



CTB Version 2.0

Receiving Community Care CC Eligibility Steps

- From the **Action** menu, select **Consult Tracking...**, and then select **Receive**. The **Receive Consult** dialog box opens:

Receive Consult

Comments

Date/time of this action: Now ...

Action by: [User Name] ...

Open Consult Toolbox OK Cancel

- Click **Open Consult Toolbox**. The **Receive CC Consult** dashboard opens.
- From the workflow menu, select **CC Eligibility (DST) tab**. The **Receive Community Care CC Eligibility (DST) Dashboard Screen** displays:

Consult Toolbox v2.0.0 What's New TBD Help Logout

Veteran Name: PATIENT, TEST
Date of Birth: Jan 1, 1900 (121)

Residential Address: (b)(3):38 U.S.C. 5701; (b)(6)

Consult to Service/Specialty: cardiology
Urgency: Routine
CID: 04/15/2021
Seen As: Outpatient

Community Care Eligibility: ? Not Established

Receive CC Consult

Consult Review
CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
 DoD Consult
 View Consult History
 User Settings

SAVE CHANGES

No community care eligibility has been found. You may save the decision information without establishing eligibility or you may manually establish eligibility by selecting an eligibility option.

Clinical Service: Cardiology

Service Type: Specialty Care
Drive Time Std: 60 minutes
Wait Time Std: 28 days

Establish CC Eligibility based on: -- Select --

Additional Comments:

VHA Facilities with recent consults in the selected Clinical Service

Facility Name (Station)	Avg Drive Time	Avg VA Wait Time	Avg CC Wait Time
Washington VA Medical Center (688)	50 - 60 min	14 days	7 days
Martinsburg VA Medical Center (613)	60 - 70 min	31 days	12 days
Baltimore VA Medical Center (512)	80 - 90 min	36 days	0 days

CHANGES NOT SAVED

- From the **Establish CC Eligibility based on** drop-down menu, select one of the options to identify Community Care eligibility. The drop-down offers the following options:
 - If 1703(e) Eligibility is selected, you will need to enter the service in the **Specify eligible service** field.
 - If **Best Medical Interest of Veteran (BMloV)** is selected, you will need to select an option from the **BMloV Criteria** drop-down menu.
 - If No clinic appointments within Wait Time Std. is selected, you will need to enter/select a date in the **Next Available Appointment** field.
- From the Veteran's Participation Preference section, select the Veteran's preference.
 - If **Opt-IN** or **Opt-OUT** is selected, you will need to select an option from the **Basis for Veteran's Preference** drop-down menu.
- In the **Additional Comments** section, enter any comments pertaining to the consult.
- Click **SAVE CHANGES**.

Community Care DoD Consult Steps

- From the **Action** menu, select **Consult Tracking...**, and then select **Receive**. The **Receive Consult** dialog box opens:

Receive Consult


Comments

Date/time of this action Action by

Now [User Name] [Role Title] [Organization]

Open Consult Toolbox OK Cancel

- Click **Open Consult Toolbox**. The Receive CC Consult dashboard opens.
- From the workflow menu, select **DoD Consult tab**. The **Receive Community Care DoD Consult Dashboard Screen** displays:


Consult Toolbox v2.0.0

[What's New TBD](#)
[Help](#)
[Logout](#)

Veteran Name
 PATIENT, TEST

Date of Birth
 Jan 1, 1900 (121)

Residential Address
 (b)(3):38 U.S.C.
 5705; (b)(6)

Consult to Service/Specialty
 cardiology

Urgency
 Routine

CID
 04/15/2021

Seen As
 Outpatient

Community Care Eligibility
 ? **Not Established**

Receive CC Consult


 Consult Review
 CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
DoD Consult
 View Consult History
 User Settings

DoD Urgency
 -- Select --

DoD facility contacted to request care

Additional Comments

SAVE CHANGES

 CHANGES NOT SAVED

- From the **DoD Urgency** drop-down menu, select the type of urgency.
- In the **DoD facility contacted to request care** field, enter the name of the DoD facility contacted to request care.
- In the **Additional Comments** section, enter any comments pertaining to the consult.
- Click **SAVE CHANGES**.

Health Share Referral Manager (HSRM)

All VAMCs should enter their VA/DoD referrals into HSRM, along with the use of the standard Community Care VA/DoD consult within the CTB. Efforts are underway to have MTFs directly access HSRM referrals through the HSRM Portal, as well. As national standardization efforts are underway but not yet finalized for VA/DoD reimbursement, VAMCs should also continue their historical method for VA/DoD referral and authorizations so that they can process VA/DoD payments as they typically have.

Due to the pending release of eCAMS 8.2 in early September 2020, which will enable DoD claims adjudication and payment through eCAMS, authorizations in FBCS will no longer be needed and the DoD referrals should be entered into HSRM. Regardless of if the VAMC is utilizing the Advanced Payment process and not processing claims through eCAMS, or is receiving DoD claims and processing them through eCAMS for payment, referrals should be entered into HSRM via the initial consult management process.

DOD Scheduling process with HSRM

- Click in "Send to HSRM for Referral" box at the bottom of the CTB authorization screen. This section will send the referral to HSRM for processing.
- Click OK.
- Once the "Send to HSRM for Referral" box is selected, it is sent to HSRM as a referral in the Approved status. *Note: This is the only way a referral can be processed in HSRM.*
- Locate referral in HSRM by using the unique consult ID (UCID), Veteran name or SSN.
- Ensure correct SEOC is present in HSRM. If SEOC is incorrect, fix SEOC in CTB and send back to HSRM.
- View either Referral Details screen (SEOC for specific referral) or Patient Details screen (all SEOCs for all the patient's referrals in HSRM).
- When selecting program authority in HSRM, select the VA DOD Sharing Agreement 8111 and the Military branch of the MTF (Army, Navy, Air Force). This allows proper payment authority as the program authority is mapped to the obligation for the site in which the payment would be made. Not selecting the correct Military branch will impact payment to the appropriate service.
- Contact MTF regarding availability of appointments, following local process.
- Assign the MTF facility as the provider when availability is confirmed. Locate MTF in PPMS provider locator menu via MTF / facility NPI.
- Advise the MTF office that the referral has been sent and has been loaded into HSRM. Follow local process.
- MTF schedules appointment and informs facility community care (CC) staff of appointment in DoD Electronic Health Record (EHR).
- Facility CC staff records appointment in HSRM: Select Option in the referral details screen and record the appointment. Select "Update" to complete the action within HSRM.
- Print Offline Referral form for MTF, unless the MTF has been granted access to the HSRM Referral Portal for receipt.
- Print Appointment letter steps here.

