under the preapproved cardiology SEOC.

Immediate Transfer Request

(1) In instances where the Veteran requires an immediate transfer from the community facility to a VA facility, the Centralized Call Center will receive notification from the community facility.

(2) If a telephone call is received by the Centralized Call Center from the community facility requesting immediate transfer to the VA , the Centralized Call Center will provide a warm handoff to the VA community care staff by transferring the call to the nearest VAMC.

(3) If a voicemail is received by the Centralized Call Center from a community facility requesting immediate transfer to the VA, the Centralized Call Center will send an encrypted email to the closest VAMC community care staff with detailed transfer information.

Suicidal Ideation (SI)/Homicidal Ideation (HI) Notification

Community facilities should notify the local VAMC if a Veteran with SI/HI self-presents to their community ED and immediate care coordination/transfer is needed. If the community facility provides notification to the Centralized Call Center within 14 days of the Date of Service and/or the community provider requests immediate care coordination, the Call Center staff will provide handoff to the closest VAMC community care staff with detailed patient information required for care coordination.
If the Veteran is specifically exhibiting Suicidal *behavior*, the local VAMC Suicide Prevention Coordinator should also be notified during care coordination activities in order to maintain partnerships with communities and implement tailored, local prevention plans for the Veteran. VA facility community care staff should follow additional local policy as needed, document the SI notification in the Community Care-Coordination Plan note and continue standard care coordination activities.

If a Veteran self-presents to a community facility with HI, VA facility community care staff should follow local policy established with local Behavioral Health Coordinators and document the HI notification in the Community Care-Coordination Plan note. VA facility community care staff should then continue standard care coordination activities.

Note: If a Veteran in crisis who has not presented to a community facility calls the Centralized Call Center, the Call Center staff will transfer them to the Veterans Crisis Line per the warm handoff guidelines.

Pharmacy Prescription Guidance

When a prescription resulting from emergency care at an in-network facility is received at a VA pharmacy, the following criteria will be reviewed and verified by VA pharmacy staff:

- The facility is in-network
- The medication and treatment seem clinically appropriate
- Prescription is in compliance with VA formulary rules

If the above criteria are met, VA pharmacy staff will assume that the care will be authorized and fill the prescription. VA pharmacy staff may contact VA facility community care office staff to verify in-network status if needed.

If the prescription is received at a community facility pharmacy, the Veteran will pay for the prescription upfront and request reimbursement from their local VA Medical Center. Veteran prescription reimbursement processes for EOCs approved under 38 U.S.C. 1725 and 1728 have not changed and will be processed per POM pharmacy processing guidelines. This guidance provides OCC staff with detailed, step-by-step instructions on how reimbursement claims should be processed for urgent/emergency EOCs. It is important to note that reimbursement requests arrive as receipts or invoices that the Veteran has retained as a result of an out-of-pocket cost. The reimbursement claim must be accompanied by a written request for reimbursement that includes an explanation as to why the prescription was obtained from a non-CCN pharmacy. In addition to the written request, the following information is required for the claim:

(1) A valid receipt showing the amount paid
(2) Quantity dispensed
(3) Prescription information
(4) Name of the medication
(5) Medication dosage/strength
(6) Prescribed amount per day
(7) Number of units dispensed
(8) Prescribing provider's name
(9) Date the medication was dispensed
(10) Amount charged
(11) Amount paid
(12) Pharmacy name and location

6. **Procedure**

The Centralized Call Center staff is available 24/7 to assist in the emergency care notification process. Telephone and voicemail notifications received during regular business hours or by the VA Administrative Office of the Day (AOD) outside regular business hours should either be transferred to the Centralized Call Center for submission or submitted directly via the Emergency Care Reporting Portal. VA facility community care leadership must have a plan in place for training all internal VA staff involved in the emergency care notification process who reside

outside the facility community care office, for example, social workers, primary care clinic, specialty clinic, AOD and any other source of information entry.

- Emergency Care Reporting Portal

  https://emergencycarereporting.communitycare.va.gov/

- Centralized Call Center Telephone: 844.72HRVHA (844.724.7842)

The VA facility community care staff will be expected to retrieve a daily worklist from the ECAT SharePoint site to ensure they monitor and review the episode of care for care coordination, transfer, and discharge planning. The VA facility community care staff is required to check the ECAT SharePoint for new entries until such a time that an email notification system can be launched. A VA locator tool will identify the VA Medical Facility nearest to the community facility where the emergent treatment was provided and would be alerted via email through the designated email group created for this process.

Mail Enabled Security Email Group

The mail enabled security email group created to access the ECAT SharePoint worklist should contain all local stakeholders involved in the emergency treatment process (i.e. facility community care staff, bed control staff, transfer coordinators, and administrative officers of the day). It is important to remove/add members as needed to ensure that necessary staff have access to the ECAT SharePoint worklist. To remove or add a member to the email group, please contact the owner of your facility's email group. If you do not know who the owner is for your facility, your supervisor will be able to direct you.

7. **ECAT SharePoint**

Submitting Notifications in the Emergency Care Reporting Portal

Community providers, VA facility community care staff, Veterans, and Veteran Representatives are encouraged to utilize the Emergency Care Reporting Portal when providing notifications of a Veteran self-presenting to a community facility for an emergency EOC. This portal will be the most efficient method for providing patient-related information necessary for proper care coordination and eligibility determinations in a convenient and secure way.

If an individual is calling the VA Medical Center to provide notification and is unable to supply the information outlined, VA facility community care staff should engage the appropriate parties to attempt to collect the information.

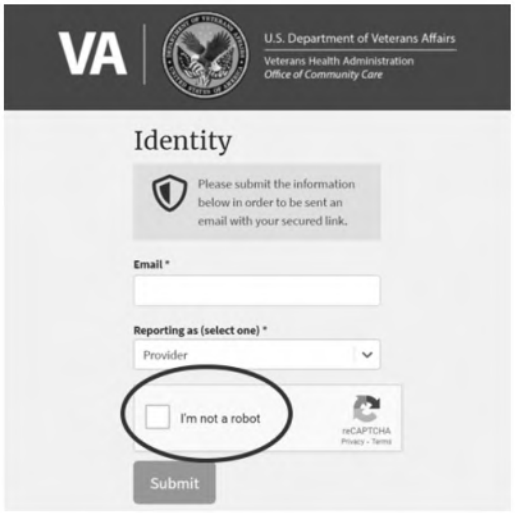
Notifications entered through the Emergency Care Reporting Portal by community providers, VA facility community care staff, Veterans, and Veteran Representatives will be uploaded directly into the ECAT SharePoint worklist currently being utilized by VA facility community care staff.

When entering notification information into the Emergency Care Reporting Portal, please follow the instructions below:

(1) Access the online portal via the link: https://emergencycarereporting.communitycare.va.gov/

(2) Once you arrive at the login screen, please enter your email address into the "Email" field

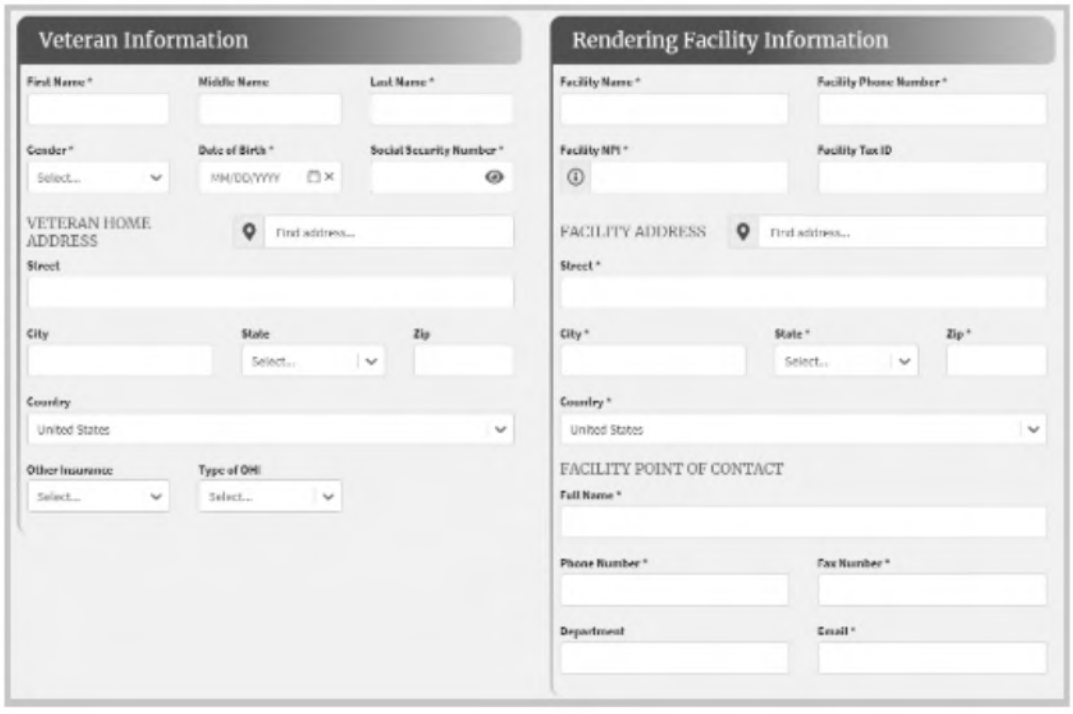
and select ‘VA Medical Center’ in the “Reporting as” field. Once entered, select the “I’m not a Robot” checkbox.



(3) Please follow the directions in selecting the appropriate images of the prompt to move forward and click “Verify”. Once the correct images have been selected, please select the “Submit” button

(4) Once submitted, you will see an “Email Sent” notification on the screen. The notification will inform you that an email has been sent with a secure link to the Non-VA Hospital Emergency Notification form. Please go to your email to access and utilize the link provided

(5) Once you access the link, you will see the Non-VA Hospital Emergency Notification portal, as shown below:



(6) In the top right of the screen, you will see the “Reporting as” field. Select ‘VA Medical Center’

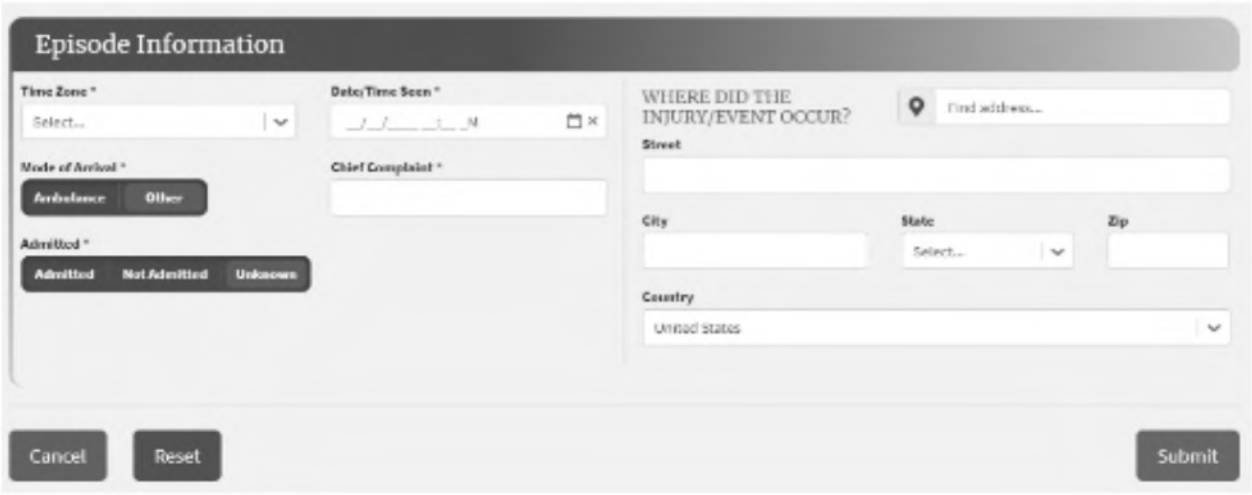
   a. The information fields in the tool will be the same for community providers and VA facility community care staff.

(7) Fill out all required fields

   a. Due to the possibility of the Veteran being homeless, the address field is not required

(8) Once the Veteran and facility information fields have been populated, the Episode Information fields must be filled in

   a. If the Veteran was admitted, there are additional fields required. Once all the information is complete, please hit the submit button.



Note: If notification submission is after the date of which it was received, (i.e. notification received on Saturday and submission is the following Monday) VA facility community care staff will continue to send notifications via email to (b)(6) @va.gov

Accessing the ECAT SharePoint Worklist

(1) Open the ECAT SharePoint: https://dvagov.sharepoint.com/sites/VHAOCCSEM/CIReports/EC/SitePages/CareCoordination.aspx

(2) Under the “VA Medical Center” tab, click on the “Notifications Needing Care Coordination”

   a. Select your VISN from the dropdown

   b. Retrieve the patient’s information and transcribe to the care coordination note

(3) Once care coordination has been initiated, click on the pad pencil icon to the left of the worksheet. A message from Webpage will appear stating “Are you sure you want to mark

care coordination started for patient XXXX?" If yes, click OK.

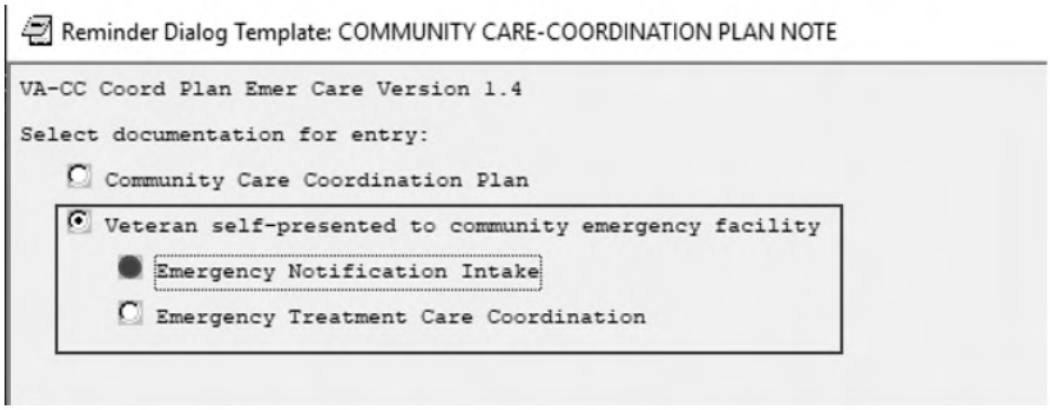
a. This will remove the patient from the worklist. If you need to retrieve the patient in the future, navigate to the search bar and utilize the notification ID or the Veteran's full Social Security Number.

Initiating the Care-Coordination Plan Note

(1) Open CPRS and select the Veteran.

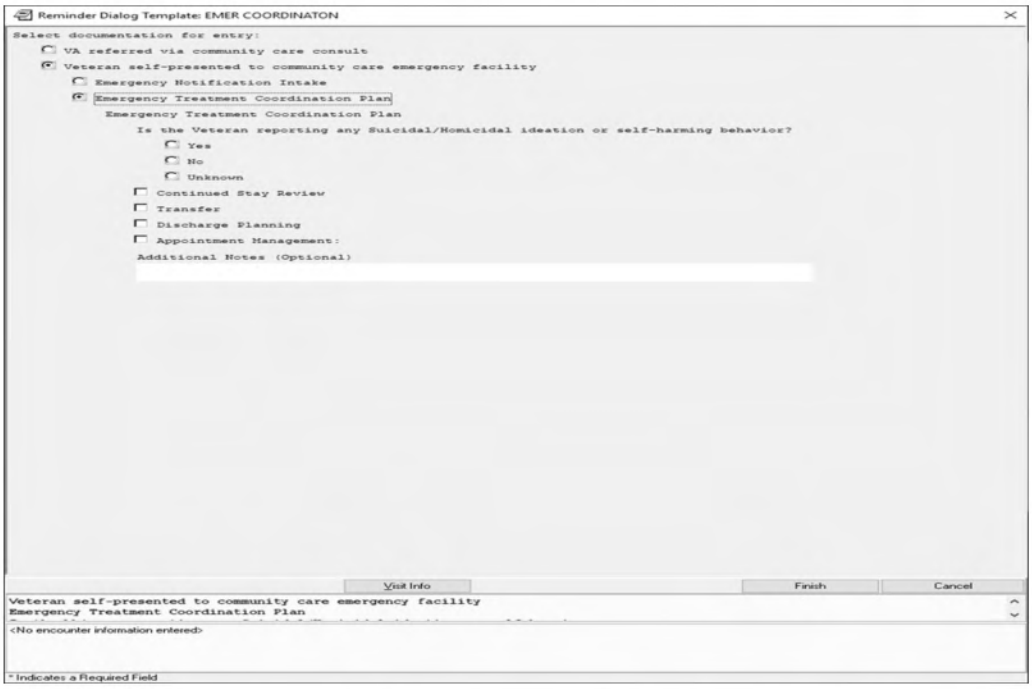
(2) Select the Community Care Coordination Plan Note as a new note.

(3) Select "Veteran self-presented to community care emergency facility" field.



(4) Once Emergency Notification Intake is selected, transcribe information from the centralized emergency care ECAT SharePoint site worklist.

(5) To conduct care coordination activities, select the original note in CPRS, use the “RELOAD BOILERPLATE TEXT” function in the Computerized Patient Record System (CPRS) to reload the template. Open the Emergency Treatment Care Coordination Plan and continue with care coordination activities. Depending on the status of the Veteran’s care, select Transfer, Discharge, or continued stay review. Add Notification ID in the Additional Notes free-text section of the Emergency Treatment Coordination Plan note for future reference.



(6) Utilize Notification ID to reference record in ECAT SharePoint and obtain visibility into decision of care.

(7) VA facility community care staff will contact the community facility for clinical information

related to care coordination and patient status.

(8) Complete all mandatory and pertinent fields in the Emergency Treatment Care Coordination section of the Community Care Coordination Plan note for timely and appropriate care coordination during the Veteran's community facility admission including discharge planning activity. Add the Interdisciplinary Team (IDT) staff, including the Transfer Coordinator, as additional signers.

Warm Handoff for Incorrectly Assigned Notifications

CAEC and POM should be notified if VA facility community care staff initiate care coordination for a notification in the ECAT SharePoint worklist that was incorrectly assigned to them. Since the notification has been archived and removed from the ECAT SharePoint worklist, VA facility community care staff should notify the Centralized Call Center and they should provide a warm handoff to the VA facility that has been verified as the closest VA facility. Please verify that the notification has been incorrectly assigned prior to conducting the warm handoff and notifying the Centralized Call Center by confirming in PPMS. Based on MISSION Act guidance, the correctly assigned VAMC will be the closest facility in miles, not the facility based on jurisdiction. For Community-Based Outpatient Clinics (CBOCs), the parent facility will be responsible for the notification and warm handoff to the CAEC.

Notification Corrections

VA facility community care staff can submit certain notification correction requests directly via the ECAT SharePoint worklist. To submit a request, follow the steps below:

(1) Access your ECAT SharePoint worklist

(2) Click on the red X icon to the left of the notification ID as shown:

Notification ID	Station	Hospital Notification Date	Date Presenting	Vet Last Name	Vet First Name
XXXXXXXXXXXX	VAMC 123	6/1/2020	6/1/2020	Patient	One
XXXXXXXXXXXXX	VAMC 123	6/1/2020	6/1/2020	Patient	Two

(3) Once you click the icon, a request form will appear with pre-defined reasons. You will need to select the field for correction by checking it off, at which point a free-text box will appear next to the field where you will type in the correction needed.

Note: Duplicate entries should now be submitted via this correction request. After the request has been submitted, VA facility community care staff must remove all duplicates from the worklist by clicking on the pad/pencil icon once care coordination is initiated.

(4) Click 'Send to POM for Review' at the end of the form to submit your notification correction request. If you have submitted a notification correction request for a notification in your worklist, you can refer to the Status column within your worklist to view the status designation.

Note: You will not be able to request corrections to a notification through this method after you have begun care coordination. Correction request should be submitted to POM before removing from your worklist.

Once correction request has been submitted and while POM is reviewing the request, payment determination cannot be made for that notification. The notification will temporarily relocate to a new SharePoint worklist for POM specifically to review notifications needing corrections. VA facility community care staff should initiate care coordination activities at this time if able.

An email will be automatically sent to the requestor's VA email address notifying them of the correction requested review completion. When POM completes the review for a notification that is still in your ECAT SharePoint worklist, the status of the notification will simply update to reflect the new status determination. If the correction request review is for a notification where care coordination has already been initiated, the notification will not repopulate the "notifications needing care coordination" worklist. If the notification has been removed from your ECAT SharePoint worklist, and you need to review POM actions, you can search by Notification ID under active or archived notifications. VA facility community care staff should initiate care coordination activities at this time if able and otherwise not underway.

Note: The notification will remain in your "notifications needing care coordination" worklist until marking 'care coordination started'. Once corrections needed have been requested, you can click on the notepad icon to the left of the red X icon to begin care coordination. This will remove the notification from the worklist.

Administrative Consult Option

Each site can work with their local Clinical Applications Coordinator (CAC) to add a care coordination administrative consult to the Community Care-Coordination Plan note. The addition of an administrative consult provides the option for VAMCs to track Veterans who self-presented for emergency care in the community. These Veterans are visible on the ECAT SharePoint site but cannot be tracked via the care coordination option within HSRM. Please note, it is up to each individual site to determine their own internal process for managing and closing the care coordination administrative consult. In doing so, VAMCs will maintain an accurate reflection of current consult volumes by status. We ask that you notify the OCC Emergency Care team via email at VHAOCCEmergencyCareTeam@va.gov if your site would like to incorporate the care coordination administrative consult within the Community Care-Coordination Plan note template.

Scanning Medical Documents

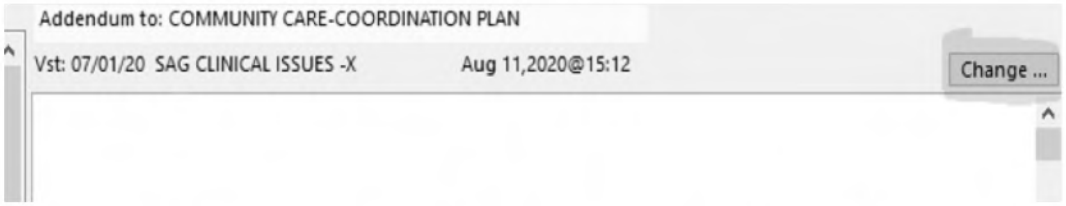
Medical documents from community providers can no longer be scanned and attached to a consult. The Community Care-Coordination Plan note should be utilized for uploading any of these documents. If the date of the Community Care-Coordination Plan note does not match the Date of Service for the EOC, VA facility community care staff can modify the date and time for the note sequencing in CPRS. The note can then be searched by the Date of Service rather than the creation date of the note. When modifying the date/time of the note to match the Date of Service, the VA facility community care staff must provide a justification for the change made. To modify the date/time of the note:

(1) If a Community Care-Coordination Plan note for the Episode of Care has already been created, utilize the existing note from CPRS to modify the date and accurately reflect the Date of Service.

a. Select the existing Community Care-Coordination Plan note

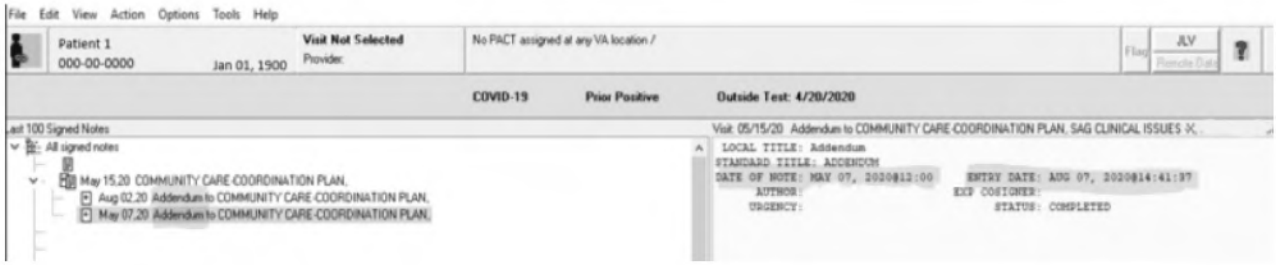
b. Click on Action Tab and select Make Addendum

c. Click on Change, as highlighted below:



d. Modify the Date/Time of Note to reflect the Date of Service:

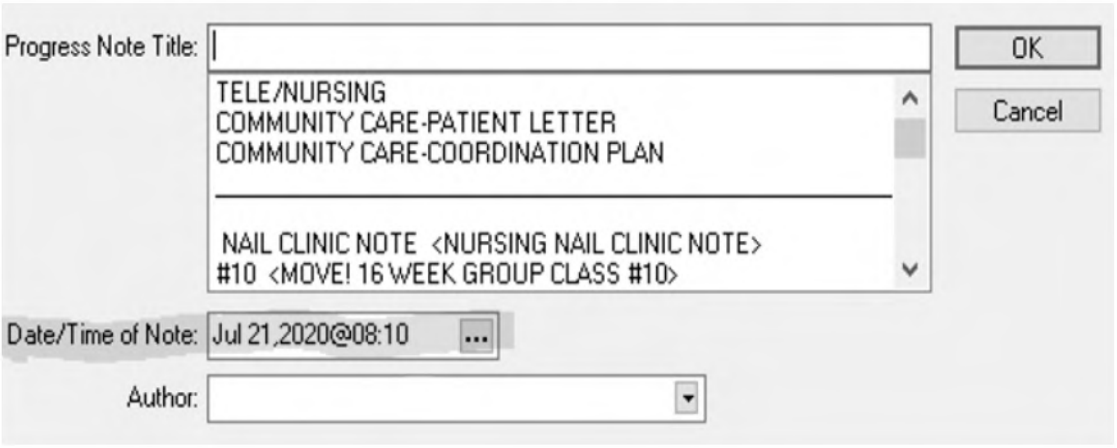
e. Once modified, you will be able to see the addendum date listed under the note:



(2) If there is no existing note for the Episode of Care, create a New Note in CPRS.

a. For the Progress Note Title, select the “Community Care-Coordination Plan” note

b. Modify the Date/Time of the Note to reflect the Date of Service as shown:



(3) Once modified, you will be able to see the Date of the Note and the Entry Date as highlighted below:

(4) Attach any medical records received to the note.

(5) Notify pertinent care coordination specialists, including PACT team, of date/time

modification.

8. **Continued Stay Review**

(1) Continued stay reviews are required on all Veterans in the community facility unless there is evidence that the Veteran refuses information sharing.

(2) Continued stay reviews are conducted in accordance with level of care and local policy and procedures. Complete all fields as applicable.

(3) Determine stability of patient.

a. If the patient is not stable, continue updating the continued stay review status until the patient is stable for transfer to VA or other discharge disposition is communicated.

b. If the patient is stable, notify VA Bed Management Solutions (BMS) personnel and follow local policy and procedures to facilitate Veteran transfer to VA.

Note: *Medical stability is defined as an acute care patient able to reasonably sustain a transport in a staffed ambulance, with no expected increase in morbidity or mortality*

(4) If a VA bed and appropriate services are available, determine if Veteran is willing to transfer, follow local transfer policy and VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017. Local or state forms which provide all the required information can be

accepted as an alternative to the VA Form.

(5) If Veteran is not willing to transfer, request the community facility complete VA Form 10-8001 Refusal of Transfer to VA Healthcare Facility. Scan the signed document into VistA imaging and attach to the Patient Only (Administrative) section, and document action in the transfer section of the Emergency Treatment Coordination note. Notify the Centralized Call Center of the refusal to transfer via an encrypted email utilizing the Refusal to Transfer email template. Include the Notification ID and date of refusal. If the Notification ID is not available, include Veteran's name, Date of Birth or Social Security Number, and Date of Admission in the email. Send email to (b)(6) @va.gov.

(6) If a Veteran's continued stay review is longer than 30 days, notify the Centralized Call Center of the discharge date and Notification ID via an encrypted email utilizing the Length of Stay Greater Than 30 Days email template. If the Notification ID is not available, include Veteran's name, Date of Birth or Social Security Number, and Date of Admission in the email. Send email to (b)(6) @va.gov. This will allow an additional authorization to be added into the system for payment of claims beyond the 30 days.

9. **Inter-facility Transfer**

(1) Facilitate patient transfer to a VA facility. Follow local Inter-facility transfer policy following VHA Directive 1094.

(2) Utilize the Community Care Coordination Plan Note "Clinical Care Coordination/Transfer status section".

a. Determine stability of patient for transfer.

b. If the patient is not stable, continue updating the continued stay review status until the patient is stable for transfer to VA or other discharge disposition and document accordingly.

c. If the patient is stable, identify VA BMS personnel and follow local policy and procedures to facilitate patient transfer to VA.

d. If a VA bed and appropriate services are available, determine if Veteran is willing to transfer, follow local transfer policy, and VHA Directive 1094 Inter-Facility Transfer Policy. Local or state forms which provide all the required information can be accepted as an alternative to the VA Form.

e. If Veteran is not willing to transfer, request the community hospital facilitate completion of the VA Form 10-8001 Refusal of Transfer to VA Healthcare Facility. Scan the signed document in VistA imaging and attached to the Patient Only (Administrative). Document action on the Clinical note section.

Critical Point: *Decision to transfer patient from community facility to VAMC inpatient bed is based upon a patient centered plan of care, which includes consideration of average length of stay for the appropriate diagnosis-related group, medical necessity, patient stability, and appropriate level of care.*

f. If discharged from a Community Facility, facilitate coordination of discharge planning

and post follow-up care per local policy (including durable medical equipment, oxygen therapy, follow-up VA and Community appointments, medications, lab work, etc.).

g. Document discharge and/or transfer plans and actions in the Community Care Coordination Plan note in CPRS, adding additional signers as appropriate.

10. Locating HSRM Authorization

How to find the HSRM Referral ID on the ECAT SharePoint site:

(1) Select and copy the Notification ID number from the ECAT SharePoint worklist identifying the Veteran

(2) On the left-hand side of the screen, select search "Active" if Veteran is still active on the worklist or search "Archive" if care coordination has started and removed from the worklist

(3) Paste the notification ID number on the search parameter field

(4) Click on "Search"

(5) Click on the pad/pencil icon to the left of the notification ID number

(6) Scroll down to the end and you will see the HSRM Referral ID which is the authorization number for the Community provider

Note: A HSRM referral ID is available when determination for USC 1703 has been completed. All entries labeled "draft status" or "submit for USC 1728/1725" will not have an authorization number as they are retrospectively reviewed by POM. The authorization number/HSRM referral ID can be located in the TriWest/Optum portals by searching with the HSRM referral ID number. For questions regarding authorizations under USC 1728/25 please contact POM. POM Claims Status Line: 1-877-881-7618

11. IT System Requirements

(1) VA Bed Management Solutions (BMS)

(2) Computerized Patient Record System (CPRS)

(3) Health Share Referral Management (HSRM)

(4) Electronic Claims Adjudication Management System (eCAMS)

(5) Provider Profile Management System (PPMS)

(6) VA Centralized Emergency Care Authorization Tool SharePoint (ECAT)

References

VHA Directive 1094

Field Guidebook

VHA Patient Flow Guidebook

Flow Coordination Center Toolkit

Inter-Facility Transfer Form (VA Form 10-2649A)

Length of Stay Greater than 30 Days Notification Email Template

Refusal to Transfer Notification Email Template

Refusal of Transfer to VA Health Care Facility Form

Emergency Care Authorization Tool

How to navigate ECAT SharePoint worklist: VA facility community care staff is responsible to view the VA ECAT SharePoint site worklist daily to capture all new notification intake information to begin care coordination activities: https://dvagov.sharepoint.com/sites/VHAOCCSEM/CIReports/EC/SitePages/CareCoordination.aspx

- Open SharePoint with the link provided.
- Under "VA Medical Center" tab, click on "Notification Needing Care Coordination".
- Select your VISN from the dropdown.
- Select your station from the dropdown.
- Retrieve the patient's information and transcribe to the care coordination note.
- Once care coordination has been initiated, click on the pad pencil icon to the left of the worksheet. A message from Webpage will appear stating "Are you sure you want to mark
- care coordination started for patient XXX?". If yes, click OK.
- This will remove the patient from the worklist. If you need to retrieve the patient in the future, navigate to the search bar and utilize the notification ID or the Veteran's full Social Security Number.

Managing Emergency Notifications in Collaboration with Community Providers

VAMC staff are required to coordinate care and assist with educating providers on needed information to assist with prompt authorization for emergency care notifications.

The Department of Veterans Affairs (VA) implemented the Community Care Centralized Authorized Emergency Care (CAEC) notification process to improve and enhance the existing emergency care notification process described in 38 CFR 17.4020. There are two elements to this process; care coordination and notification. Care coordination and patient transfer activity should be conducted directly between the local VA medical center and the community emergency department. Local VAMC staff are responsible for care coordination and transfer activity when notified of a Veteran receiving treatment at a community emergency department. The notification process is administered by VA's Emergency Care Centralized Notification Center. Community providers are asked to notify VA of a Veteran who self-presents to an emergency department within 72 hours of the start of the episode of care.

How to navigate ECAT SharePoint worklist: VA facility community care staff is responsible to view the VA ECAT SharePoint site worklist daily to capture all new notification intake information to begin care coordination activities: https://dvagov.sharepoint.com/sites/VHAOCCSEM/CIReports/EC/SitePages/CareCoordination.aspx

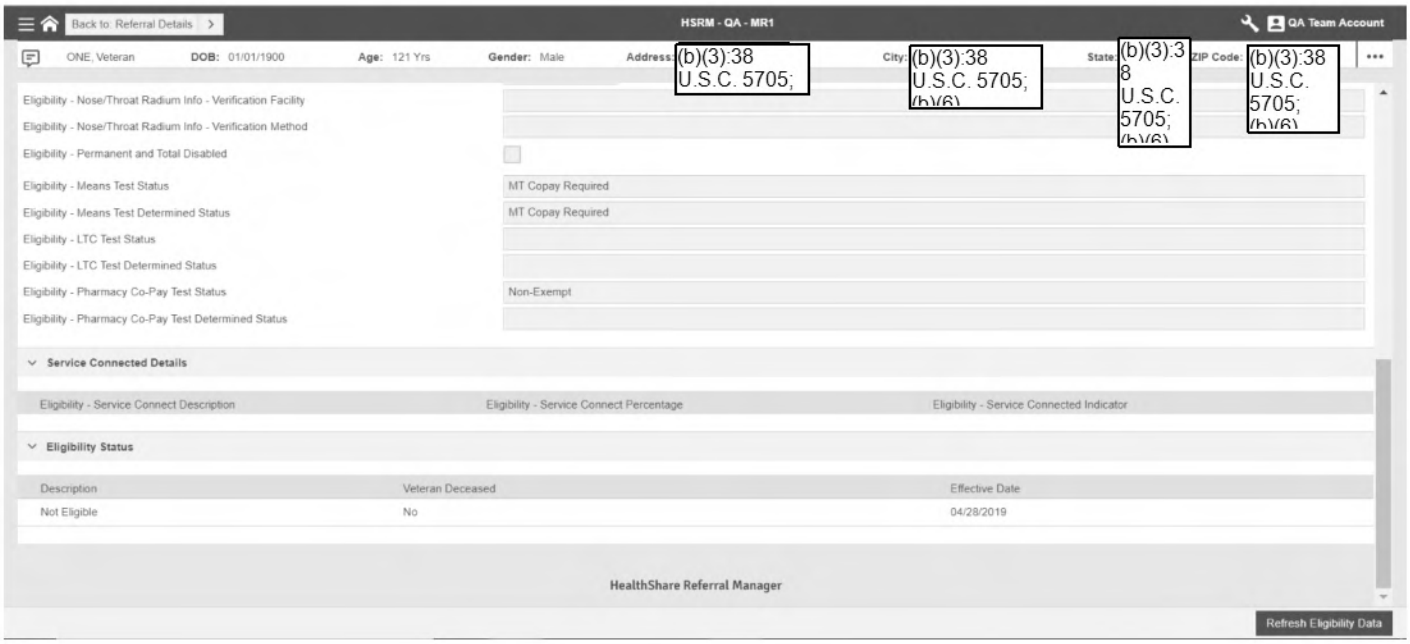
- Open SharePoint with the link provided.
- Under "VA Medical Center" tab, click on "Notification Needing Care Coordination".
- Select your VISN from the dropdown.

- Select your station from the dropdown.
- Retrieve the patient's information and transcribe to the care coordination note.
- Once care coordination has been initiated, click on the pad pencil icon to the left of the worksheet. A message from Webpage will appear stating "Are you sure you want to mark
- care coordination started for patient XXX?". If yes, click OK.
- This will remove the patient from the worklist. If you need to retrieve the patient in the future, navigate to the search bar and utilize the notification ID or the Veteran's full Social Security Number.

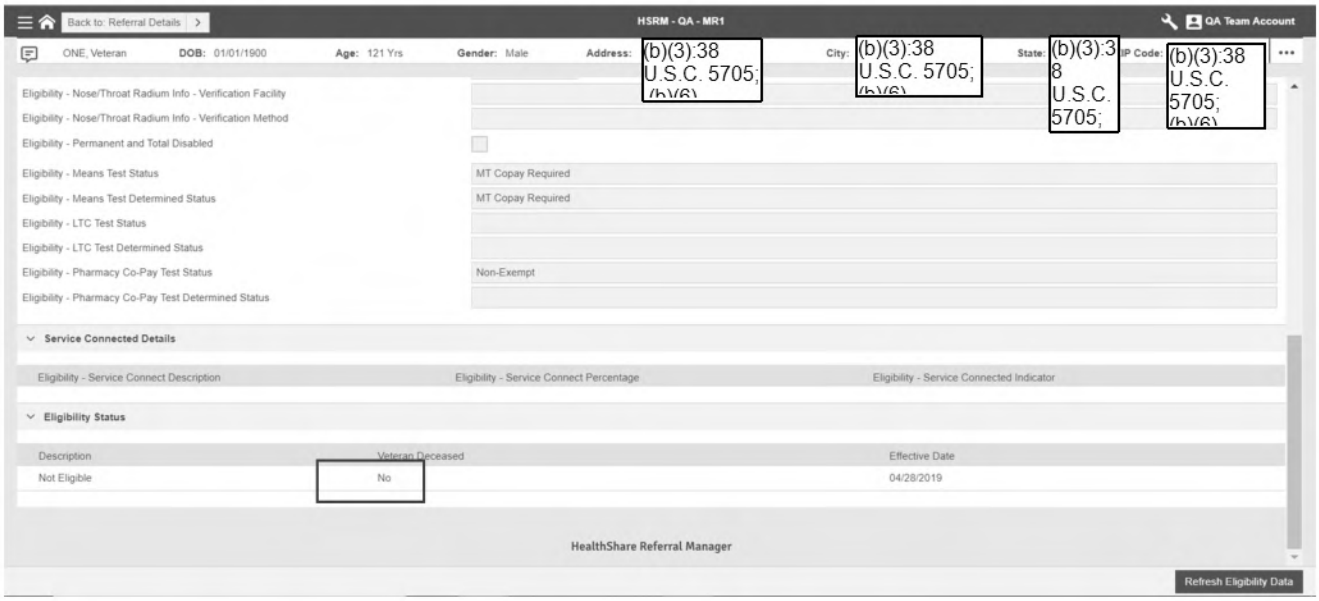
Utilizing ECAT SharePoint to Create Referrals for In-Network Deceased Veterans

On November 23, 2020, the HSRM Release 11 hard stop eligibility requirement caused an unintended consequence for deceased Veterans who are automatically assigned an X code upon entry of a date of death.

If no eligibility status is present or if any combination of status includes an 'X' Veteran Community Care Eligibility (VCE) code of "Not Eligible", a user is prevented from sending a referral through the system.