- MTF staff will notify the Veteran of the appointment.
- MTF sends Veteran an appointment letter with scheduled date and time and MTF access information.
- MTF and VAMC will utilize their local process for the MTF to communicate the date and time of the appointment to VAMC Facility Community Care staff. This might include: 1) phone, fax or secure email 2) direct VA staff access to the MTF appointment management system in the case of joint staffing scenarios between MTFs and VAMCs 3) direct entry of the appointment date and time into HSRM via the MTF if the MTF has HSRM access.
- If MTF changes date or time of the scheduled appointment, the MTF will send out a new appointment letter, and will notify the VAMC
- Facility CC staff will update the HSRM referral information to accurately reflect the updated time or will validate that the MTF has entered the appointment date and time into HSRM if the MTF is directly accessing HSRM.
- In the case of MTFs that are directly entering scheduled appointment date and time into HSRM, the Facility CC staff will need to enter the appointment date and time into VSE. Note: the write back function for HSRM to VSE will not occur when MTFs are directly entering appointment date and time into HSRM.

Managing Community Care DoD Referral

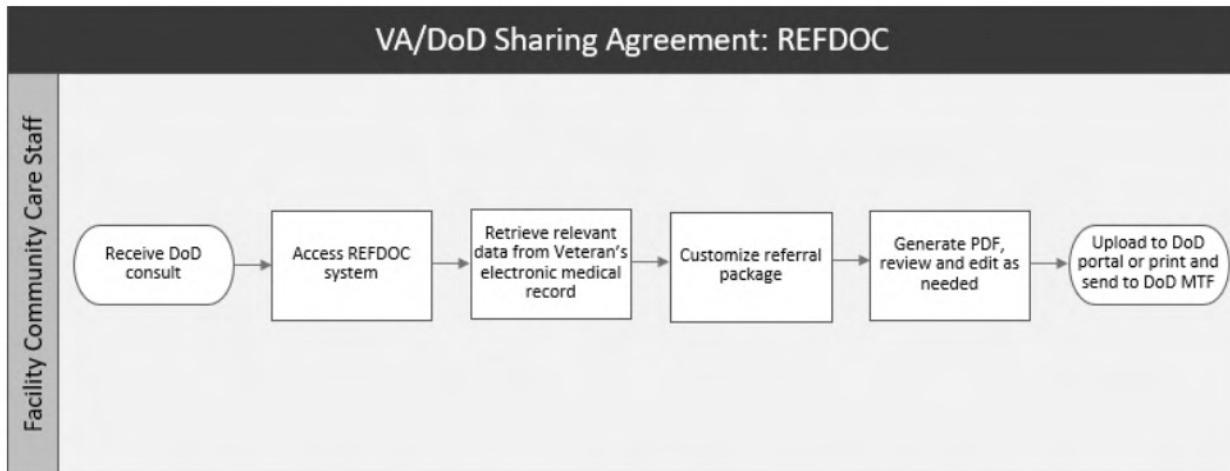
- When first appointment is scheduled, VAMC Facility CC staff or MTF staff who have access to HSRM will enter information regarding appointment into HSRM “appointment detail” section. Ensure that the appointment is also captured on the consult via the
- HSRM write back functionality and that the consult is in a scheduled status.
- If appointment is cancelled or there is a No Show, change status of appointment to cancelled or no show as appropriate in HSRM.
- After appointment, review Medical Documentation and take any appropriate care coordination actions.
- Upload medical documentation and attach in order to close consult in CPRS VistA imaging. Alternatively, the Facility CC staff can utilize the community care consult result note to upload medical documentation.
- After final care for referral has been provided, review all medical documentation to ensure EOC is complete and all medical documentation has been received.
- Upload final medical documentation into CPRS via VistA imaging, or enter the community care consult result note, and indicate in HSRM referral that the EOC is complete.
- Initiate the Community Care Coordination Plan Note for outpatient care, as necessary, and for continued stay reviews and discharge planning for inpatient care.
- Continue to follow the Veteran during the EOC for coordination of care and discharge planning.

For further details on HSRM functions, refer to the HSRM End User Guide:

<https://dvagov.sharepoint.com/sites/vacovha/DUSHCC/DC/DO/CI/CCRA/default.aspx>

Utilizing REFDOC to generate the Referral Package

REFDOC simplifies the process of submitting medical records for Community Care. It enhances care coordination and supports patient safety through improving communication and timely data sharing with community providers.



REFDOC has included a standardized HSRM Informational Sheet option to the REFDOC package menu. Please check the field "Include HSRM Informational Sheet" when sending a REFDOC package to community providers that are not provisioned with HSRM. The goal is to encourage community providers to become provisioned with HSRM by giving details on how to opt in, available training, and how to access HSRM.



Alert

REFDOC users. A new release of REFDOC will be deployed on Monday 3/1/2021 at 0700 EDT. There will be 30 minute outage during the deployment. Please plan accordingly.

GENERATE REPORT

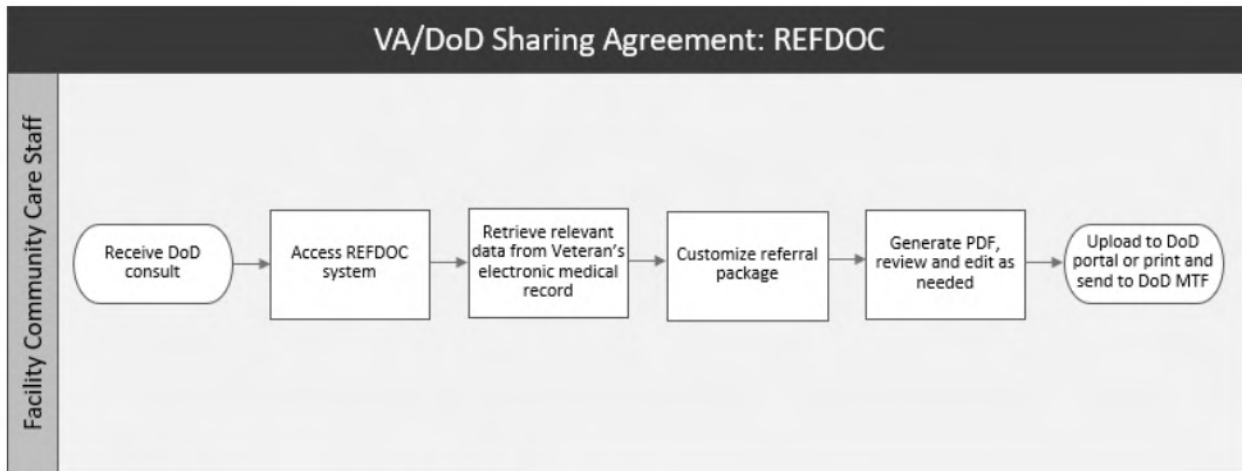


Include HSRM Informational Sheet

Patient Profile

PATIENT





How to obtain access to REFDOC

General Users must have the following to access REFDOC:

- Have a VA network login ID associated with the patient's station (e.g. VHAPOR for Portland patient).
- Have approved access to PHI/PII data in the Corporate Data Warehouse (CDW) [Local Data Access \(BISL website\)](#) for the station associated with the patient. This is the authorization needed to retrieve data from the <https://vaww.cdw.va.gov/sites/security/Pages/Home.aspx>, which will require supervisor's approval.
- Have "VIAB WEB SERVICES OPTION" associated with your VistA profile as a secondary menu. This is the authorization needed to retrieve data directly from VistA, which will require supervisor's approval.
- If you have met these requirements and are still experiencing issues, please contact the REFDOC Team via email, REFDOCNATIONALFEEDBACK@va.gov or submit a ticket through the 'YourIT' desktop link on your device for assistance.

REFDOC Reference: [REFDOC User Information](#)

Scheduling

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.

Was DoD MTF able to respond in a timely manner?

- No: Follow up with DoD POC and follow Facility Community Care process.
- Yes: DoD MTF schedules appointment with Veteran and notifies Facility Community Care staff.

If DoD is unable to contact the Veteran for an appointment, or unable to schedule, DoD will notify the Facility Community Care staff using local procedures.

Facility Community Care staff will attempt to contact the Veteran two times before the

“Unable to contact Veteran letter” is sent to the Veteran (see Section 4.2, below, for more information).

HSRM Scheduling

VA facilities will work directly with MTFs to schedule care. For MTFs which have yet to receive direct access to the HSRM Portal, then HSRM should be utilized by the VAMC to document the date and time of the scheduled appointment, as coordinated by the MTF. For those MTFs, which are directly utilizing HSRM, then DoD can directly update appointment dates and times within HSRM.

How to Follow Up if Unable to Contact Veteran

If unable to contact Veteran after the scheduling attempts, cancel the consult in collaboration with VA Ordering Provider and add comment documenting justification in the CTB (Status changed to Cancelled).

For **sample** letters, please refer to the **Unable to Contact Veteran Letter: VA Services Unavailable Template** and the **Unable to Contact Veteran Letter: Appointment Greater than**

30 Days Template

For additional information refer to Contact Veteran and Fulfill Minimum Contact Requirements within Chapter 3 on the **FGB**.

Additional services requested by DoD MTF provider (RFS)

- Review the, Request for Service (RFS) from the MTF provider.
- Determine if the RFS is related to the EOC of the Community Care - DoD consult.
- If the RFS is on the SEOC, a new authorization is not needed. If the RFS is not identified on the SEOC, the clinical reviewer will communicate with the VA Provider to initiate a new Community Care identified - DoD Consult for the additional services requested. If not approved, follow your local not approved process.
- If the RFS is related to the EOC of the original Community Care - DoD Consult, and consult is closed, the clinical reviewer will communicate with the VA Provider to initiate a new Community Care - DoD Consult for the additional services requested.
- When the RFS is NOT related to the EOC of the original Community Care – DoD Consult, the clinical reviewer will communicate with the VA Provider to initiate a new Consult for the additional services requested if approved and appropriate
- When the RFS is not approved, Facility Community Care will notify DoD MTF POC.
- For full processes related to RFS requests, please see Chapter 3.43 of the **FGB**



(CTB Version 1.9.0078)

Community Care Comments - Consult Toolbox

MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | **SAR/RFS** | Consult Completion

Secondary Authorization Request (SAR)/Request

SAR/RFS Urgency: Routine
w/in 48 hrs
w/in 1 wk
w/in 1 month

SAR/RFS was entered into Vista Imaging

SAR/RFS Details of what was Requested:

Actions Taken

☐ Request is Clinically Appropriate ☐ Additional Time: ☐ Additional Services ☐ Approved as req. above
☐ Service Available at VA

Details:

☐ Request is not Clinically Appropriate ☐ Not a covered benefit ☐ Missing Documentation ☐ Reassessment by VA Provider Required
☐ Other reason ☐ Not Clinically Appropriate

Denial Details:

[Visit VA Consult Help Site for additional consult management guidance.](#)

OK



(CTB Version 2.0)

Consult Toolbox v2.0.0

What's New TBD | Help | Logout

Veteran Name: PATIENT, TEST
Date of Birth: Jan 1, 1900 (121)

Residential Address: (b)(3):38 U.S.C. 5705; (b)(6)

Consult to Service/Specialty: cardiology
Urgency: Routine
CID: 04/18/2021
Seen As: Outpatient

Community Care Eligibility: ? Not Established

CC CONSULT COMMENT

Consult Review
CC Eligibility (DST)
Contact Attempts
Patient Preferences
Admin Screening
Clinical Triage
DoD Consult
Appointment Tracking
Request for Service (RFS)
Consult Completion
View Consult History
User Settings

SAVE CHANGES

CC Contact Attempts Page

Date Received (required) Sent for scanning (required)

RFS Urgency: -- Select --

RFS - Details of what was requested:

☐ Requires Delegation of Authority clinical review

Delegation of Authority - Clinical Review Method: -- Select --

Clinical Evaluation of RFS: -- Select --

RFS Decision: -- Select --

Notification of RFS Decision
☐ Requesting provider notified of RFS decision

Additional Comments:

CHANGES NOT SAVED

Community Care - DoD Hospital Notification

A **Community Care-DoD Hospital Notification Note** is a CPRS Progress Note template that is initiated and continued each time the VA is notified of a patient in the MTF emergency department or inpatient setting. It serves as a documentation and communication tool for all interdisciplinary team members (e.g., Patient Aligned Care Team [PACT], social workers, case managers, behavioral health, Home Based Primary Care [HBPC]/Geriatric Extended Care [GEC]) to track the potential Veteran. It also serves to notify the Facility Community Care Team/Transfer Center staff to verify and document administrative eligibility and/or clinical criteria, and to transmit the clinical status through the episode of medical care to the interdisciplinary team responsible for the Veteran's care. The Community Care - DoD Hospital Notification Note is only opened as a *NEW NOTE* once; then it continues to be utilized in CPRS under the *MAKE ADDENDUM* function for the same episode of care.