UPDATE: Users will be able to process a referral when the enrollment status of a Veteran in HSRM has a deceased 'X' code. Users will see a new field added to the Eligibility page in HSRM labeled 'Veteran Deceased' which will display as a 'yes' or 'no'.



The HSRM solution is due for release Q4 2021 and therefore, the ECAT SharePoint will no longer be utilized to create referrals for deceased Veterans.

Note: Enrollment status must be validated to ensure the Veteran was eligible for community care prior to the date of death.

3.7 Urgent Care Benefit

What is the Urgent Care Benefit?

- As part of implementing the VA MISSION Act of 2018, VA began offering urgent care services to provide Veterans with greater access to timely, high-quality care.
- Urgent care providers treat injuries and illnesses that require immediate attention but are not life-threatening, such as influenza, minor burns, and skin infections.
- This benefit is considered open access, allowing Veterans to access urgent care within VA's network and receive care without prior authorization from VA. The benefit first became available in June 2019.

Administration of the Urgent Care Benefit

- The urgent care benefit is only available through a Third-Party Administrator (TPA).
- Initially, TriWest built the urgent care network under the Patient Centered Community Care (PC3) contract as the TPA.
- On March 18, 2020, the urgent care benefit transitioned from TriWest to Optum as the TPA for Region 1 only.

- On September 1, 2020, the urgent care benefit transitioned from TriWest to Optum as the TPA for Regions 2 and 3.
- Effective **September 30, 2020**, the contract vehicle for urgent care benefits in VA's CCN Region 4 will transition from Patient-Centered Care (PC3) to the Community Care Network (CCN).
- TriWest will continue to be the TPA for Regions 4-6.

The VHA Office of Community Care (OCC) released a video overview of the urgent care benefit for Veterans as provided under the VA MISSION Act. The video, available on YouTube, is entitled **Veteran Community Care: Urgent Care,** and is available here: https://youtu.be/Jk-eg4N29w0

Difference between Urgent Care and Emergency Care

- Urgent care is defined as medical services provided for illnesses or injuries which require prompt attention but are not life-threatening such as strep throat, pink eye or influenza.
- Emergency care is defined as inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health such as severe chest pain; seizures or loss of awareness; heavy uncontrollable bleeding; or moderate to severe burns.
- Urgent care is not a replacement for care a Veteran might need in an emergency. If a Veteran has a medical emergency or requires immediate assistance due to an accident or injury, they should call 9-1-1 immediately.

Eligibility

- Veterans are eligible for the urgent care benefit if they are enrolled in VA health care and have received care through VA within 24 months prior to receiving urgent care. Urgent care eligibility can be found in the Computerized Patient Record System (CPRS), the Enrollment System (ES), VistA, and the Decision Support Tool (DST)/CTB 2.0 CC Eligibility tab in the consult toolbox.
- Eligible Veterans are able to access an urgent care provider in VA's network and receive care without prior authorization from VA.
- VA provides a daily urgent care eligibility file to the TPA containing a "U" code for eligible Veterans produced by the Enrollment System through the DAS system. The file includes:
    - Veteran Demographics
    - A "U" code, indicating Urgent Care eligible
    - Priority Group for general copayment questions
    - Associated VAMC for medical record submission
- The TPA is responsible for providing eligibility information to their network of providers. The TPA makes this eligibility information available to their network of Retail and Urgent Care locations via an Interactive Voice Response (IVR) system that operates 24 hours a day and 7 days a week.
- The TPA instructs urgent care locations to confirm the Veteran's eligibility via the IVR prior to rendering care. If a provider does not check a Veteran's eligibility using the

TPA's IVR system, Veterans will have difficulty filling any prescriptions resulting from the urgent care visit.

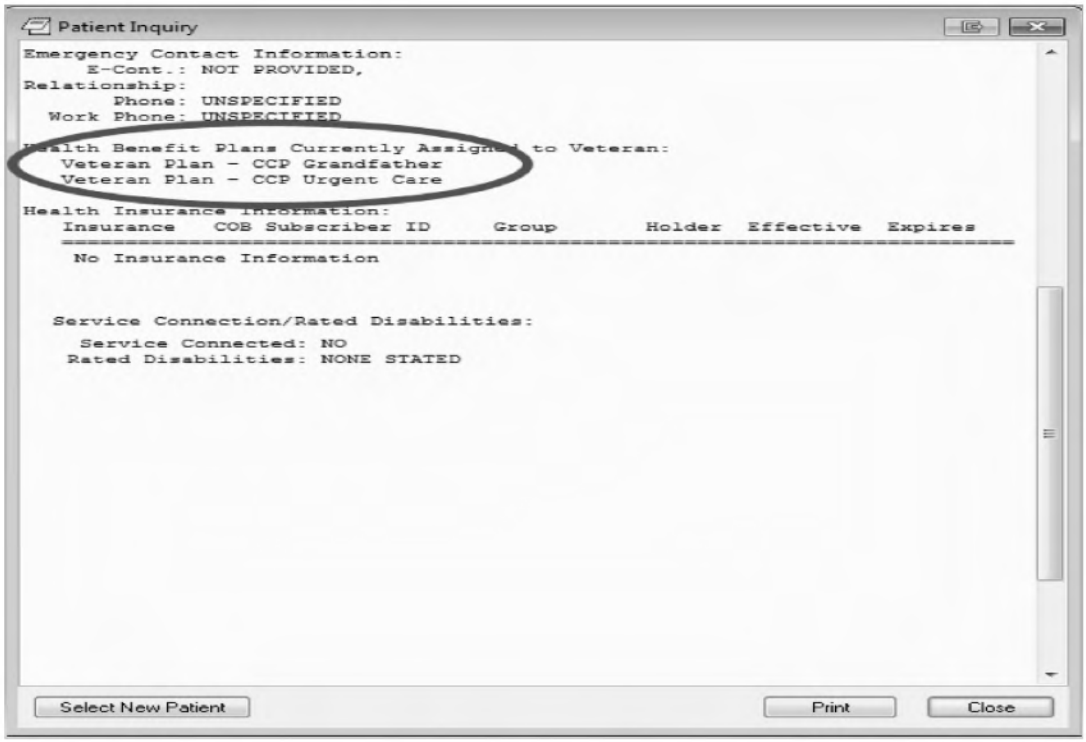
How to Check a Veteran's Eligibility
VA staff should use the following procedures to determine if a Veteran is eligible for the urgent care benefit.

PROCEDURES

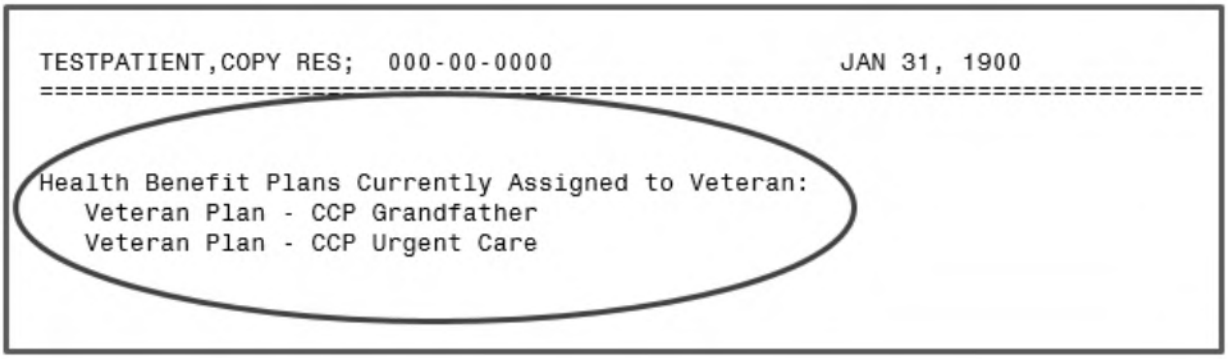
General Considerations:

The purpose of this process is to check a Veteran's eligibility for the urgent care benefit when a general inquiry is made to VA. The five options for determining this information are the Computerized Patient Record System (CPRS), the Enrollment System (ES), Veterans Integration System Technology Architecture (VistA), the DST/Consult Toolbox 2.0 CC Eligibility tab, and by IVR. VA staff can use any of these tools to verify a Veteran's eligibility information.

STEP	ACTIVITY
1	**CPRS PATHWAY** Log into CPRS and search for the Veteran under consideration.
2	**Navigate to the Patient Inquiry window** Click on the Veteran's name in the upper left corner of the screen. Open the Patient Inquiry window with demographic information.
3	**Review eligibility criteria shown** Review the eligibility criteria shown to see if the Health Benefit Plan "Veteran Plan – CCP Urgent Care" is listed. If the plan is listed, the Veteran is eligible for the urgent care benefit.

PROCEDURES	
	 Health Benefit Plan Names as Shown in CPRS
4	**VistA PATHWAY** Log into VistA with your credentials. To access the Patient Inquiry Option, type Patient Inquiry, press <Enter>
5	**Search for Veteran's Record** Enter the identity traits (for example SSN, Member ID, or First Letter of Last Name and last four of SSN, etc.) to search for record (depending on the identity traits used, the record will present, or staff must select the appropriate patient)
6	**Review eligibility criteria shown** Press <Enter> until you get to the page that displays the Health Benefit Plan (HBP) information. Review the eligibility criteria shown to see if the Health Benefit Plan "Veteran Plan – CCP Urgent Care" is listed. If the plan is listed, the Veteran is eligible for the urgent care benefit.

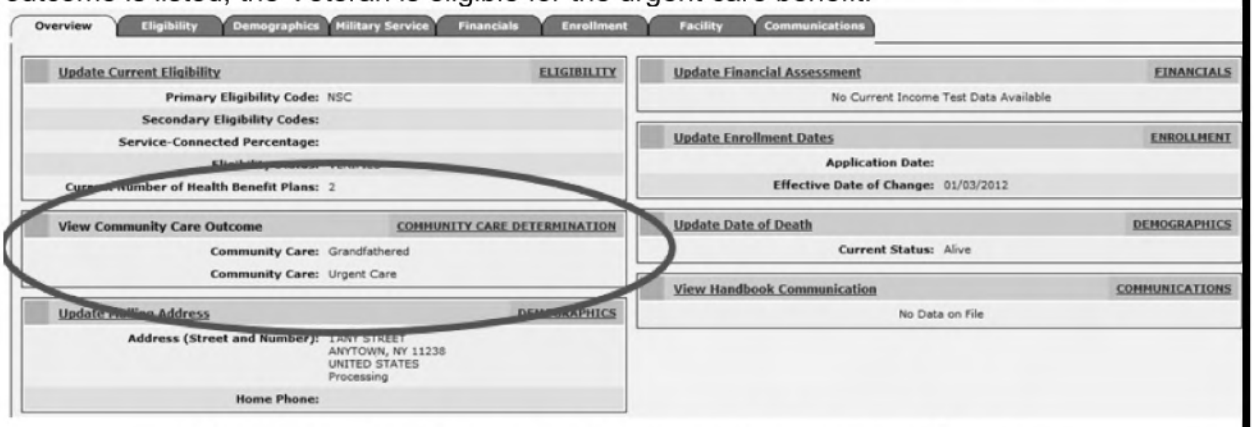
PROCEDURES



Health Benefit Plan Names as Shown in VistA

Note: The HPBs can also be viewed using the following DG VistA options: View Registration Data, Load/Edit Patient Data, Register a Patient, Eligibility Verification on Screen 11, select 5.

7	**ES PATHWAY** Log into ES and search for the Veteran under consideration
8	**Community Care Outcome Panel** View the Community Care Outcome Panel
9	**Review eligibility criteria shown** Review the eligibility criteria shown to see if the outcome “Urgent Care” is listed. If the outcome is listed, the Veteran is eligible for the urgent care benefit.
10	**IVR PATHWAY** A Veteran or VA staff can check a Veteran’s urgent care eligibility at any time using an automated Interactive Voice Response (IVR).



Community Care Outcomes as Shown in the Enrollment System

PROCEDURES	
	When a Veteran walks into an urgent care location, the urgent care location must dial into their TPA's Interactive Voice Response (IVR) to check the Veteran's eligibility for urgent care. This call triggers the Veteran's pharmacy eligibility for any prescriptions resulting from the urgent care visit. The IVR for Veterans will be accessible through the MyVA311 line at 1-844-MyVA311 (1-844-698-2311). Beginning March 18, 2020, providers can check eligibility by contacting their respective TPA IVR line. The urgent care location calls their TPA's IVR to check urgent care eligibility. • Providers at TriWest urgent care locations call 833-4VETNOW (833-483-8669) • Providers at Optum urgent care locations call 888-901-6609

The Urgent Care Network: Retail vs. Urgent Locations

- Community providers must be part of VA's contracted network to provide care to Veterans under the urgent care benefit.
- Providers must enter into a contract with the TPA for their region to provide urgent care services.
- There are two types of urgent care network locations: **urgent** and **retail.**
    - **Retail (POS 17)** locations include: a walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic located within a retail operation. Retail locations provide preventive and primary care services on an ambulatory basis.
    - **Urgent (POS 20)** locations include an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention for conditions that to do not require a visit to the emergency room.

Finding an Urgent Care Location

- Veterans can search for urgent and retail locations in their area using VA's Provider Locator tool at https://www.va.gov/find-locations/
    - Job Aid Urgent Care VA-gov Provider Locator
- Veterans can also always find a location by contacting their local VA medical facility.
- VA's Provider Profile Management System (PPMS) indicates whether network providers and pharmacies (contracted through the appropriate TPA) are a Retail (POS 17) or Urgent Care (POS 20) location. This allows in-network

locations that offer the urgent care benefit to be identified through the PPMS Provider Locator.

- Network locations will post TPA-developed signage to indicate they are a VA Urgent Care benefit participating location.

Important: The urgent care location must be part of VA's network in order for VA to pay for the care. Veterans can contact their local VA medical facility prior to seeking care to find an urgent care location in VA's network or they can use VA's facility locator tool.

TPA Urgent Care Network Development

If a VAMC or VISN in CCN Regions 1-3 has specific urgent care provider needs, please submit those requests to https://www.vacommunitycare.com portal under "I Am A VA Staff Member".
If a VAMC or VISN in CCN Regions 4-6 have specific urgent care provider needs, please send those requests to (b)(6) @triwest.com.

Copayment

There are copayments associated with the urgent care benefit that are different from current VA medical copayments. The copayments depend on the Veteran's assigned priority group and whether or not a Veteran is in a copay required status.

There is no limit on the number of times a Veteran is able to access the urgent care benefit.

- Copayment charges are billed separately by the VA as part of VA's normal billing process. Copayments are not paid at the time a Veteran receives care at the urgent care provider.
- Please contact the VA Health Resource Center (HRC) for questions related to copayments at 1-877-222-VETS (8387).
- For additional information on Veteran copayments, visit: https://www.va.gov/COMMUNITYCARE/revenue_ops/copays.asp

Priority Groups

- **Priority Groups 1-5**. There is no copayment for the first three visits during a calendar year. For the fourth visit and all subsequent visits in a calendar year, the copayment is $30.
- **Priority Group 6.** There is no copayment for the first three visits during a calendar year if the visit is related to special authority or exposure. For the fourth visit and all subsequent visits in a calendar year, the copayment is $30. If the visit is not related to special authority or exposure, the copayment is $30 per visit, regardless of which visit it is.
- **Priority Groups 7-8**. The copayment is $30 per visit.

- **Priority Groups 1-8**: No copayment for a flu shot-only visit. Visits consisting only of a flu shot do not count as a visit for the number of visits in a calendar year for eligible Veterans.
- Special authorities include those related to combat service and exposures (e.g. Agent Orange, active duty at Camp Lejeune, Ionizing Radiation, Project Shipboard Hazard and Defense (SHAD/Project 112), Southwest Asia Conditions) as well as Military Sexual Trauma, and presumptions applicable to certain Veterans with psychosis and other mental illnesses.

Copayment Quick Reference Table

Priority Group(s)	Copayment Amount
1-5	• No copayment for the first three visits during a calendar year. • For four or more visits in a calendar year, the copayment is $30.
6	• If the visit is related to a condition covered by special authority or exposure: ○ First three visits (per calendar year), the copayment is $0. ○ Fourth and greater visits (per calendar year), the copayment is $30. • If not related to a condition covered by a special authority or exposure, the copayment is $30 per visit.
7-8	• Copayment is $30 per visit
1-8	• $0 copay for visit consisting of only a flu shot

Pharmacy

Urgent Care Pharmacy Eligibility Process for the Retail Pharmacy Network

- For urgent prescriptions written by an urgent care provider, Veterans have the option to fill eligible prescriptions at a contracted pharmacy within the VA network.
- The current process in place for urgent care pharmacy eligibility notification to the TPA's pharmacy network is as follows:
    - The urgent care location calls their TPA's IVR to check urgent care eligibility

  - Providers at TriWest urgent care locations call 833-4VETNOW (833-483-8669)
  - Providers at Optum urgent care locations call 888-901-6609
- The call to the TPA's IVR system generates a task for TPA staff to update the Veteran's profile to activate their prescription benefit for two days
- TPA staff then update the Veteran's profile to extend their prescription benefit
- If a provider does not check a Veteran's eligibility using the TPA's IVR system, Veterans will have difficulty filling any prescriptions resulting from their urgent care visit.
- In this situation, the Veteran or pharmacist will need to call the TPA-specific on-site assistance number to manually update the Veteran's profile.
- Veterans must fill their prescription at a Pharmacy in the same state as their urgent care visit to prevent eligibility issues.
- Effective **September 1, 2020**, Veterans can find in-network pharmacy locations by visiting the VA.gov Provider Locator (https://www.va.gov/find-locations) VA staff can also use the VA.gov Provider Locator to assist the Veteran in finding an in-network location to fill their prescription.

Submitting Prescriptions

Routine prescriptions – All routine prescriptions should be forwarded to VA pharmacy for processing and fulfillment.

The prescription and any documentation must be submitted to the VA to be filled by a VA pharmacy. VA will verify the urgent care visit information before filling by verifying the Veteran's urgent care eligibility and verifying that the prescription came from an urgent care network location.

Community urgent care providers are required to fax, mail, or electronically prescribe non-urgent/emergent prescriptions to the appropriate VA pharmacy. Incomplete prescriptions will not be processed and will be returned to the prescribing provider to re-submit to VA for re-processing once completed.

Dispensing Prescriptions

- The TPA's procedures must instruct the Veteran to go to a local pharmacy in the retail pharmacy network established by the TPA's PBM.
- An urgent/emergent prescription is available for a maximum fourteen (14) day supply of medication without refills **(or shorter supply of opioid medication if required by state law)**, when it is determined medically appropriate by the urgent care provider.

- The TPA will not approve any claims for compounded medications. Retail pharmacy network prescriptions that are not dispensed will be reversed seven (7) days after the date they were filled.
- The TPA will ensure that network pharmacies have procedures to reasonably assess the validity of prescriptions ordered by fax, telephone, or e-prescribing. The TPA will educate its contracted providers and confirm that all applicable prescription information is submitted with each prescription request.
- The TPA will ensure that the retail pharmacist dispenses prescriptions in accordance with VA's urgent/emergent formulary linked from: https://www.pbm.va.gov/PBM/NationalFormulary.asp

In-Network Claims and Copayments

- Prescription claims at participating retail pharmacies will be submitted to the TPA for adjudication at the point of care and the Veteran will not have out of pocket expenses for prescriptions filled at retail pharmacy location.
- If the Veteran brings their urgent/emergent prescription to a VA pharmacy, the VA pharmacy staff will be able to verify the urgent care location is part of the TPA's network as well as the Veteran's eligibility with a Computerized Patient Record System (CPRS) or Enrollment System (ES) electronic tools.
- Pharmacy prescription copayments still apply (where applicable based on priority group) and are not included in the copayment for the urgent care visit. For more information about pharmacy copayments, please visit the VA.gov Health Benefits Copay Rates website: https://www.va.gov/healthbenefits/cost/copay_rates.asp

Pharmacy Reimbursement

If a Veteran fills an urgent/emergent prescription at a non-network retail pharmacy location, then the Veteran must pay for the prescription up-front and then request reimbursement from the local VAMC. NOTE: Veteran prescription reimbursement processes for episodes of care approved under 38 U.S.C. 1725 and 1728 have not changed and will be processed as usual.