Care Coordination begins when the VA is notified of a patient in an MTF emergency department or inpatient setting. It is expected that the DoD will notify VA within three (3) calendar days of patient's MTF Emergency Department EOC. However, the three calendar days notification is NOT an eligibility requirement for approving care.

This process includes initiation and consistent use of the standardized Community Care - DoD Hospital Notification Note that supports communication, coordination and facilitation of services to the eligible Veteran, transfer back to the VA facility or follow-through to discharge (e.g. home, skilled nursing facility, death, etc.). For Inpatient transfer back to the VA, follow your local DoD sharing agreement/local policy.

The hospital notification process is utilized for Veterans **self-presenting** and admitted to emergency department or inpatient status and follows the **VHA Directive 1601A.02.**

The hospital notification progress note has the approved/disapproved decision within the progress note. Once approved, the Community Care-DoD Hospital Notification Approval XXXX Consult will be automatically initiated to use for the referral and authorization utilizing the CTB and HSRM.

DoD – VA Hospital Notification Procedures

All Veterans who present independently (self-referred) to the DoD Emergency Department will require a Community Care-DoD Hospital Notification XXXX Progress Note for that EOC for continuous stay review and approval/disapproval determination.

MTF notifies the VA of Veteran in the ED or inpatient. It is expected that the DoD will notify VA within three (3) calendar days of patient's MTF Emergency Department EOC. However, the three calendar days is NOT an eligibility requirement.

VA staff initiates the Community Care - DoD Hospital Notification Note XXXX.

- Select the first option > DoD Treatment Facility – Intake Section.
- Complete all the required fields and all other information available.
- If you are unable to continue with the other sections of the Community Care - DoD

Hospital Notification note, click on Finish, sign the note, and add all pertinent VA staff as additional signers, including the Transfer Coordinator.

- If you can continue with the note, scroll down and other options will appear for completion. Click Finish, sign the note and add all pertinent VA staff, including the Transfer Coordinator.
- Select Clinical Care Coordination Information for completion of this section template.
 - Follow the patient throughout the entire EOC, documenting continued stay reviews, transfer status, discharge planning, discharge disposition, and appointment management.
 - For post discharge DoD appointments, it may require an additional Community Care- DoD Specialty XXXX Consult.
 - Surgical procedures and associated care will be covered within the SEOC.

Reminder Dialog Template: COMMUNITY CARE-DoD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION
☐ CLINICAL CARE COORDINATION INFORMATION
☐ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

Visit Info Finish Cancel

<No encounter information entered>

* Indicates a Required Field

- a. After completion of each section, click on Finish, sign the note, and add all pertinent VA staff, including the Transfer Coordinator.

Reminder Dialog Template: VA-DoD HN

☒ DOD TREATMENT FACILITY - INTAKE SECTION

Facility:

Hospital Notification Date: *May 17, 2018@13:35 ...

Method of Contact: [v] []

Point of Contact Name: *

Point of Contact Dept: [v] []

Point of Contact Phone #: *

Point of Contact Fax #: *

DoD Treatment Facility Name: *

Address: *

City: *

State: *

Zip: *

Phone: *

Date Presenting to the DoD Facility: *

Chief Complaint: *

Patient Admitted?

☐ Yes:
☐ No:
☐ ...

Visit Info Finish Cancel

DOD TREATMENT FACILITY - INTAKE SECTION

<No encounter information entered>

* Indicates a Required Field

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☐ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

Visit Info Finish Cancel

No encounter information entered

* Indicates a Required Field

b. Select VA HEALTH CARE ELIGIBILTY WITH DETERMINATION

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☐ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

Health Care Eligibility Administrative Review

Approval (Administrative Review):

- Select VA Health Care Eligibility with determination.
- Select Administrative Review.
- Determine Veteran's 1601A.02 eligibility.
- If Veteran meets administrative eligibility under VHA 1601A.02, select YES, and

- notify Clinical staff to place Community Care-DoD Hospital Notification Approval consult. Add additional comments as needed. Select Finish and sign the note, adding all pertinent VA staff as additional signers.

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☒ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

☒ Administrative Reviewer

 It is expected that the DoD Emergency Department or inpatient staff will notify VA Facility Community Care office from the time patient presented to the DoD or within 3 calendar days.
 All patients who presents independently to DoD Emergency Department will require a Community Care-DOD Hospital Notification progress note for that episode of care for continuous stay review and approval/disapproval determination.

Service Connected Disabilities: **Replace this field with facility service connection object**

 Please use VHA DIRECTIVE 1601A.02 (Amended July 27, 2017) for Determining Veterans eligibility for VA Health Care Benefits. Do not use VHA 1601.F Community Care Directive for VA/DOD Process.

Health Care Eligibility:

Does Veteran meet 1601A.02 eligibilty?:

☒ Yes - Veteran meets 1601A.02 eligibility
 Notify Clinical Staff to place Community Care-DOD Hospital Notification Approval consult.

☐ No - Veteran does not meet 1601A.02 eligibility

Additional comments:

☐ No

☒ Yes

*

Visit Info Finish Cancel

Not Approval (Administrative Review):

- If Veteran does not meet administrative eligibility under VHA 1601A.02, select NO and communicate to DoD POC and VA Clinical reviewer for alternative care plan.
- Add additional comments.
- Select Finish, sign the note and add any pertinent VA staff as additional signers.

Note: Contact your local Eligibility/Enrollment Office for appropriate guidance on non- eligible Veterans under VHA 1601A.02

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☒ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

☒ Administrative Reviewer

It is expected that the DoD Emergency Department or inpatient staff will notify VA Facility Community Care office from the time patient presented to the DoD or within 3 calendar days.

All patients who presents independently to DoD Emergency Department will require a Community Care-DOD Hospital Notification progress note for that episode of care for continuous stay review and approval/disapproval determination.

Service Connected Disabilities: **Replace this field with facility service connection object**

Please use VHA DIRECTIVE 1601A.02 (Amended July 27, 2017) for Determining Veterans eligibility for VA Health Care Benefits. Do not use VHA 1601.F Community Care Directive for VA/DOD Process.

Health Care Eligibility:

Does Veteran meet 1601A.02 eligibility?:

☐ Yes - Veteran meets 1601A.02 eligibility

☒ No - Veteran does not meet 1601A.02 eligibility

Communicate to DOD POC eligibility status

Additional comments:

☐ No

☒ Yes

*Veteran does not meet 1601A.02 eligibility, Clinical review notified, DOD POC notified

Visit Info Finish Cancel

Not Approval (Clinical Review)

- For VAMC Clinical reviewers performing both Administrative review and Clinical review, if Veteran does not meet administrative eligibility under VHA 1601A.02, select NO and communicate with DoD POC for alternative care plan.
- Add additional comments.
- Select Finish, sign the note and add any pertinent VA staff as additional signers.

Note: Contact your local Eligibility/Enrollment Office for appropriate guidance on non- eligible Veterans under VHA 1601A.02.

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☒ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

☐ Administrative Reviewer

☒ Clinical Reviewer

☒ Health Care Eligibility

 It is expected that the DoD Emergency Department or inpatient staff will notify
 VA Facility Community Care office from the time patient presented to the DoD or
 within 3 calendar days.
 All patients who presents independently to DoD Emergency Department will require
 a Community Care-DOD Hospital Notification progress note for that episode of care
 for continuous stay review and approval/disapproval determination.

Service Connected Disabilities: **Replace this field with facility service connection object**

 Please use VHA DIRECTIVE 1601A.02 (Amended July 27, 2017) for Determining
 Veterans eligibility for VA Health Care Benefits. Do not use VHA 1601.F
 Community Care Directive for VA/DOD Process.

Does Veteran meet 1601A.02 eligibility?

☐ Yes - Veteran meets 1601A.02 eligibility

☒ No - Veteran does not meet 1601A.02 eligibility

Communicate to DOD POC eligibility status

Additional comments:

☐ No

☒ Yes

*Pt does not meet 1601A.02 eligibility criteria , E/E notified , DoD POC notified

Visit Info Finish Cancel

Approval (Clinical Review):

For VAMC Clinical reviewers performing both Administrative review and Clinical review, complete the following steps:

- The clinical reviewer will select VA Health Care Eligibility With determination.
- Select Clinical Reviewer.
- Select Health Care Eligibility.
- Determine Veteran's 1601A.02 eligibility.
- If Veteran meets administrative eligibility under VHA 1601A.02, select YES.
- Select the appropriate MTF.
- Add additional comments.
- Click on Place Community Care DoD Hospital Notification Approval Consult.
- Select Finish.

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☒ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

☐ Administrative Reviewer

☒ Clinical Reviewer

☒ Health Care Eligibility

It is expected that the DoD Emergency Department or inpatient staff will notify VA Facility Community Care office from the time patient presented to the DoD or within 3 calendar days.

All patients who presents independently to DoD Emergency Department will require a Community Care-DOD Hospital Notification progress note for that episode of care for continuous stay review and approval/disapproval determination.

Service Connected Disabilities: **Replace this field with facility service connection object**

Please use VHA DIRECTIVE 1601A.02 (Amended July 27, 2017) for Determining Veterans eligibility for VA Health Care Benefits. Do not use VHA 1601.F Community Care Directive for VA/DOD Process.

Does Veteran meet 1601A.02 eligibility?

☒ Yes - Veteran meets 1601A.02 eligibility

Select the MTF Facility, then click Finish to enter note and place consult.

☒ Pensacola Navy Hospital

☐ MTF 2

☐ No - Veteran does not meet 1601A.02 eligibility

Additional comments:

☒ No

☐ Yes

☒ Place Community Care-DOD Hospital Notification Approval consult

Visit Info Finish Cancel

- The Community Care-DoD Hospital Notification Approval XXXX consult will display in CPRS for completion.
- The Community Care-DoD Hospital Notification Approval XXXX consult order template will appear on your screen.
- Complete the Community Care DoD Hospital Notification Approval consult.
- Justification for Community Care defaults to other: Veteran self-referred.
- Type of Services defaults to Evaluation and Treatment.
- Complete all mandatory fields on the consult.
- Select Approved for 1601A.02 Eligibility.
- Click OK.

Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL

Justification for Community Care:
Other: Veteran self-referred

Type of Service: Evaluation and Treatment
(If diagnostic or treatment option is selected a procedure entry is required)

Chief Complaint: *
chest pain

Patient History / Clinical Findings / Diagnosis (Co-Morbidities):
(Include Relevant Dx Test and Treatment to Date)
*55 y/o male with Hx of HTN, DM

Third Party Liability: (Examples: Motor Vehicle Accident, Work Related Injury, Other)
*☐ Yes ☒ No

DOD Hospital name/address/telephone: *
Pensacola Navy Hospital 123 main St

Date/Time presented to the DOD Facility: *May 30, 2019@08:50

Disposition: *
☐ ED treated and released
☐ Observation
☒ Admitted:

VA Health Care Eligibility with Determination:
*☒ Approved for 1601A.02 eligibility

* Indicates a Required Field Preview OK Cancel

Completing the Community Care DoD Hospital Notification Approval Consult

- Click OK and the Order a Consult will appear.
- Select "STAT" on the Urgency section of the order.
- Select the CID. This date will be the date you are entering the consult.
- On the Attention section, select the appropriate provider/staff from the dropdown. This will send an alert to the individual selected.
- Select the appropriate status of the patient: Inpatient or Outpatient.
- Select the appropriate Provisional Dx. This information can be obtained from the medical documentation received from the Community provider.
- Click on Accept Order.
- Sign your Community Care DoD Hospital Notification note.



CTB Version 1.9.0078

COMMUNITY CARE-DoD HOSPITAL NOTIFICATION NOTE
 Vst: 04/05/19 COMMUNITY CARE-ACUPUNCTURE 548 Apr 05,2019@13:07

VA HEALTH CARE ELIGIBILITY WITH DETERMINATION
 Service Connected Disabilities:

Order a Consult

Consult to Service/Specialty
 COMMUNITY CARE-DoD HOSPITAL NOTIFICATION A
 COMMUNITY CARE-DoD HOSPITAL NOTIFICATION A

Urgency: STAT Attention: (b)(6) REMOT

Clinically indicated date:
 Apr 5,2019

Patient will be seen as an:
☐ Inpatient ☒ Outpatient

Place of Consultation:
 CONSULTANT'S CHOICE

Provisional Dx (REQUIRED)
 Acute myocardial infarction, unspecified (I21.9) Lexicon

Reason for Request

COMMUNITY CARE-DoD HOSPITAL NOTIFICATION APPROVAL Cons
 CONSULTANT'S CHOICE STAT

Accept Order Quit

NEW Screen shot

Signing the Community Care-DoD Hospital Notification Approval Consult

- Click on the order tab and highlight the Community Care-DoD Hospital Notification Approval consult order as indicated with the number "1" on the screenshot below. The consult should appear as the first order for selection.
- Select the "Action" tab on the top left indicated as number "2" on the screenshot, then right click.
- Select Release without MD Signature shown as number "3" on the screenshot below.