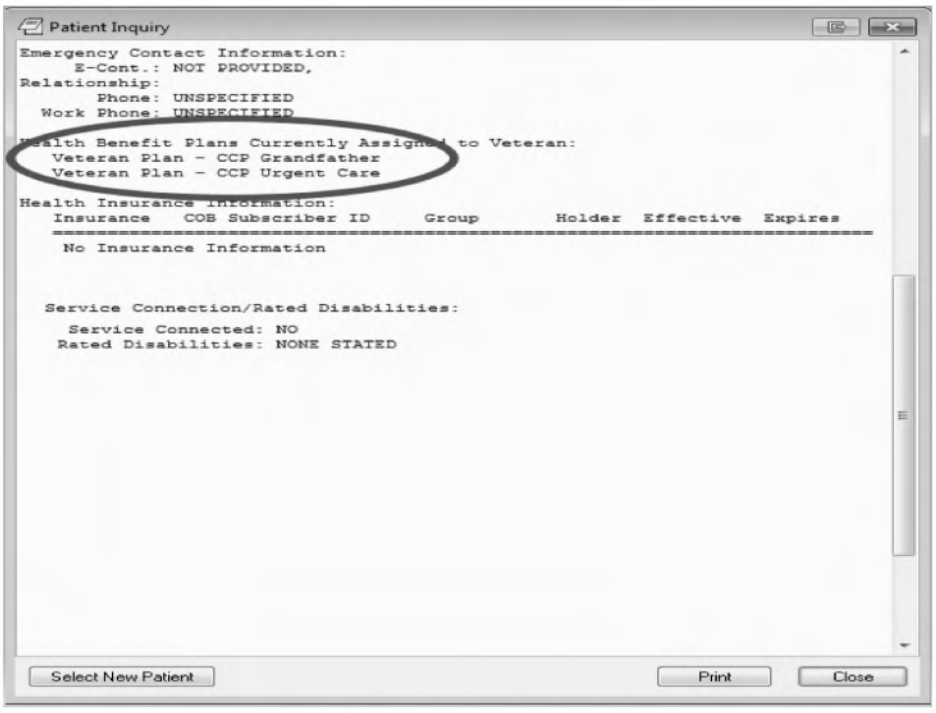
The regulation allows for payment or filling of over the counter items. The limit is for up 14 days.

- Prescriptions: Notwithstanding any other provision of this part, VA will:
    - Pay for prescriptions written by qualifying Non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for urgent care no longer than 14 days.
    - Fill prescriptions for urgent care written by qualifying Non-VA entities or providers for eligible veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

- Pay for prescriptions written by qualifying Non-VA entities or providers for eligible veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent conditions (e.g., splints, crutches, manual wheelchairs).
- Payments. Payments made for urgent care constitute payment in full and shall extinguish the veteran's liability to the qualifying Non-VA entity or provider. The qualifying Non-VA entity or provider may not impose any additional charge on a veteran or his or her health care insurer for any urgent care service for which payment is made by VA. This section does not abrogate VA's right, under 38 U.S.C. 1729, to recover or collect from a third party the reasonable charges of the care or services provided under this section.

- Reimbursement requests will be forwarded to the claims processing department.
- The claims processor will validate that the veteran was eligible for the MISSION Act Urgent Care benefit at the time of services and has received care from an approved urgent care vendor validated through use of the provider locator tool appropriate for the region in which the care was rendered.
- The Community Care program does not reimburse for recurring or refill medications.
- VA Pharmacists do not need to conduct retrospective Formulary reviews for prescriptions that may lead to the denial of reimbursement of a Veteran's urgent/emergent prescription filled at a retail pharmacy.
- Review the Veteran Prescription Reimbursement SOP for the payment process.

How to Determine a Veteran's Eligibility for VA Pharmacy Fulfillment

PROCEDURES	
General Considerations: This guidance describes the process for determining a Veteran's eligibility for fulfillment of an urgent care prescription at a VA pharmacy. There are two parts of the process: **1)** checking the Veteran's eligibility for urgent care, and **2)** checking if the prescribing location is in the TPA network.	
STEP	**ACTIVITY**
1	CPRS PATHWAY Log into CPRS and search for the Veteran under consideration.
2	Navigate to the Patient Inquiry window Click on the Veteran's name in the upper left corner of the screen. Open the Patient Inquiry window with demographic information.
3	**Review eligibility criteria shown** Review the eligibility criteria shown to see if the Health Benefit Plan "Veteran Plan – CCP Urgent Care" is listed. If the plan is listed, the Veteran is eligible for the urgent care benefit. 
4	Navigate to the VA.gov provider locator at: https://www.va.gov/find-locations Use the Job Aid Urgent Care VA-gov Provider Locator for step by step process on how locate VA approved urgent care locations and pharmacies using the Locator Tool

Durable Medical Equipment (DME)

The TPA will ensure that providers submit all prescriptions for routine DME and medical devices for eligible Veterans to VA for fulfillment. The TPA will notify providers that VA reserves the right to issue comparable, functionally equivalent DME and medical devices to what is prescribed by the provider.

Network providers can prescribe urgent/emergent DME to a Veteran at the time of treatment or before the Veteran leaves the provider's care site. After provisioning, providers will submit the claims to the TPA. If DME is issued by an external DME Vendor, the Vendor will submit the claim to the TPA. Urgent and Emergent DME may be prescribed as a rental, NTE 30 days. Veterans should follow up with their VA provider to determine if additional DME rental days are required.

Claims

- Urgent care providers will submit the healthcare claim to the TPA after rendering services.
- The TPA will ensure the following claim criteria are met before submitting to VA for reimbursement:
    - Claim is from a network urgent care location
    - Claim is for a Veteran with urgent care eligibility
    - Preventive care services, except for flu shots, are not reimbursed
    - Claim is billed with a POS 17 or 20 (exceptions apply for ancillary services such as labs and radiology; other exceptions also apply for locations that are a part of VA's contracted network and have agreed to furnish urgent care services in accordance with the contract requirements.
- The TPA and urgent care provider are not responsible for copayment determination during the claim submission process. VA will determine Veteran copayment requirements and bill the Veteran after services are rendered, as needed.

Covered Services

- VA will cover and reimburse for any urgent care services that meet the payment criteria listed above.
- The urgent care benefit covers the treatment of non-emergent symptoms that need immediate attention like flu-like symptoms, strep throat, minor burns, pinkeye, ear and skin infections, and flu shots.
- Veterans seeking medical care through an urgent care provider are able to receive diagnostic services like X-Rays, medications with some limitations, diagnostic lab testing, and therapeutic vaccines.
- Flu shots and therapeutic vaccines are covered. Therapeutic vaccines are covered when they are required for the treatment of certain conditions covered under the urgent care benefit.

- Urgent care is not a replacement for a Veteran's preventive health care services or longer-term disease prevention and treatment goals. Veterans should work with their primary care provider for these types of care.
- Preventive health services are excluded because such services are best coordinated and managed by a primary health care provider who can work with Veterans to address their specific disease prevention and treatment goals.

Seasonal Flu Shots Available through Community Care Partners

The VHA Office of Community Care (OCC) is pleased to announce new, easy access for Veterans to receive their seasonal flu shots at more than 60,000 Community Care in-network retail pharmacies and urgent care locations. This replaces the Walgreens Retail Immunization Care Coordination Program, which ended in March 2020.

Community retail pharmacies and urgent care

In addition to availability at VA medical facilities, eligible Veterans can receive the seasonal flu vaccination through Community Care Network (CCN) in-network retail pharmacies or urgent care locations. Click on the VA Community Care Regions link below to find where the Veteran is located. The chart shows what VA medical facility or community in-network location availability is for Veterans to receive their flu shots.

VA Community Care Regions

	In-Network Retail Pharmacy	In-Network Urgent Care Location	VA Health Care Facility
Regions 1, 2 & 3	Available	Available Sept. 1	Available
Region 4	Available	Available Sept. 30	Available
Region 5	Not Available	Available	Available
Region 6*	Not Available	Not Available	Available

Veterans should call ahead to make sure the flu shot is available at the location of their choosing.

These no-cost flu shots are available Sept. 1, 2020, through March 31, 2021, to eligible Veterans. Vaccines are subject to availability and may be in limited supply after March 1, 2021.

No appointment or VA referral is required

Eligible Veterans do not require a VA referral. Veterans can go to an in-network retail pharmacy or urgent care location, present a valid government-issued identification (e.g. Veterans Health ID Card, Department of Defense ID card, state-issued driver's license or ID card, etc.) and

receive their flu shot Eligible Veterans can receive a no-cost standard-dose (quadrivalent) or high-dose flu shot.

How do Veterans locate an in-network retail pharmacy or urgent care location near them?

Veterans who live in CCN Regions 1 – 4 can locate an in-network retail pharmacy or urgent care location by using the VA Locator.

Veterans who live in CCN Region 5 can receive a flu shot through an in-network urgent care location.

Veterans who live in CCN Region 6 can receive a flu shot through the VA Pacific Islands Health Care System's clinic in Guam, and at flu shot clinics in the Northern Mariana Islands and American Samoa.

Other community providers and pharmacies

Many local retail pharmacies offer flu shots that may be covered by private insurance or programs such as Medicare. There may be a charge for a Veteran's flu shot at these locations. If Veterans do not have insurance, and receive a flu shot at a retail pharmacy that is not in VA's Community Care Network, there will usually be a charge.

Eligibility

- **Retail pharmacies:** Veterans must be enrolled in the VA health care system
- **Urgent care locations:** Veterans must be enrolled in the VA health care system and have received care from a VA or in-network community provider in the past 24 months

To check eligibility, Veterans should call their local VA medical facility **OR** call 844-MyVA311 (844-698-2311), select option 1, and then select option 1 again.

Copayments

Eligible Veterans whose visit to an in-network urgent care location that consists of only a flu shot do not incur a copayment. In addition, flu-shot only visits to an in-network urgent care location does not count toward the first three visits per calendar year that determines copayment rates based upon the number of visits and the Veteran's VA eligibility priority group

Support

- Access the OCC Flu Webpage: Seasonal Flu Shots
- Questions: (b)(6) @va.gov

Care Coordination

The TPA will educate urgent care providers to generate and submit medical documentation within 30 days of the date of service to the Veteran's associated VA facility. VA facilities can be found at https://www.va.gov/find-locations/

VA staff can provide the Veteran with information on the urgent care benefit such as:

- Eligibility: Explain eligibility criteria and offer to check eligibility for Veteran using CPRS or ES.
- Network: Provide available in-network locations and offer to check the closest locations based on the Veteran's zip code using available tools.
- Copayments: Describe the number of visits allowed under the benefit and the copayment structure.
- Claims Payment: Provide information on claims payment.

Beneficiary Travel

The Beneficiary Travel (BT) program provides eligible Veterans and other beneficiaries mileage reimbursement, common carrier (plane, train, bus, taxi, light rail etc.), or when medically indicated, "special mode" (ambulance, wheelchair van) transport for travel to and from VA health care, or VA authorized Non-VA health care for which the Veteran is eligible. Beneficiary travel benefits will be available to Veterans that seek care under the new urgent care benefit.

Urgent Care Beneficiary Travel Benefits

- VA will reimburse beneficiary travel (BT) for eligible Veterans that must travel to receive community care. Payment will be made for the distance to either the nearest VA or in-network community medical facility that could have provided the care or services.
- Veterans may apply for beneficiary travel benefits for care received from an in-network urgent care facility.
- The Veteran must meet the eligibility criteria for the traditional Beneficiary Travel program.
- Claims for reimbursement must be submitted within 30 calendar days of the date of travel.
- If a Veteran’s application for Beneficiary Travel benefits for urgent care is approved, VA will reimburse the travel as a one-way trip payment (return visit).
- If a Veteran is sent to ancillary locations as part of the episode of urgent care, mileage will be calculated for each part of the trip from the original point of urgent care treatment to the Veteran’s residence and totaled for a one-way payment.

For assistance with Beneficiary Travel program benefits, please identify the appropriate POC via this website: Beneficiary Travel Points of Contact.

Urgent Care Medical Records

When a facility receives the clinical documentation for Urgent Care visits, there will not be a consult entered. However, urgent care documentation should be attached to the COMMUNITY CARE – URGENT CARE RECORD note title.

To capture urgent care records in VistA Imaging: Urgent Care documents are scanned as a packet.

- Attach the captured document to the appropriate Community Care-Urgent Care Note. Reference the Urgent Care Record Note SOP for step by step guidance on how the facility Clinical Application Coordinator (CAC) will create this note in CPRS
- **ORIGIN:** FEE
- **DOCUMENT IMAGE DATE:** Date of Urgent Care visit
- **DOCUMENT IMAGE TYPE:** MEDICAL RECORD
- **SPECIALTY**: Medicine
- **PROCEDURE/EVENT:** VISIT
- **IMAGE DESCRIPTION:** Type in the facility name for the Urgent Care visit

Guidance on alerting VA Provider of urgent care medical records:

When urgent care clinical documentation is routed through facility community care staff for review prior to coming to Health Information Management (HIM), facility community care staff will create the Urgent Care Record note in CPRS and identify the Primary Care Provider (PCP) as a signer. If the Veteran does not have an assigned PCP a clinician should be designated by the Chief of Staff. Upon receipt of the documentation, HIM will scan the document(s) and attach to the COMMUNITY CARE – URGENT CARE RECORD note title previously created by facility community care.

When HIM is not involved in the indexing of the clinical documentation, the facility community care staff will review, scan, and attach the documentation to the COMMUNITY CARE – URGENT CARE Record note title with the PCP on as a signer (or signer designated by the Chief of Staff if patient does not have an assigned PCP). The clinician identified as the signed will be alerted at the time of creating the Urgent Care Record Note.

For additional information regarding the indexing of medical records, please review the "Office of Community Care – Vista Imaging Best Practice and Minimum Documentation Requirements".

3.8 Transplantation Care Process (Pre/Post CCN)

Background

VHA health care facilities should continue to use Transplant Referral and Cost Evaluation/ Reimbursement (TRACER) as it is required to determine if a comprehensive transplantation evaluation is clinically indicated. Organ-specific referral checklist in TRACER contains required tests/diagnostic assessments to be completed in order to successfully submit a transplant referral. Current TRACER process provides the referring facility the option to seek a second opinion from another VA Transplant Center (VATC) as well as a third opinion through an appeal to the national Transplant Surgical Board. The final decision of the appeal review is communicated to the referring facility/Veteran/VATC through TRACER. Decisions regarding clinical care are ultimately made at the local VAMC/referring facility. The information provided by the VATC is provided to support and aid the local VAMC/referring facility in making a well-informed clinically appropriate decision regarding the authorization of VA care to a community provider.

If the Veteran and their referring provider elect to proceed with transplant care in the community, they need to determine if the Veteran is eligible for referral to a community transplant center. Eligibility is based upon any of the six criteria that provides a Veteran access to community care, including whether it is in the best medical interest for the Veteran to receive the transplant services from a community provider. The eligible Veteran may then choose to opt-in to receive the transplant evaluation and services at a participating contracted provider within the Organ Procurement and Transplantation Network (OPTN) Region of his or her residence.

The National Surgery Office (NSO) is developing future modifications to TRACER to document the decision of the VAMC/ referring facility's authorization of care in the community for Veterans initially reviewed within TRACER, as required, but who sought and were approved for community care following the eligible or ineligible decision from the VATC. For more information regarding community care please contact your local Office of Community Care. Also see Guidance for Transplantation Through Community Care.

Live Donors

The current CCN contract ***does not*** include the ability to authorize referrals for transplant services involving ***direct*** live donors for solid organ and allogenic stem cell/bone marrow. CCN can cover allogenic stem cell/bone marrow transplants when the cells are obtained through a donor bank (***indirect*** donor). As part of the MISSION Act, federal regulations and CCN contract modifications for ***direct*** live donation are being developed and finalized. The non-Veteran live donor is identified as a "collateral" to the Veteran recipient and may have initial screening studies performed at a VA facility. If eligible to proceed with comprehensive evaluation, live donors who

elect to receive community services require establishment of a single patient medical care local contract with the non-VA transplant center under authority of 38 U.S.C. § 8153, as initiated by the Veteran recipient's home VA. Contracts may include formal donor evaluation, the surgical donation procedure, and two years of post-donation care for the non-Veteran collateral.

For donors and their support person (attendant), who obtain authorized community care associated with the Veteran's solid organ or allogenic stem cell (from a ***direct*** living donor, not cells procured from a donor bank) transplant, the referring VA Medical Center is responsible for providing assistance or reimbursement of travel to the non-VA transplant location, IAW 38 U.S.C. § 1788, regardless of the Veteran's Beneficiary Travel eligibility. The referring VAMC is also responsible for reimbursement of lodging and meals as prescribed within 38 CFR Part 70, subpart A, paragraph 70.30, if required.

Regions 1-4

- Region 1-3: Contract Modification Effective September 17, 2020
- Region 4: Contract Modification Effective September 28, 2020
- To include:
- Solid Organ Transplant.
- Bone Marrow Transplant.
- Chimeric Antigen Receptor T-Cell Therapy.
- Excludes Living Donor coverage for transplant
- Community care transplant centers must meet defined quality and competency standards to join the Community Care Network (CCN).

Note: All care under a PC3 authorization expired on March 31, 2021. All care required after March 31, 2021 requires an authorization under CCN.

Initial Transplant Referral Process

Provider determines potential need for transplant by inputting the Veteran's information into the VA Transplant Referral and Cost Evaluation/Reimbursement (TRACER). If the Veteran is approved from the TRACER review by the VA Transplant Center (VATC) the VA facility staff may enter the community care consult for the comprehensive evaluation for community care eligible Veterans. **For R1-3,** VA facility staff should consult the targeted provider list to ensure that Veterans are receiving care from community transplant centers that are COE/TAP certified prior to sending the consult. Once the consult for transplant evaluation is entered the appropriate Transplant SEOC may be applied:

- Transplant Bone Marrow Comp Eval

- Transplant Solid Organ Comp Eval
- Chimeric Antigen Receptor T-Cell Therapy Eval

The Transplant consult is sent to HSRM. The preferred provider needs to be located in Provider Profile Management System (PPMS). If the consult and Standardized Episode of Care (SEOC) are for a comprehensive evaluation, then then Veteran should be scheduled per the existing CCN scheduling process and care coordination should be determined by the local facility.

Transplant and Treatment Referral Process

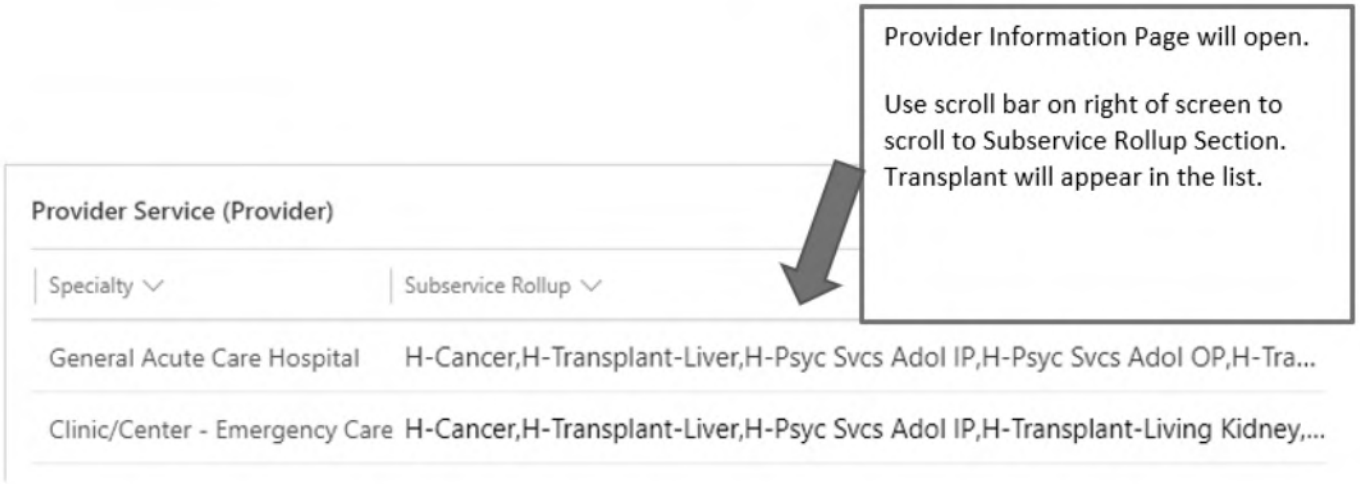
If the comprehensive evaluation determined Veteran is candidate for transplant the community provider should submit a Request for Service (RFS) for Transplant. The facility community care office staff will process the RFS and route to the appropriate Delegation of Authority (DOA) for review. The VA facility provider or DOA will enter the community care consult for transplantation. Once the consult is entered the appropriate SEOC should be applied:

- Transplant Bone Marrow Transplantation
- Transplant Solid Organ, Wait List Management, Transplantation
- Chimeric Antigen Receptor T-Cell Therapy Pre-Infusion and/or Treatment

The completed consult and SEOC will be sent to HSRM.

Identifying when a Single Case Agreement (SCA) is required:

Before assigning a provider within the HSRM referral, the VA facility community care staff must confirm that the provider is approved to perform transplant within CCN. In order to ensure that the provider is approved for transplant within CCN the facility community care staff must locate the Facility/Provider Profile in PPMS and review the provider specialty listed in the Provider Specialty section. Use the facility NPI to search for active CCN facilities/providers in Regions 1-4 that have the **transplant specialty** designation**.** Facilities (Regions 1-3) or providers (Regions 4 and 5) will be able to receive referrals through HSRM to perform the transplant. If the transplant specialty is present the facility/provider may be assigned to the HSRM referral and the facility community care staff may proceed with scheduling the Veteran. In Region 4 & 5 HSRM referrals can also assign facility providers/acute care hospitals that have a transplant subservice listed in the provider profile.



Use of Single Case Agreement (SCA) Request

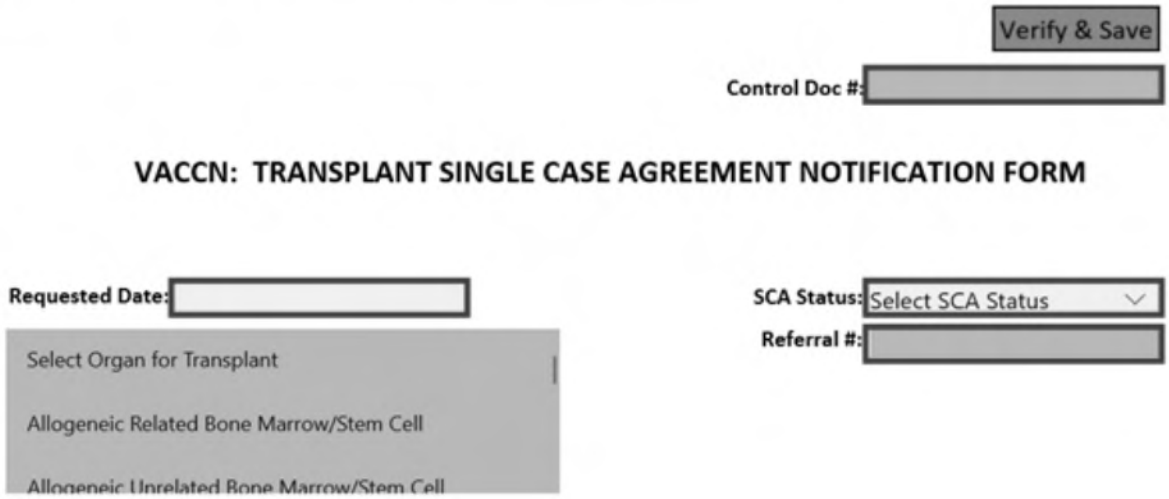
If transplant specialty is not present, a request for a Single Case Agreement (SCA) from Optum should be initiated. The SCA Notification form is located on the CI SharePoint. The VA facility community care staff should complete all sections designated for the VA to complete. To track and control document version control, each SCA notification form will be assigned a Control Document Number. The Control Doc Number will follow the following format:

1. Veteran City_VAMC Station Number_Last Initial Last 4 SSN_Date of Doc Creation

- Example: Muskogee_456_Z1234_09.17.2020

The SCA Notification form has a drop-down menu to update the status of the SCA to include:

- New: Initial SCA Notification form
- Update: For SCA Notification forms that have been updated with provider or other pertinent information
- Close: For all SCA Notification forms that have been closed out and no further processing is required



Note: Find a completed example of an SCA Notification form in the appendix of the Transplant SOP found on the CI SharePoint.

The created/updated SCA Notification form should be saved as a PDF in a secure location and uploaded to HealthShare Referral Manager (HSRM) referral using the 'Add/View Document' function.

Once the SCA Notification Form has been uploaded to HSRM the online referral will be populated with the Generic Provider Profile from PPMS. One generic provider profile has been developed per CCN region for SCA requests. Once complete the online HSRM referral may be submitted to Optum.

Provider Name	Provider Identifier (NPI)
Region 1 CCN SCA, SCA Provider	1987654321
Region 2 CCN SCA, SCA Provider	1987654322
Region 3 CCN SCA, SCA Provider	1987654323
Region 4 CCN SCA, SCA Provider	1987654324

Once Optum receives the HSRM online referral they will export the SCA notification form and contact the community provider to initiate the SCA negotiation. Optum will notify the VA facility POC to clarify any questions or obtain additional information. Once the SCA is executed it will be uploaded to HSRM and the VA will be notified of the SCA availability. The SCA contract modification allows 15 days to execute the SCA once the VA and Optum have agreed to the use of a specific provider. If an agreement cannot be reached between Optum and the targeted SCA provider, Optum will engage the VA with additional providers for consideration. Once final, executed SCA is received through HSRM. The VA facility community care staff should update the offline referral form with the provider information and send it to the provider. The HSRM online referral form will remain populated with the Generic Provider profile. The VA facility community care staff should proceed with scheduling and care coordination in accordance with facility policies.

Authorization Renewal with an Active SCA

If authorization expires and a new consult/authorization is required to continue waitlist management/transplantation the VA facility community care staff should check PPMS for the transplant specialty, as described above. If the provider now has a transplant specialty, the provider can be populated into the online HSRM referral and proceed with scheduling and care coordination according to facility policy. If the provider does not have a transplant specialty the VA facility community care staff will continue to use the generic provider profile for the HSRM online referral. The provider information will be updated on the HSRM offline referral form and send to the provider. Please note that the SCA does not expire, therefore a new SCA request will not be required. If the consult is for post-transplant care, the HSRM online referral form will be populated with the provider information and the facility community care staff may proceed with scheduling and care coordination according to facility policy.

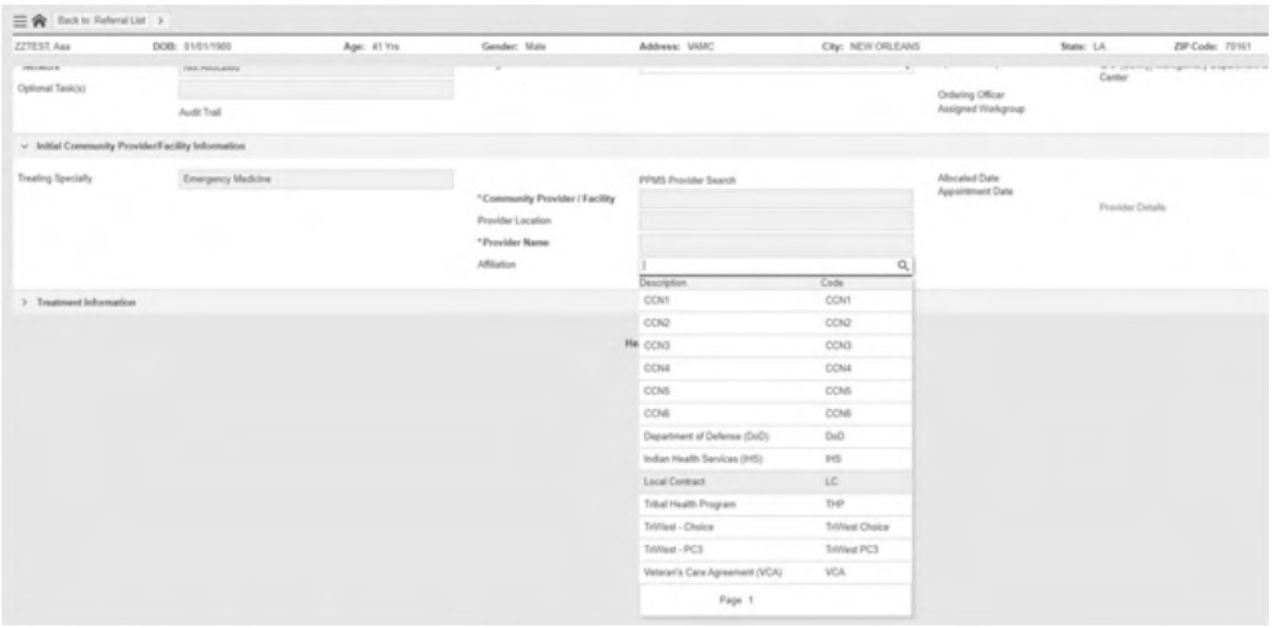
In-Network Provider not Found in PPMS

If an in-network provider is not found in PPMS, the VA facility community care staff should assist the Veteran to identify a preferred provider. Optum has provided a listing of transplant providers participating in its parent network. A review of the

targeted provider list will assist the VA facility community care staff to identify a preferred provider for the SCA Notification form.

Live Donor Referral Process

As noted above, live donor is currently not available under the CCN contract. Therefore, all live donor referrals must be processed under HSRM utilizing the "local contract" option.



Transitioning Care – Existing Transplant Authorization

Authorizations issued under PC3 can continue to their expiration date. Once the PC3 authorization expire a new consult/referral should be issued per the steps noted above for a new transplant referral. VA facility community care offices should review existing transplant referrals issued under CCN with the transplant/treatment SEOCs applied. Optum will advise the VA of any updates to the provider network status.

Emergency Transplant Referral

For emergency cases, referring facilities must first communicate directly with the VA Transplant Center (VATC) or in-network community provider to determine a plan of care including potential hospital-to-hospital transfer. Community providers should respond to VA requests within 6 hours of notification of need to transplant. After direct communication with VATC or in-network community provider, submit referral to TRACER site and enter community care consult, if applicable. The SCA request should not be used for emergency referrals due to the administrative time required to establish an SCA.

Note: If a Veteran is at an out-of-network facility and requires an emergency transplant, please reach out to the VHA Community Care CIFO Transplant team for assistance.

To contact the CC Transplant Team, search the GAL for "VHA Community Care Transplant Team"

Post-Transplant Care

Transplant SEOCs include follow-up care, however if post-transplant care is required beyond the expiration of the current transplant authorization a post-transplant SEOC can be used. Post-transplant SEOCs include:

- Transplant Bone Marrow, Post Transplant Follow
- Transplant Solid Organ, Post Transplant Follow

Care coordination is important to determine when post-transplant care and post-transplant medication management can be transitioned back to VA.

(Pre CCN)

Solid organ (kidney, kidney/pancreas, liver, heart, heart/lung, and lung) and bone marrow/stem cell transplants are life-saving procedures provided to eligible Veterans by the Department of Veterans Affairs (VA). VA Transplant Centers are located across the country. The VA has offered solid organ transplant services since 1962 and bone marrow transplant services since 1982. Learn more about the VA National Transplant Program by visiting the VA National Transplant Intranet (internal VA access only) or VA National Transplant Internet (public site) websites.

Resources:

CC Transplant SharePoint

3.9 How to Review Community Care Programs and Determine Community Care Purchasing Authorities

(Pre/Post CCN)

VHA Office of Community Care purchases health care for eligible Veterans when a VA medical facility, clinic, or other federal facility is not feasibly available to furnish care.

In accordance with the "Revised Community Care Purchasing Authorities" memorandum, and the VA MISSION Act; the Program and services authorized under 38 USC 1703 ended on June 6, 2019 ; Provider Agreements (PAs) can no longer be

orchestrated to furnish community care. Whereas, all traditional community care must end or transition to the Patient Centered Community Care (PC3) contract by the date the regulations are published for the new community care program (i.e., by September 30, 2019).

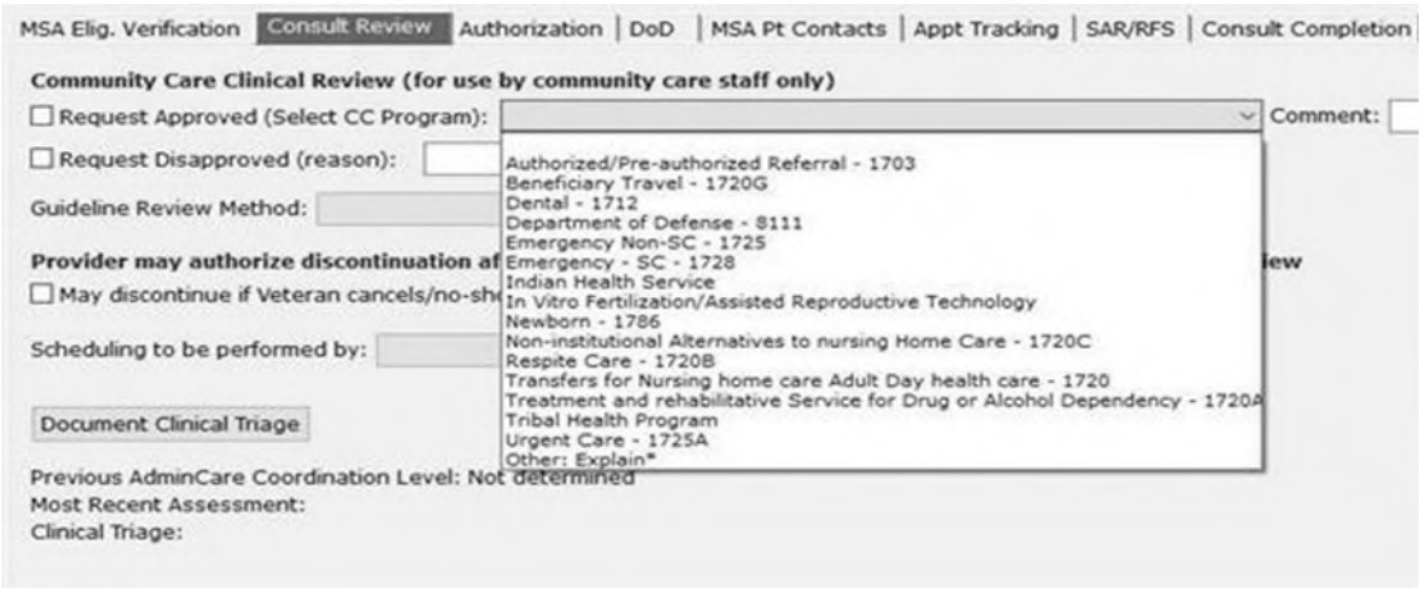
When requested care is not available at the local VA, facility staff shall use the following process for eligible Veterans being referred into the community:

- Schedule at another VA, Department of Defense or other Federal Facility with whom the VA has an Agreement.
    - If no other VA or Federal Facility is available:
        - Use National Contracts such as the PC3 contract. Utilization of the PC3 contract is the preferred routing for referrals until the Community Care Network Contract is implemented.
    - If no national contract is available:
        - With an approved waiver, use local contracts signed by a warranted contracting officer as outlined in the May 9, 2019 Deputy Under Secretary for Health for Operations and Management Memo Titled, "Direct Purchasing of Community Care."
    - If no local contract is available:
- **As a last resort,** facility staff can use VCP provider agreement (PA) or Individual Authorizations (traditional community care) if end date do not pass June 6, 2019.

When using the Consult Toolbox, it is important to note the correct payment authority for the applicable category of care.

(CTB Version 1.9.0078)

The image below is an example of the Community Care program drop-down selection in the Consult Toolbox.



(CTB Version 2.0)

The image below is an example of the Community Care program drop-down selection in the Consult Toolbox Version 2.0.

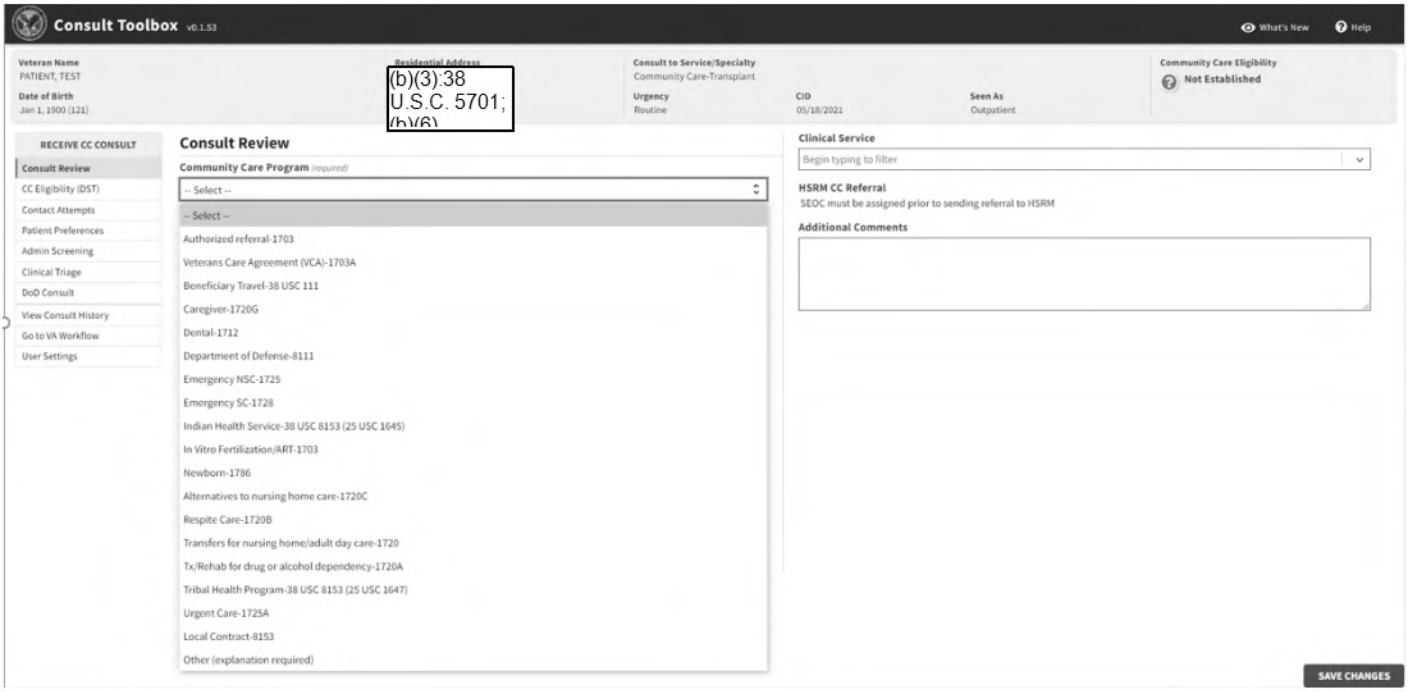


Table 1. Provides reference information on the different community care program pathways for receiving care outside of a VA facility. This table presents the programs; the type of provider associated with those programs, and the source of funding needed to provide care under those programs.

Facility Community Care Office staff should use this table to help understand the various options available for sending Veterans for care outside of the VA.

Table 1: Reference information on how to align the avenue of care to the appropriate program authority:

Avenues to Route Care	Appropriate Program Authority

• **TPA**
  ○ PC3
  ○ CCN
• **VCA**
	Authorized/Preauthorized Referral – 1703 (Geriatrics and Extended Care Services are under 1720, 1720B, and 1720C.)