Vista CPRS in [redacted] (test.west-palm.med.va.gov)

File Edit View **Action** Options Tools Help

Patient 0000-00-0

View Orders

Active Orders (includes Pending & Released Orders)

Write Delayed Orders

Write Orders

Alerts/Adverse Reactions

Outpatient Medication

Outpatient Medication

Non VA Medications

Outpt Med Quick Order

Nursing Text Order

Outpatient Nursing Orders

Policy Orders PC

MAS use ONLY:

Direct Scheduling

Direct Scheduling

Laboratory

Labs Today Routine...

Change...

Copy to New Order...

Discontinue / Cancel...

Change Release Event

Hold...

Release Hold...

Renew...

Alert when Results...

Complete...

Flag...

Unflag...

Verify...

Chart Review...

Release without MD Signature...

Signature On Chart...

One Step Clinic Admin

29

ACE

No PACT/HBPC assigned at any VA location /

Active Orders (includes Pending & Released Orders) - ALL SERVICES

Service Order

Consults

COMMUNITY CARE DOD HOSPITAL NOTIFICATION APPROVAL

Cons. Consultant's Choice STAT "UNSIGNED"

Clinic Scribes

Return to WPB ADDRO PO on or around (DEC 14, 2018)

for a total of 1 appointment(s)

labs to be done prior

Vitals

>> TPR B/P & PAIN : Q8H

A pain score of 4 or more requires assessment or reassessment

Nursing

>> EAR LAVAGE (b)(6) Dec 14, 2018 Dec 17, 2018

>> EAR LAVAGE (b)(6) Dec 13, 2018@12:54 Dec 13, 2018@13:10

>> 24hr CHART REVIEW: Completed

>> NPO for 24 hours except sips of water with medications. Start NOW

Out. Meds

CARBAMIDE PEROX 6.5% OTIC SOLN 15ML

PLACE FIVE DROPS IN THE EAR(S) DAILY FOR THE EAR

Quantity: 1 Refills: 0

Non-VA Med

Non-VA ICDOEXTIN

SPECIFY AMOUNT INTRAVENOUS BID EXT Prescribed by non-VA provider.

Non-VA FLUOROURACIL 5% SOLN TOP 5%

APPLY SMALL AMOUNT EXTERNALLY TWICE A DAY Prescribed by a remote

3

- Release Orders to Service(s) screen will appear.
- Select Policy, then OK.

Release Orders to Service(s)

The following orders will be released -

COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL Cons Consultant's

Nature of Orders

☐ Verbal ☐ Telephone ☒ Policy

OK Cancel

- Enter your Signature code.
- Click OK.

Release Orders to Service(s)

The following orders will be released -

COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL Cons Consultant's

Electronic Signature

Enter your electronic signature to release these orders.

Signature Code

OK Cancel

Nature of Orders

☐ Verbal ☐ Telephone ☒ Policy

OK Cancel

Finalizing with ConsultToolbox



CTB Version 1.9.0078

- Continue to work through the consult utilizing the CTB Community Care functions.
- On the Consult Review Tab of the CTB, click on Request Approved (select CC Program) and select Department of Defense -8111 from the dropdown. Continue with consult management for the EOC.
- On the Authorization tab of the CTB, select Emergency Care as the SEOC.
- Continue to follow the patient throughout the entire EOC, documenting continued stay reviews, transfer status, discharge planning, discharge disposition, and appointment management.

Community Care Comments - Consult Toolbox

MSA Elig. Verification | COVID-19 Priority | **Consult Review** | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult Completion

Community Care Clinical Review (for use by community care staff only)

☒ Request Approved (Select CC Program): Department of Defense - 8111 Comment:

☐ Request Disapproved (reason):

Clinical Review Method:

Hardship Request Approval

☐ Is this a Community Care-Hardship Determination?

☐ Request Approved by COS or by his or her designee
 ☐ Approved for 6 months
 ☐ Approved for 12 months
 ☐ Request Disapproved by COS or by his or her designee

Provider may authorize discontinuation of care

☐ May discontinue if Veteran cancels/no-show

Is responsible for scheduling

☐ Community Care Contractor
 ☐ VA Staff

Previous AdminCare Coordination Level: Not determined

Most Recent Assessment:

Clinical Triage:

Visit VA Consult Help Site for additional consult management guidance.

Finalizing with ConsultToolbox



CTB Version 2.0

- Continue to work through the consult utilizing the CTB Community Care functions.
- On the “Consult Review” tab of the CTB, click on the Community Care Program drop down listing and select “Department of Defense -8111”.
- While still on the Consult review tab, select “Emergency Care” as the SEOC.
- Continue with the consult management for the EOC.

https://dtt-demo.va.gov/ctb/?dttID=a3304b32-6935-40ed-a3a9-155fa1b2a80f

Search...

abouttabs Action Item Internal Tracker AUTHOR CONSOLE CC NATIONAL PORTAL CHOICE FIRST - Veterans ... Choice First CHOICE-F Free Hotline Huntington VA Medical C... Suggested Sites (2) Suggested Sites (4) Suggested Sites (3)

Consult Toolbox v0.1.72 What's New Help

Veteran Name PATIENT, TEST Date of Birth Jan 1, 1900 (121)	Residential Address (b)(3);38 U.S.C. 5701; (b)(6)	Consult to Service/Specialty COMMUNITY CARE-DOD Urgency Routine	CID 05/24/2021 Seen As Outpatient	Community Care Eligibility <input checked="" type="radio"/> Drive Time
---	---	--	--	--

RECEIVE CC CONSULT
 Consult Review
 CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
 DoD Consult
 View Consult History
 Go to VA Workflow
 User Settings

Consult Review

Clinical Service (required)

Emergency Department

COVID-19 Scheduling Triage (required)

☐ Priority 1 - Proceed with scheduling

-- Select --
 Authorized referral-1703
 Veterans Care Agreement (VCA)-1703A
 Beneficiary Travel-38 USC 111
 Caregiver-1720G
 Dental-1712
Department of Defense-8111
 Emergency NSC-1725
 Emergency SC-1728
 Indian Health Service-38 USC 8153 (25 USC 1645)
 In Vitro Fertilization/ART-1703
 Newborn-1786
 Alternatives to nursing home care-1720C
 Respite Care-1720B
 Transfers for nursing home/adult day care-1720
 Tx/Rehab for drug or alcohol dependency-1720A
 Tribal Health Program-38 USC 8153 (25 USC 1647)
 Urgent Care-1725A
 Local Contract-8153
 Other (explanation required)

Preferred modality options for this consult (required)

☐ Any modality/patient choice
☐ In-person appointment

Responsible for Scheduling (required)

-- Select --

Veteran's Participation Preference (required)

☒ Opt-IN for Community Care
☐ Opt-OUT of Community Care
☐ TBD/Deferred

Basis for Veteran's Preference (optional)

-- Select --

Standardized Episode of Care (SEOC)

Emergency Care_TestSEOC **View SEOC**

HSRM CC Referral

Current HSRM referral status

Not Sent
☐ Send consult to HSRM as an approved referral

Additional Comments

SAVE CHANGES

- Continue to follow the patient throughout the entire EOC, documenting continued stay reviews, transfer status, 3discharge planning, discharge disposition, and appointment management.

CC ELIGIBILITY (DST)

Consult Toolbox v0.1.72

[What's New](#)
[Help](#)

Veteran Name
 PATIENT, TEST
Date of Birth
 Jan 1, 1900 (121)

Residential Address
 (b)(3):38
 U.S.C. 5705;
 (b)(6)

Consult to Service/Specialty
 COMMUNITY CARE-DOD
Urgency
 Routine
CID
 05/24/2021
Seen As
 Outpatient

Community Care Eligibility
☒ Drive Time

RECEIVE CC CONSULT
 Consult Review
CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
 DoD Consult
 View Consult History
 Go to VA Workflow
 User Settings

CC Eligibility (DST)

Clinical Service *(required)*

Emergency Department

Specialty Care - Wait Time Std: 28 days - Drive Time Std: 60 min

Veteran's Participation Preference *(required)*

☒ Opt-IN for Community Care

☐ Opt-OUT of Community Care

☐ TBD/Deferred

Basis for Veteran's Preference *(optional)*

-- Select --

Standardized Episode of Care (SEOC)

Emergency Care_TestSEOC

View SEOC

Additional Comments

No VHA facilities found with service availability within the drive-time standard.

DOD Consult

Consult Toolbox v0.1.72

[What's New](#)
[Help](#)

Veteran Name
 PATIENT, TEST
Date of Birth
 (b)(3):38 U.S.C.
 5705; (b)(6)

Residential Address
 (b)(3):38 U.S.C.
 5705; (b)(6)

Consult to Service/Specialty
 COMMUNITY CARE-DOD ORTHO
Urgency
 Routine
CID
 05/24/2021
Seen As
 Outpatient

Community Care Eligibility
☒ Service not available at VA

RECEIVE CC CONSULT
 Consult Review
 CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
DoD Consult
 View Consult History
 Go to VA Workflow
 User Settings

DoD

DoD Urgency

Routine - 2 Business days

DoD facility contacted to request care

wbamc

Additional Comments

SAVE CHANGES

Consult Toolbox v0.1.72

Veteran Name: PATIENT, TEST
Date of Birth: Jan 1, 1900 (121)

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

Consult to Service/Specialty: COMMUNITY CARE-DOD ORTHO

Community Care Eligibility: ☒ Service not available at VA

RECEIVE CC CONSULT

Consult Review
CC Eligibility (DST)
Contact Attempts
Patient Preferences
Admin Screening
Clinical Triage
DoD Consult
View Consult History
Go to VA Workflow
User Settings

DoD

DoD Urgency: Routine - 2 Business days

DoD facility contacted to request care: wbamc

Additional Comments

Preview of CTB-Generated Consult Comments

CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Shorter wait time
CSC-Consult stop code: 409
CSN-Clinical service: Orthopedics/Joint Surgery
CST-Consult service type: Specialty Care
SEV-CC Eligibility: Specific clinical service not available at VA
CCE-----

CAP-CC approved: Department of Defense-8111
CV1-COVID-19 Priority 1: Proceed with scheduling
DLA-DOAMS List reviewed: Does not require clinical review
PMO-Preferred modality for this consult: Any modality/patient choice
ME-May cancel if Veteran fails to respond to mandated scheduling effort
CCH-CC scheduling to be performed by: Community provider
DDU-DoD Urgency: Routine - 2 Business days
DDE-DoD facility contacted to request care: wbamc

! If you are finished, click the Close button below to transfer the comments and return to CPRS, otherwise, click CONTINUE EDITING to make changes.

CHANGES SAVED

Clinical Review

For VAMC Clinical reviewers performing only Clinical review, complete the following steps after the administrative review is complete:

- Select VA Health Care Eligibility with Determination.
- Select Clinical Reviewer.
- Select Place Community Care -DoD Hospital Notification Approval consult.
- Select the DoD MTF facility.
- Click on Finish.

Reminder Dialog Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION NOTE

☐ DOD TREATMENT FACILITY - INTAKE SECTION

☐ CLINICAL CARE COORDINATION INFORMATION

☒ VA HEALTH CARE ELIGIBILITY WITH DETERMINATION

☐ Administrative Reviewer

☒ Clinical Reviewer

☐ Health Care Eligibility

☒ Place Community Care-DOD Hospital Notification Approval consult

Select the MTF Facility, then click Finish to enter note and place consult.

☒ Pensacola Navy Hospital

☐ MTF 2

Visit Info Finish Cancel

VA HEALTH CARE ELIGIBILITY WITH DETERMINATION
Clinical Reviewer
Place Community Care-DOD Hospital Notification Approval consult
A COMMUNITY CARE-PENSACOLA NAVY HOSPITAL NOTIFICATION APPROVAL

Orders: Community Care-DOD Hospital Notification Approval

Completing the Community Care DoD Hospital Notification Approval consult:

- After clicking on Finish, the Community Care-DoD Hospital Notification Approval XXXX Consult will display in CPRS for completion.
- Template will appear on your screen.
- Complete the Community Care DoD Hospital Notification consult.
- Justification for Community Care DoD defaults to Other: Veteran self- referred.
- Type of Services defaults to Evaluation and Treatment.
- Complete all mandatory fields on the consult.
- Click Approved for 1601A.02.
- Click on OK.
- Sign the note.