• **FBCS** used to approve the care	Beneficiary Travel - 1720G
• **VCA** • **TPA** ○ CCN Only	Dental - 1712
• DoD Prepaid	Department of Defense - 8111
• Paid by Payment and Operations Management Team. Authorizations entered in HSRM or FBCS	Emergency Non-SC - 1725

• Paid by Payment and Operations Management Team. Authorizations entered in HSRM or FBCS	Emergency – SC - 1728
• **TPA** ○ Processed in FBCS/VistA ○ CNN	Indian Health Service
• **TPA** ○ PC3 Only ○ CCN	In Vitro Fertilization/Assisted Reproductive Technology
• **TPA** ○ PC3 ○ CCN	Newborn - 1786
• **VCA** • **TPA** ○ PC3 (may be used for Skilled Home Care and Home Infusion) ○ CCN	Non-institutional Alternatives to Nursing Home Care – 1720C • Purchased Skilled Home Care • Home Hospice/Palliative Care • Homemaker/Home Health Aide • Veteran Directed Care (**VCA Only**) • PACE (VCA Only) • Home Infusion Therapy • & Bladder (VCA Only- provided by a family member) • Traumatic Brain Injury Residential Rehabilitation (TBI-RR) (VCA Only)
VCA • Beneficiary travel is a separate VA benefit and has additional administrative eligibility requirements. The transportation associated with Adult Daycare services is considered a part of the delivery of care, is furnished by the ADHC facility, and does not necessitate the additional administrative eligibility requirement that the Beneficiary Travel Benefit would require.	Transfers for Nursing Home Care • Up to 100 days per calendar year of rehabilitation is covered by CCN • All other community nursing home placements are under a local Contract or VCA • CADHC is covered by CCN Adult Day Health Care – 1720
○ Coming soon	Treatment and Rehabilitative Service for Drug or Alcohol Dependency – 1720A
• Tribal Health Provider bills VA direct Processed in FBCS/VistA	Tribal Health Program
• **CCN**	**Caregiver Support Program**

• **VCA**	Caregiver Non-VA Oversight – 1720G-8210 Caregiver Respite – 1720G-8210
• **VCA** • **CCN**	General Respite Care – 1720B See Caregiver Support Program section for Caregiver Respite Care

3.10 How to Review Available Community Care Options

(Pre/Post CCN)

(Pre CCN)
Community Care Inpatient Authorizations with FBCS and VistA

As of August 6, 2019, the utilization of VA form 7078, Authorization for Inpatient Hospitalization, will cease for authorizing inpatient care in the community. Instead, VAMC staff authorizing non-network inpatient care in the Fee Basis Claims System (FBCS) and Vista will use VA Form 7079 to create a placeholder authorization. VA Form 7079 remarks will stipulate the approval for inpatient hospitalization. Please review the Fact Sheet for full details.

(Post CCN)
The process for reviewing available community care options consists of reviewing the Veterans current clinical needs, available community care pathways and funding availability. VA staff will determine the most appropriate available community care option for the Veteran, considering his or her clinical needs and provider availability.

When reviewing the available community care options, Facility Community Care Office staff must also consider funding availability under the preferred option(s) guided by local leadership.

3.11 Initiating Community Care Under Selected Option

(Pre/Post CCN)

Once the appropriate community care option is determined, the Facility Community Care Office can begin the process of scheduling the Veteran's care. The scheduling process is dependent on the selected Community Care option (i.e. Patient-Centered

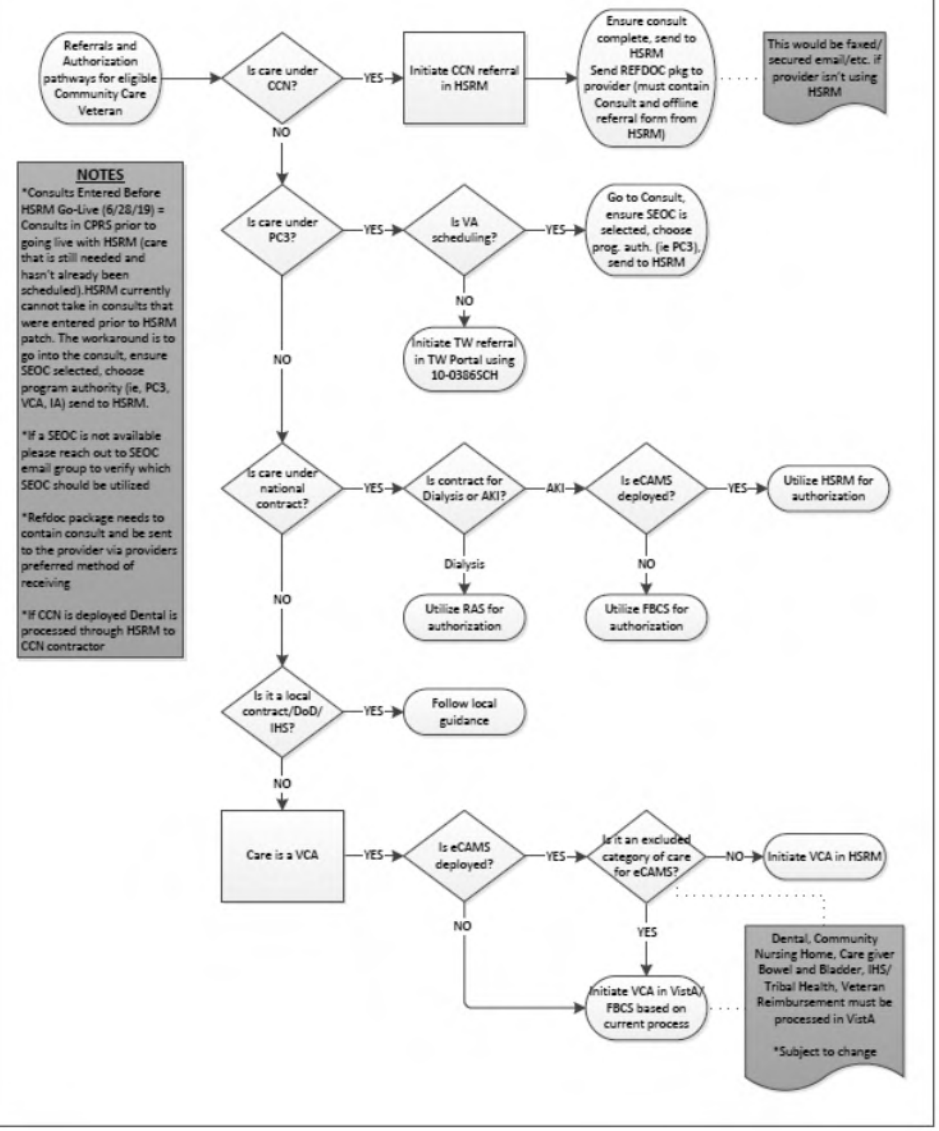
Community Care (PC3) contract, Veterans Care Agreements (VCA), and Community Care Network (CCN).

GENERAL CONSIDERATIONS
Administrative and clinical staff within the Facility Community Care Office must collaborate to ensure that the Veteran receives care in a timely manner, based on his/her clinical needs. In instances when the Veteran chooses to have the VA schedule with the community provider on their behalf, Veteran preferences for their preferred community providers (to prevent multiple calls if a provider does not accept, have them choose up to 3 providers), day of the week, and time of day MUST be documented. For more information regarding VHA scheduling requirements, please refer to: VHA Directive 1230: Outpatient Scheduling Processes and Procedure **Distance Eligible Veterans (DEV)** • On May 1, 2019, VAMCs began care coordination for Distance Eligible Veterans (DEV). Please review the DEV Requesting an Appointment Process Guide for detailed instructions when receiving an appointment request from a DEV

Community Care Referral and Authorization Pathway for Eligible Veterans

11/13/19

Community Care



3.12 How to Continue Care Initiation Using the Selected Community Care Option – VA/DOD

(Pre/Post CCN)

Procedure Guide - VA/DoD Sharing Agreement Process: Consult Management

VA DoD Sharing Agreements Care Coordination Standard Operating Procedure SOP

The purpose of this guide is to provide instructions for managing consults referred to the Department of Defense (DoD)-Military Treatment Facility (MTF) from a VA Medical Center (VAMC) facility with required standardized Facility Community Care processes and specific VA and DoD-MTF functions.

VA will continue to follow local processes for care coordination, authorization and payment for direct care provided by MTFs to Veterans through the VA/DoD Sharing Agreement Program.
The standardized Community Care-DoD <Specialty Name> XXXX Consult will be utilized for tracking services rendered by an MTF and approved by VA.

If a community care consult is received for a service that is offered at a DoD facility, an attempt should be made to work with the local MTF and Veteran to refer and schedule the Veteran at MTF. The scheduling should include utilization of the standard Community Care-DoD <Specialty Name> XXXX Consult. (Per the Revised Community Care Purchasing Authorities 10N Memo from May 2019.)

Facility Community Care:

When a Community Care consult is received, always check to see if the care can be delivered in a MTF and is the Veteran would be amenable to being seen at an MTF, if so, forward the consult to the standard Community Care-DoD <Specialty Name> XXXX Consult

Receipt of a Community Care request for Do D-MTF services

During check-in, Facility Community Care Office staff must confirm Veteran enrollment/eligibility, current demographics, Veterans Other Health Insurance (OHI) and capture all updates per policy. This must be completed prior to initiating or forwarding the consult to the Facility Community Care Office.

Delegation of Authority (DOA)

Leveraging the Delegation of Authority for routing Community Care Consults:
Clinical review should be completed by clinical staff who have been given DOA by facility Chief of Staff to review services for clinical appropriateness. If the person entering the

consult for community care is also the delegated authority to approve that service, the clinical review requirement is met. This routing determination is designed to streamline the consult management process by sending consults to the appropriate reviewers and not reviewing those entered by delegated providers.

A streamlined DOA also helps ensure consult reviews take place within the timelines mandated in the 10N Memorandum-Enhancements to the Community Care Clinical Review Process.

For additional Information refer to FGB Chapter 3.1.

VA/DoD Sharing Agreement Consult Management Processes / Procedure Guide

- Veteran presents to VAMC for evaluation and requires additional services.
- If services are not available or not available timely, VA Provider will enter either a Community Care-<Specialty Name>Consult OR if DoD services are known, enter Community Care-DoD <Specialty Name>XXXX Consult.

Note: VA ordering Provider or VA Specialty Clinic or Community Care staff determines if services are available within VA (Intra-Facility) or nearby VA Facility (Inter-Facility). If services are available within the VA or VA sister facility, coordinate the appointment internally or place an Inter-facility consult (IFC). Follow local process for forwarding consults, DoD MTF is not used for intra or inter facility transfers.

- VA Provider enters Community Care or Community Care-DoD consult or Internal Specialty consult.
- For Urgent consult – VA Provider will contact Facility Community Care Office staff to notify clinical staff of urgent request.

DoD response times:

- Urgent Consult - 90 minutes from the time phone call received from Facility Community Care staff
- Routine - 2 business days following receipt of referral packet.
- Facility Community Care receives the consult via View Alert and prioritizes by Urgency status.
- Perform Receive process.

CTB Version 1.9.0078

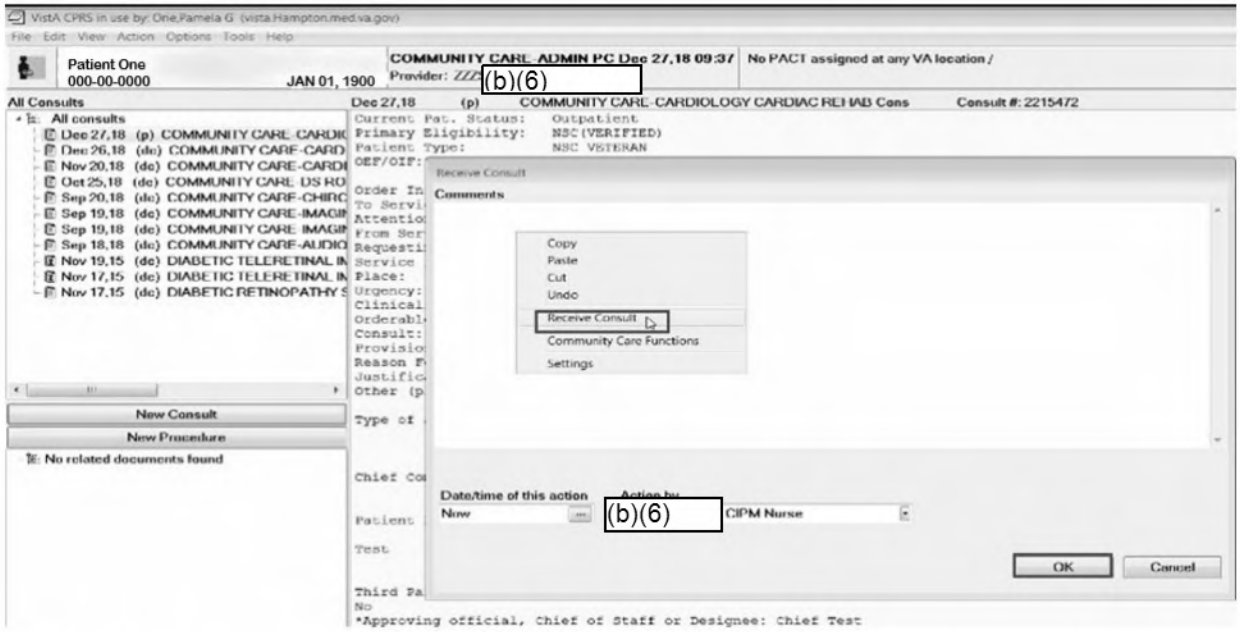
How to Receive a Community Care-DoD Consult

- Select consult in CPRS.
- In the Tool bar, select Action.
- Hover over Consult Tracking. This will open a menu to the right.

- Select Receive.
- A new box for additional comments will appear on the screen.
- Document any additional comments.
- Click on OK.
- Consult will change to Active (a).

Note: *After-hours consults may be received and processed by the AOD or per local policy.*

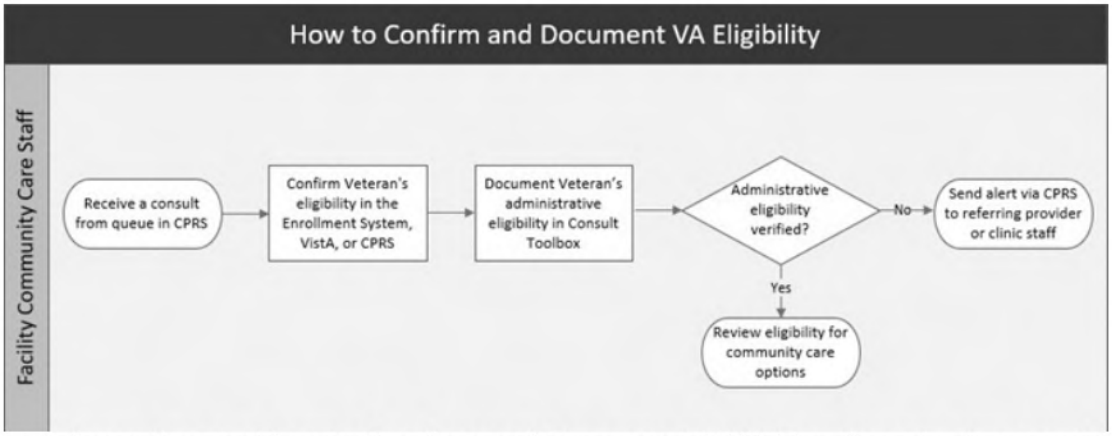
- Administrative review is performed. Confirm the Veteran is eligible to receive VHA Healthcare Benefits services under VHA Directive 1601A.02.
- Once VA contacts DoD (and they respond within 90 minutes and can see Veteran), the appointment will be determined based on the Clinically Indicated Date (CID) and between the VA Facility Community Care Clinical Reviewer and DoD POC.



Note: Confirm VA Enrollment: Veterans must be enrolled with the VA health care system for VA health care benefits to receive care in the DoD MTF. Some exceptions apply. Contact your local Eligibility*/Enrollment Office for appropriate guidance.*

Veteran Eligibility

Is Veteran eligible to receive VHA Healthcare Benefits services under VHA Directive 1601A.02?

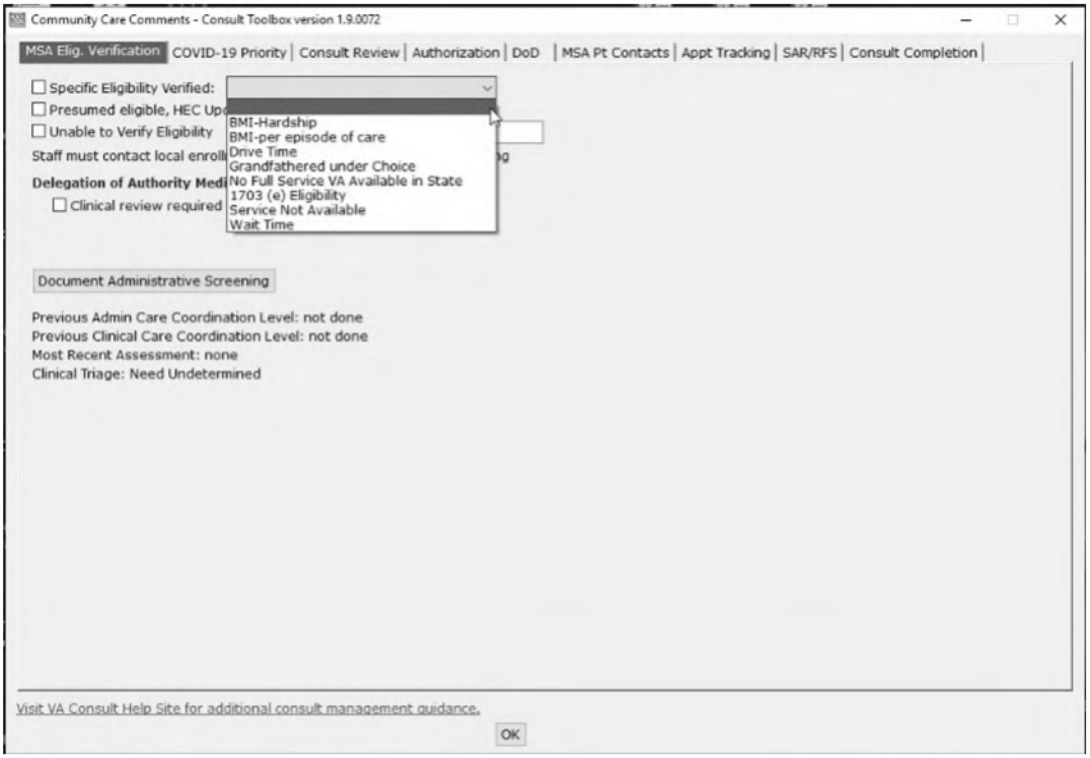


For further information on How to Confirm and Document VHA Enrollment, please refer to the FGB Chapter 2.

Consult Toolbox

Veteran's Administrative eligibility verification:

Verify Veteran's eligibility by selecting the MSA Elig. Verification tab. Select the appropriate eligibility community care justification from the dropdown and complete all other choices, as appropriate.
For additional information regarding VA/DoD Eligibility, please refer to the following link:
VHA Directive 1601A.02.



If Veteran is **NOT** eligible to receive VHA Healthcare Benefits services, cancel consult in CPRS.

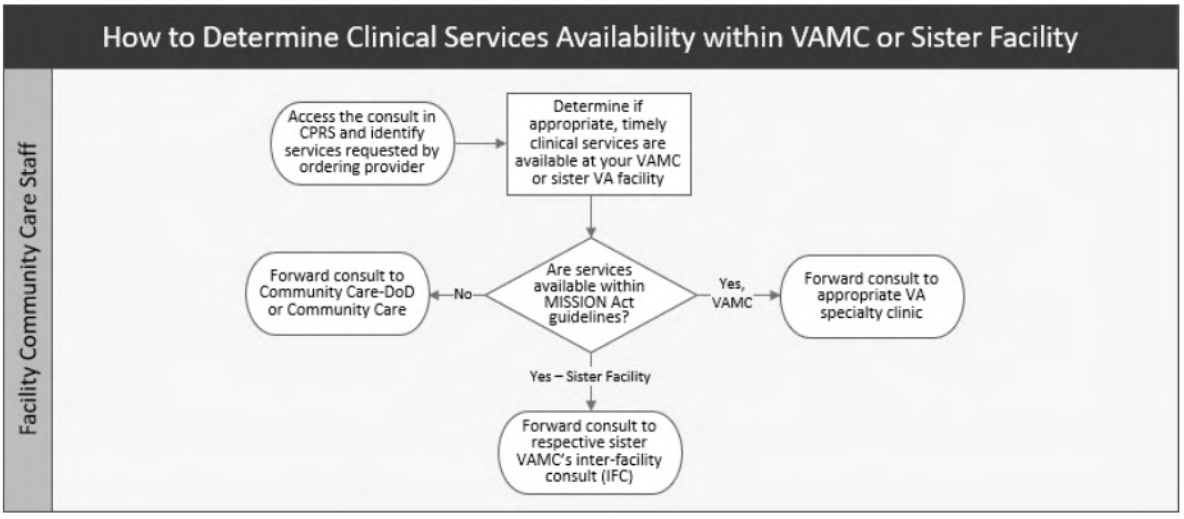
Clinical Review for Services Requested

The purpose of clinical review is to determine if the service is clinically appropriate and/or whether it can be delivered at the local VAMC prior to sending the consult to the DoD MTF. Clinical appropriateness should be determined by clinical staff who have been given DOA for services identified in the consult. The determination should be documented by the clinical reviewer using the Consult Toolbox under the "Consult Review" tab. Clinical appropriateness and Consult Toolbox documentation should be based on the following considerations:

- Can the service be provided within the VAMC or a Sister facility in a timely manner? If services cannot be provided within the VAMC or sister facility, the services may be referred to DoD MTF (please refer to local guidance on locally offered services and availability) after clinical review.
- Is the service clinically appropriate according to evidence-based medicine, local clinical review guidance, and/or established industry standards (MCG, InterQual, etc.)?
- Is additional documentation required? If the information provided on the consult is not sufficient or if medical documents are incomplete, a request for additional documentation will need to be made to determine clinical appropriateness.

Determine Clinical Services Availability within VAMC

If a Sister facility can accept the services requested or services can be scheduled internally, the Community Care - DoD <Specialty> XXXX Consult can be forward to IFC or internal specialty service.



For additional information on How to Determine Clinical Services Available within VAMC or at a Sister Facility refer to FGB Chapter 3.2.1.

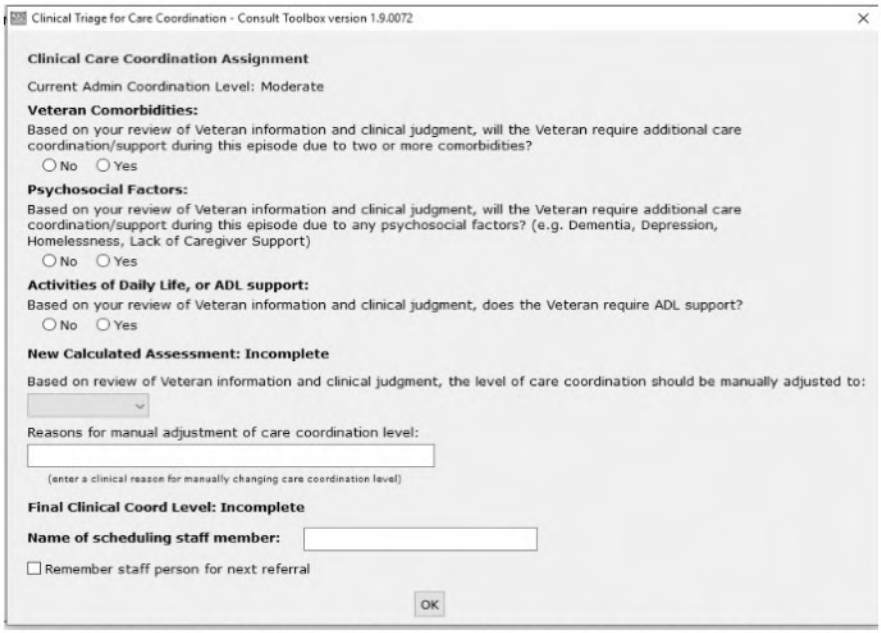
Consult Approval

Facility Community Care Clinical reviewer will go to the Consult Review tab in CTB, select Department of Defense-8111 as the Community Care program for DoD referrals.

- For Urgent services, contact DoD POC and allow 90 minutes to respond to determine if able to accept Veteran.
- For routine services, allow 2 business days from the date DoD MTF receives the Referral package.

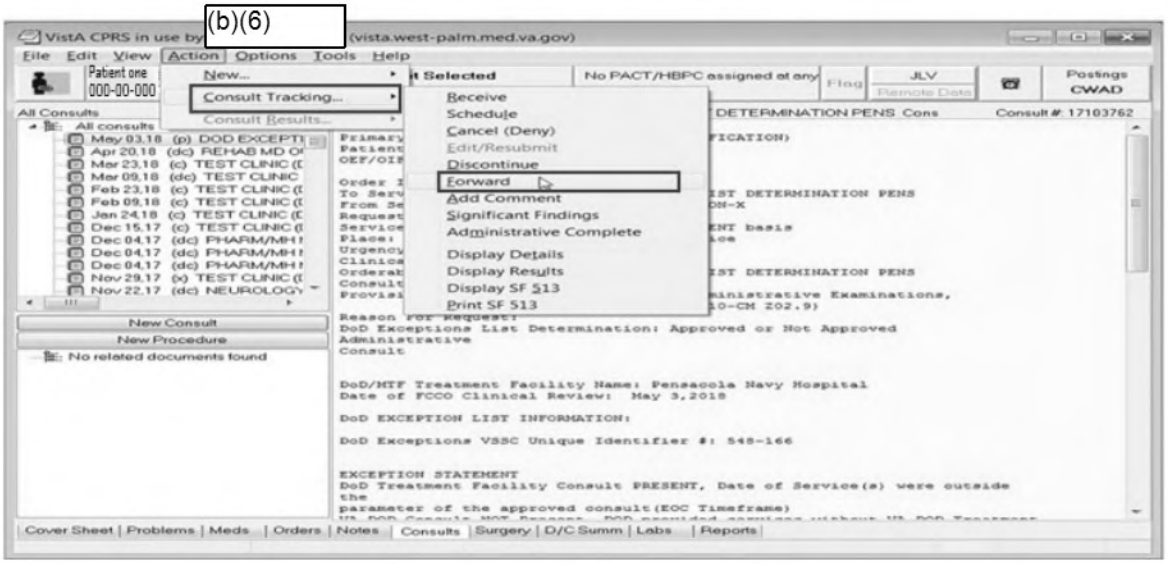
The clinician will then complete the clinical triage portion of the Screening/Triage toolbox using the following steps:

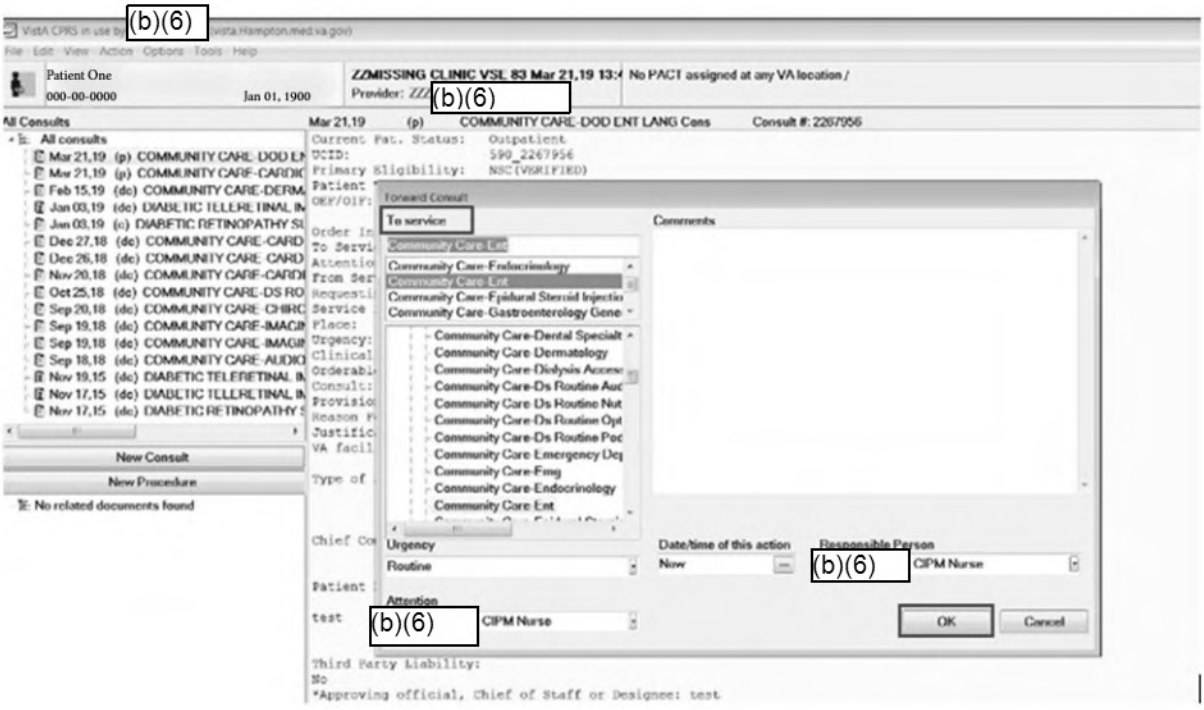
- Complete the required questions in this section based on information in the consult, conversations with Veteran and providers, and clinical judgement.
- Review the newly updated care coordination level.
- The Clinical staff member can override the results of the tool (which may be viewed in “New Clinical Triage Coordination Level” above) by selecting a new level from the drop- down box and documenting the reason for the change in the comment section. The reason should be brief (no more than 10-12 words).
- Input the full name of the scheduler who is scheduling the appointment.
- Click “OK” to submit the results.



How to Forward a Community Care-DoD Consult when not approved for DoD

- Select consult in CPRS.
- In the Tool bar, select Action.
- Hover over Consult Tracking. A menu will open to the right.
- Select Forward.
- The Forward consult box will load.
- Type in the service.
- Select the Service.
- Type a comment in the comments area.
- Select Urgency.
- Click OK.
- Consult will automatically forward to the selected service.



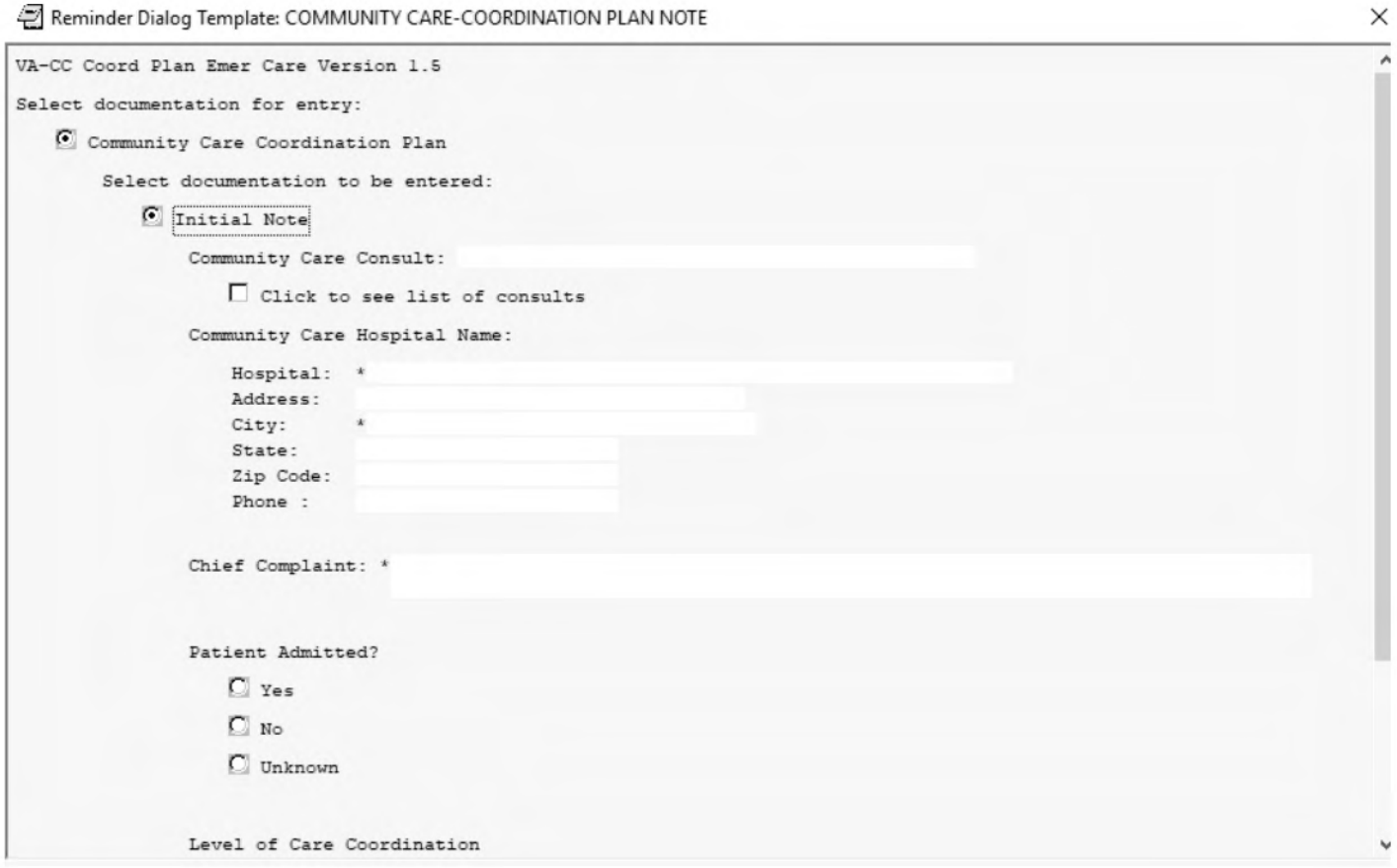


Community Care Coordination Plan Note

During this time, it may be appropriate to generate a Community Care Coordination Plan Note in the CPRS to document the facilitation and coordination of services required for the Veteran during Veteran's inpatient or outpatient EOC.

For inpatients, utilize the Community Care Coordination Plan Note to follow the Veteran throughout the EOC until discharge and assist with discharge planning. For inpatient transfer back to the VA, follow your local DoD sharing agreement/local policy.

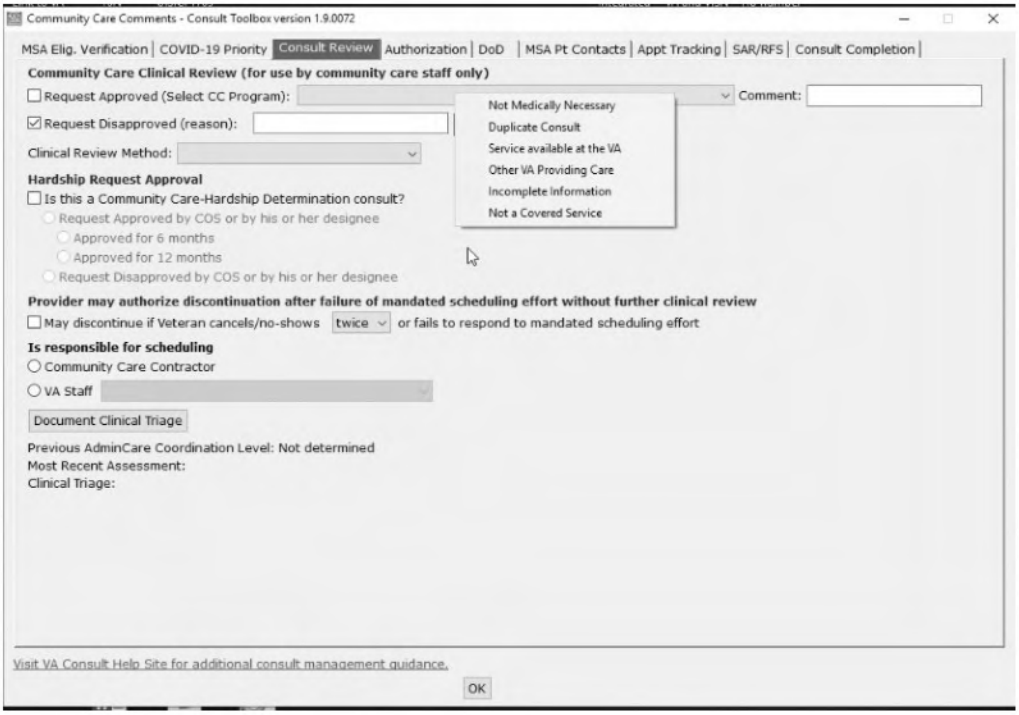
To generate a Community Care Coordination Plan Note, select the note title in CPRS and complete the template, filling out all required fields. Provide shared information with specific VA staff using the MAKE ADDENDUM feature and identify additional signers to notify and/or assist in coordinating services for the Veteran (e.g., Transfer Coordinator, Patient Aligned Care Team, social worker, etc.).


Reminder Dialog Template: COMMUNITY CARE-COORDINATION PLAN NOTE
VA-CC Coord Plan Emer Care Version 1.5
Select documentation for entry:
Community Care Coordination Plan
Select documentation to be entered:
Initial Note
Community Care Consult:
Click to see list of consults
Community Care Hospital Name:
Hospital: *
Address:
City: *
State:
Zip Code:
Phone :
Chief Complaint: *
Patient Admitted?
Yes
No
Unknown
Level of Care Coordination

Consult Disapproval

After the Clinical review has been completed and disapproval has been determined, select “Request disapproved reason” under the Consult Review Tab, click on “Opt” and then select the appropriate reason from the options displayed in box. Cancel the consult based on justification or secondary clinical review by Licensed Independent Practitioner (LIP).

Note: Follow local policy on cancelling a consult.

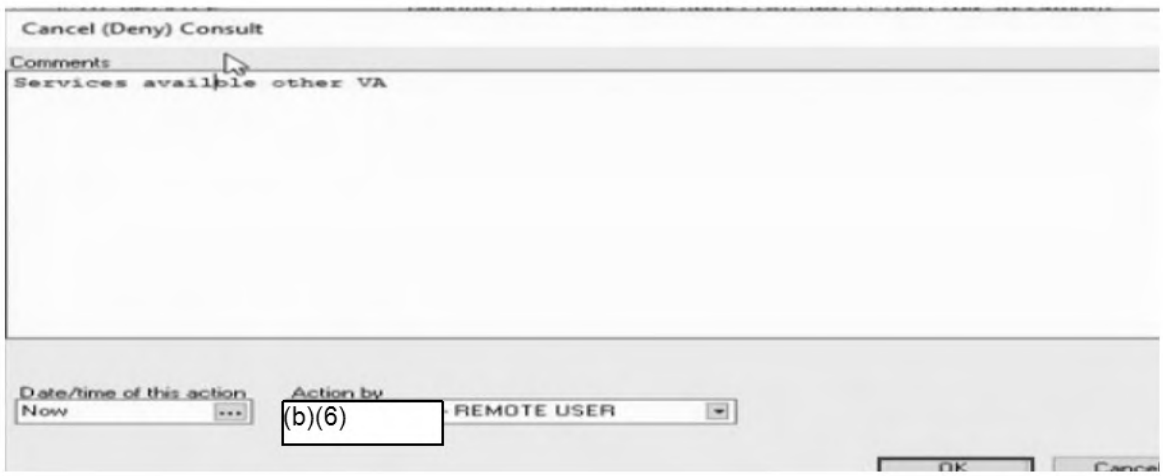


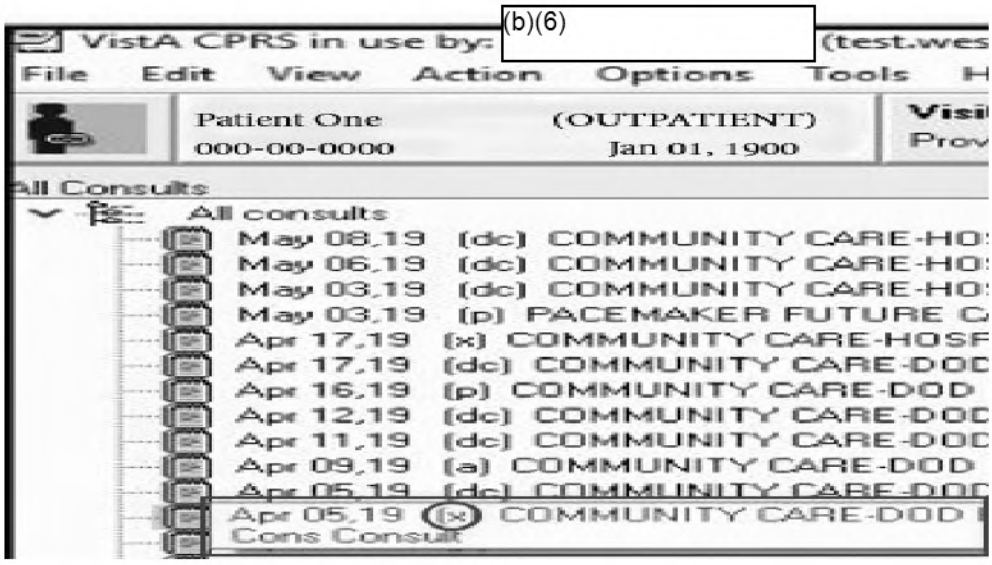
How to Cancel a Consult

Cancel Consult on CPRS and document reason for disapproval, add ordering VA provider as View Alert or per local process for alternate care plan.

- Select consult in CPRS.
- In the Tool bar, select Action.
- Hover over Consult Tracking. This will open a menu to the right.
- Select Cancel Deny.
- Document reason for cancelling the consult in the comment box.
- Select OK.
- Consult status will be marked as an “X” indicating cancelled consult.
- Contact VA ordering provider for alternate care plan.


(b)(6)
Action
Consult Tracking...
Consult Results...
Receive
Schedule
Cancel (Deny)
Discontinue
Forward
Add Comment
Significant Findings
Administrative Complete
Display Details
Display Results
Display SF 513
Print SF 513
New Consult
New Procedure
No related documents found


Cancel (Deny) Consult
Comments
Services available other VA
Date/time of this action
Now
Action by
(b)(6)
REMOTE USER


(b)(6)
File Edit View Action Options Tools
Patient One (OUTPATIENT)
000-00-0000 Jan 01, 1900
All Consults
All consults
May 08,19 [dc] COMMUNITY CARE-HO
May 06,19 [dc] COMMUNITY CARE-HO
May 03,19 [dc] COMMUNITY CARE-HO
May 03,19 [p] PACEMAKER FUTURE C
Apr 17,19 [x] COMMUNITY CARE-HOSF
Apr 17,19 [dc] COMMUNITY CARE-DOD
Apr 16,19 [p] COMMUNITY CARE-DOD
Apr 12,19 [dc] COMMUNITY CARE-DOD
Apr 11,19 [dc] COMMUNITY CARE-DOD
Apr 09,19 [a] COMMUNITY CARE-DOD
Apr 05,19 [dc] COMMUNITY CARE-DOD
Apr 05,19 [x] COMMUNITY CARE-DOD
Cons Consult

Standardized Episodes of Care (SEOCs)

Standardized Episodes of Care (SEOCs) are a standard set of services and/or procedures that can be authorized as a bundle to treat certain diagnoses/conditions. SEOCs help improve timely access to care for Veterans by reducing the need for secondary authorizations from community providers. SEOCs should be used by VA medical facilities nationally when referring care to the community and can be found in the "Authorization" tab in the CTB in CPRS. For additional information please refer to:

- FGB SEOC Chapter 3.3
- https://seoc.va.gov/

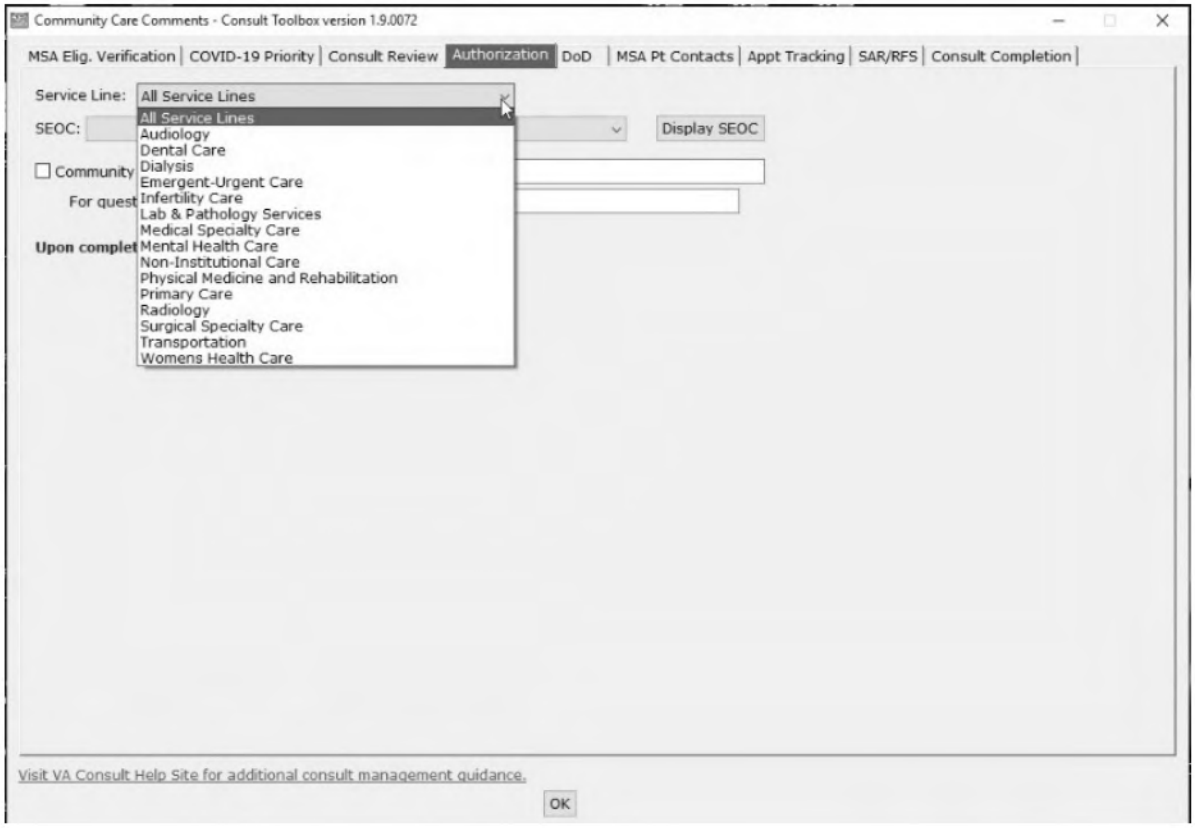
Consult Toolbox - Authorization

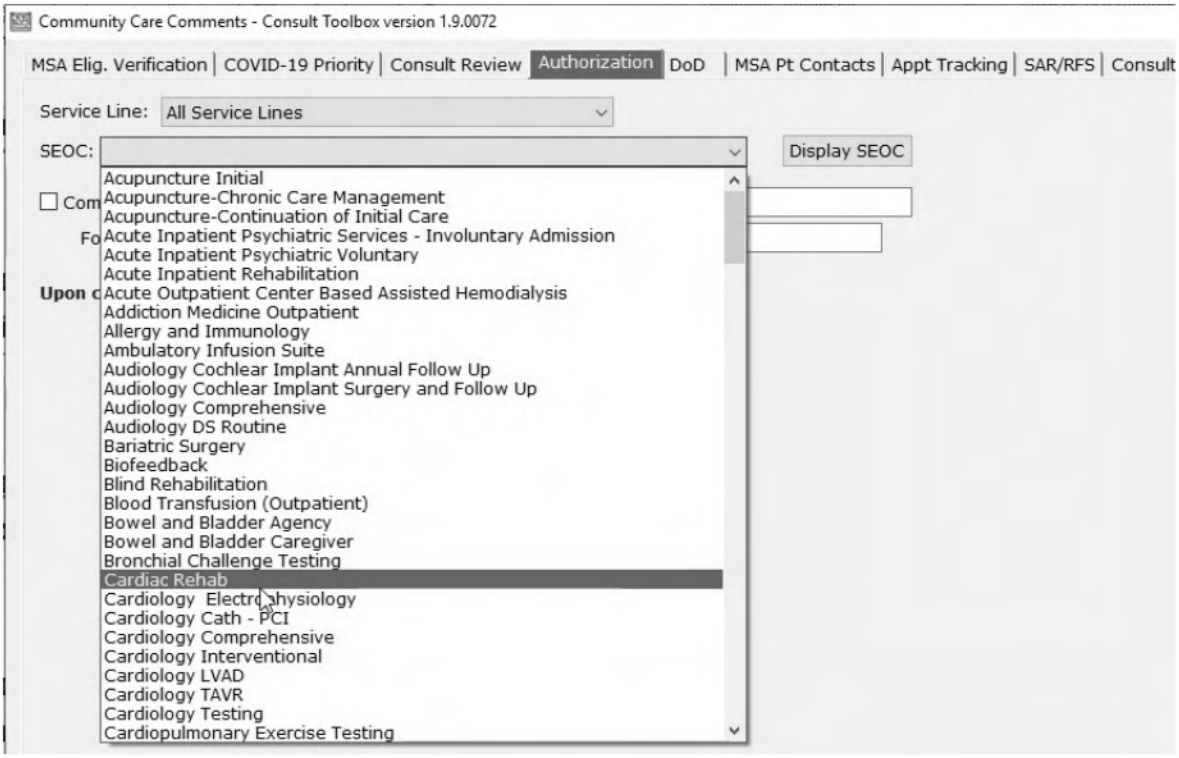
On the CTB, the Facility Community Care Office Clinical reviewer will select the Authorization Tab in the CTB for all authorization sections related to services authorized.

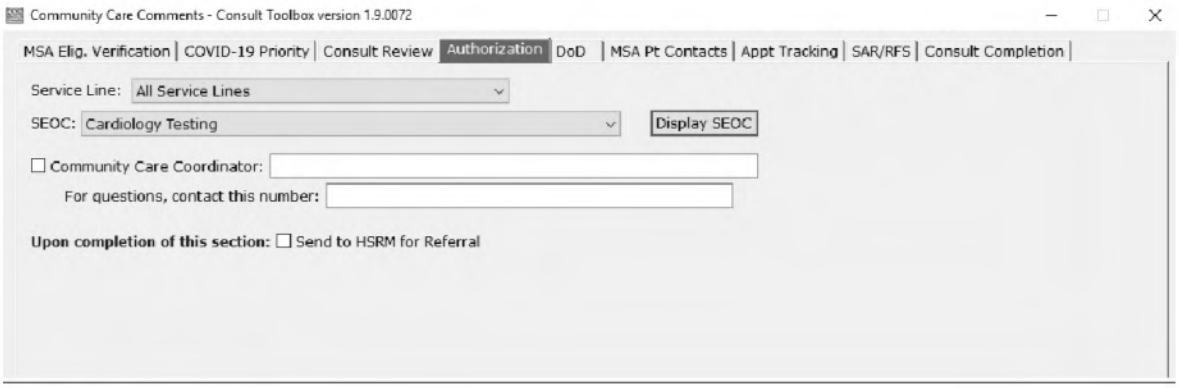
Complete the following highlighted sections:

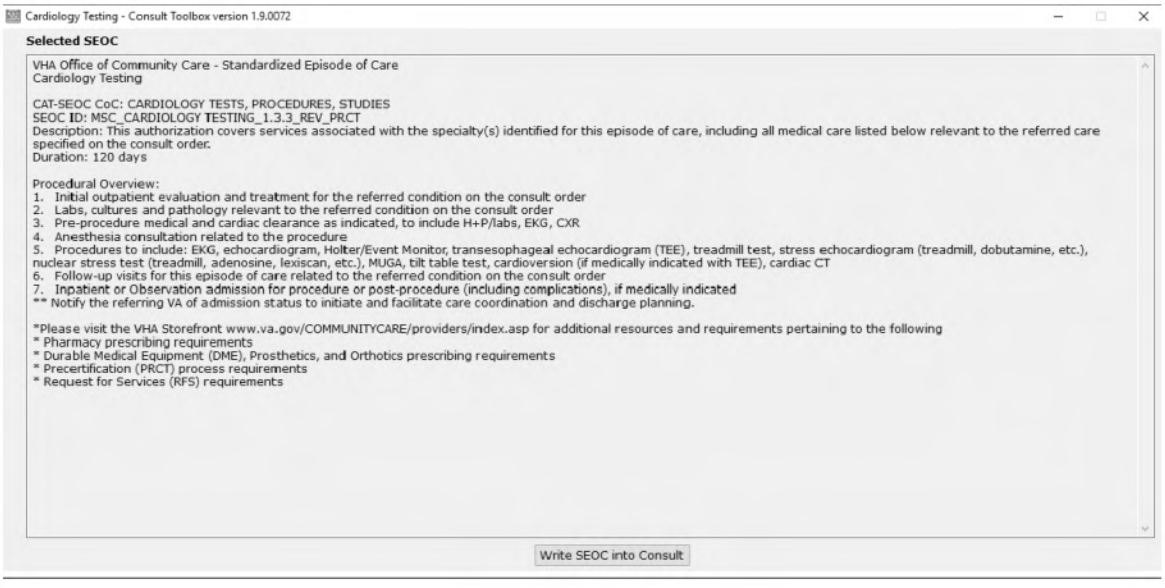
- Select the Service Line from the drop-down options.
- Select the appropriate SEOC.
- Select the appropriate SEOC from the Display SEOC section.
- Review and select Write SEOC into consult.
- Complete other sections, as needed.
- For sites utilizing HSRM, check the box Send to HSRM for referral. This will send the consult/referral to HSRM for processing.
- Click OK. This will auto-populate the SEOC to the comment section of the consult.
- Click OK again.

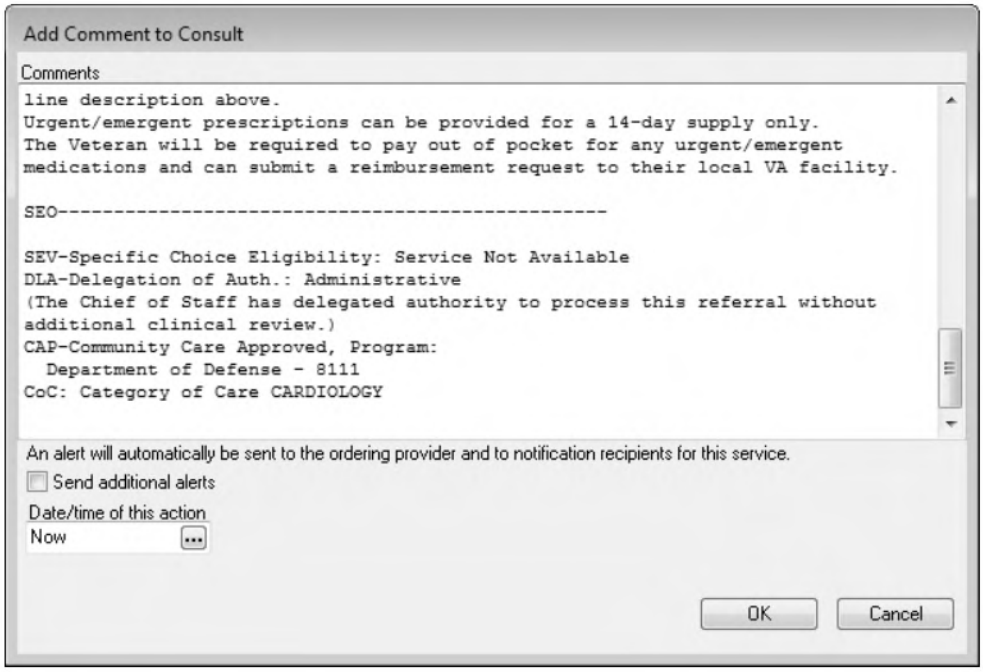
Note: Do not change any verbiage from the CTB comment section. Please add comments at the bottom after SEOC instructions.


Community Care Comments - Consult Toolbox version 1.9.0072
MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult Completion
Service Line:
All Service Lines
SEOC:
Display SEOC
Community
For quest
Upon complet
All Service Lines
Audiology
Dental Care
Dialysis
Emergent-Urgent Care
Infertility Care
Lab & Pathology Services
Medical Specialty Care
Mental Health Care
Non-Institutional Care
Physical Medicine and Rehabilitation
Primary Care
Radiology
Surgical Specialty Care
Transportation
Womens Health Care
Visit VA Consult Help Site for additional consult management guidance.
OK


Community Care Comments - Consult Toolbox version 1.9.0072
MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult
Service Line: All Service Lines
SEOC:
Display SEOC
Acupuncture Initial
Acupuncture-Chronic Care Management
Acupuncture-Continuation of Initial Care
Acute Inpatient Psychiatric Services - Involuntary Admission
Acute Inpatient Psychiatric Voluntary
Acute Inpatient Rehabilitation
Acute Outpatient Center Based Assisted Hemodialysis
Addiction Medicine Outpatient
Allergy and Immunology
Ambulatory Infusion Suite
Audiology Cochlear Implant Annual Follow Up
Audiology Cochlear Implant Surgery and Follow Up
Audiology Comprehensive
Audiology DS Routine
Bariatric Surgery
Biofeedback
Blind Rehabilitation
Blood Transfusion (Outpatient)
Bowel and Bladder Agency
Bowel and Bladder Caregiver
Bronchial Challenge Testing
Cardiac Rehab
Cardiology Electrophysiology
Cardiology Cath - PCI
Cardiology Comprehensive
Cardiology Interventional
Cardiology LVAD
Cardiology TAVR
Cardiology Testing
Cardiopulmonary Exercise Testing


Community Care Comments - Consult Toolbox version 1.9.0072
MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult Completion
Service Line: All Service Lines
SEOC: Cardiology Testing
Display SEOC
Community Care Coordinator:
For questions, contact this number:
Upon completion of this section: Send to HSRM for Referral


Cardiology Testing - Consult Toolbox version 1.9.0072
Selected SEOC
VHA Office of Community Care - Standardized Episode of Care
Cardiology Testing
CAT-SEOC CoC: CARDIOLOGY TESTS, PROCEDURES, STUDIES
SEOC ID: MSC_CARDIOLOGY TESTING_1.3.3_REV_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order.
Duration: 120 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition on the consult order
2. Labs, cultures and pathology relevant to the referred condition on the consult order
3. Pre-procedure medical and cardiac clearance as indicated, to include H+P/labs, EKG, CXR
4. Anesthesia consultation related to the procedure
5. Procedures to include: EKG, echocardiogram, Holter/Event Monitor, transesophageal echocardiogram (TEE), treadmill test, stress echocardiogram (treadmill, dobutamine, etc.), nuclear stress test (treadmill, adenosine, lexiscan, etc.), MUGA, tilt table test, cardioversion (if medically indicated with TEE), cardiac CT
6. Follow-up visits for this episode of care related to the referred condition on the consult order
7. Inpatient or Observation admission for procedure or post-procedure (including complications), if medically indicated
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
*Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Precertification (PRCT) process requirements
* Request for Services (RFS) requirements
Write SEOC into Consult



Consult Toolbox – DoD Section

DoD response times:

- Urgent Consult: 90 minutes from the time phone call received from Facility Community Care staff.
- Routine: 2 business days following receipt of referral packet.
- Community care staff will identify the urgency of the consult, selecting the appropriate selection from the dropdown box.
    - Document the DoD referring MTF.
    - Click on OK and proceed with scheduling process.