Template: COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL

Justification for Community Care:
Other: Veteran self-referred

Type of Service: Evaluation and Treatment
(If diagnostic or treatment option is selected a procedure entry is required)

Chief Complaint: *
chest pain

Patient History / Clinical Findings / Diagnosis (Co-Morbidities):
(Include Relevant Dx Test and Treatment to Date)
*50 y/o male with Hx HTN,DM

Third Party Liability: (Examples: Motor Vehicle Accident, Work Related Injury, Other)
* ☐ Yes ☒ No

DOD Hospital name/address/telephone: *
Pensacola Navy

Date/Time presented to the DOD Facility: *May 30, 2019@09:49

Disposition: *
☐ ED treated and released
☐ Observation
☒ Admitted:

VA Health Care Eligibility with Determination:
* ☒ Approved for 1601A.02 eligibility

* Indicates a Required Field Preview OK Cancel

The Order a Consult template will appear on the screen. Complete the following mandatory and appropriate steps:

- Select "STAT" on the Urgency section of the order.
- Select the CID. This date will be the date you enter the consult.
- On the "Attention" section, select the appropriate provider/staff from the dropdown. This will send an alert to the individual selected.
- Select the appropriate status of the patient: Inpatient or Outpatient.
- Select the appropriate Provisional Dx. This information can be obtained from the medical documentation received from the Community provider.

- Click on Accept Order.
- Complete the order by signing the consult.

COMMUNITY CARE-DoD HOSPITAL NOTIFICATION NOTE
Vet: 04/05/19 COMMUNITY CARE-ACUPUNCTURE 548 Apr 05, 2019@13:07
VA HEALTH CARE ELIGIBILITY WITH DETERMINATION
Service Connected Disabilities:

Order a Consult

Consult to Service/Specialty
COMMUNITY CARE-DoD HOSPITAL NOTIFICATION APPROVAL CONSULTANT'S CHOICE STAT

Urgency: STAT (b)(6) REMO1

Clinically indicated date: Apr 5, 2019

Patient will be seen as an:
☐ Inpatient ☒ Outpatient

Place of Consultation: CONSULTANT'S CHOICE

Provisional Dx (REQUIRED): Acute myocardial infarction, unspecified (I21.9) Lexicon

Reason for Request

COMMUNITY CARE-DoD HOSPITAL NOTIFICATION APPROVAL CONSULTANT'S CHOICE STAT

Accept Order Quit

SCREEN SHOT

Signing the Community Care-DoD Hospital Notification Approval Consult

- Click on the order tab and highlight the Community Care-DoD Hospital Notification Approval consult order as indicated with the number "1" on the screenshot below.
- The consult should appear as the first order for selection.
- Select the "Action" tab on the top left, indicated as number "2" on the screenshot. Right click and select Release without MD Signature shown as number "3" on the screenshot below.

Vista CPRS in (b)(6) (test.west-palm.med.va.gov)

File Edit View **2** Action Options Tools Help

Patient 000-00-0

View Orders

Active Orders (Include)

Write Delayed Orders

Write Orders

Align/Adverse Reaction

Outpatient Medication

Outpatient Medication

Non VA Medications

Outpt Med Quick Onc

Nursing Text Order

Outpatient Nursing Order

RN Policy Orders PC

MAS use ONLY:

Direct Scheduling Order

Direct Scheduling Order

Laboratory

Lab Today Routine

Change...

Copy to New Order...

Discontinue / Cancel...

Change Release Event

Hold...

Release Hold...

Renew...

Alert when Results...

Complete...

Flag...

Unflag...

Verify...

Chart Review...

3 Release without MD Signature...

Signature On Chart...

One Step Clinic Admin

29

FACE

No PACT/HBPC assigned at any VA location /

Active Orders (includes Pending & Released) - ALL SERVICES

Service Order

1

Consults

COMMUNITY CARE-DoD HOSPITAL NOTIFICATION APPROVAL CONSULTANT'S CHOICE STAT "UNSIGNED"

Clinic scheduled to visit (b)(6) on or around (Dec 14, 2018) for a total of 1 appointment(s) labs to be done prior

Vitals

>> TPR B/P & PAIN : Q8H
A pain score of 4 or more requires assessment or reassessment

Nursing

>> EAR LAVAGE (b)(6) Dec 14, 2018 Dec 17, 2018

>> EAR LAVAGE (b)(6) Dec 13, 2018@12:54 Dec 13, 2018@13:10

>> 24hr CHART REVIEW: Completed

>> NPO for 24 hours except sips of water with medications. Start NOW

Out. Meds

CARBAMIDE PEROX 6.5% OTIC SOLN 15ML
PLACE FIVE DROPS IN THE EAR(S) DAILY FOR THE EAR
Quantity: 1 Refills: 0

Non-VA Med

Non-VA CODEXTRIN
SPECIFY AMOUNT INTRAVENOUS BID EXT Prescribed by non-VA provider.

Non-VA FLUOROURACIL 5% SOLN TOP 5%
APPLY SMALL AMOUNT EXTERNALLY TWICE A DAY Prescribed by a remote

- Release Orders to Service screen will appear.
- Select Policy, then OK.

Release Orders to Service(s)

The following orders will be released -

COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL Cons Consultant's

Electronic Signature

Enter your electronic signature to release these orders.

Signature Code

OK Cancel

Nature of Orders

☐ Verbal ☐ Telephone ☒ Policy

OK Cancel

- Enter your Signature code.
- Click on OK.

Release Orders to Service(s)

The following orders will be released -

COMMUNITY CARE-DOD HOSPITAL NOTIFICATION APPROVAL Cons Consultant's

Electronic Signature

Enter your electronic signature to release these orders.

Signature Code

OK Cancel

Nature of Orders

☐ Verbal ☐ Telephone ☒ Policy

OK Cancel

- Continue to work through the consult utilizing the CTB Community Care functions.
- On the Consult Review Tab of the CTB, click on Request Approved (select CC Program) and select Department of Defense -8111 from the dropdown. Continue with consult management for the EOC.
- On the Authorization tab of the CTB select Emergency Care as the SEOC.
- Continue to follow the patient throughout the entire EOC, documenting

continued stay reviews, transfer status, discharge planning, discharge disposition, and appointment management.

NOTE: Remember to sign the approved Community Care-DoD Hospital Notification progress note that you initiated prior to completing this consult.

To add additional information on the template note, follow the reloaded boiler plate for addendum.

Follow the Consult management process to complete consult, including CTB and HSRM process.

Acronyms/Abbreviations

Acronym	Description
ACP	Alternate Care Plan
AHLTA	Armed Forces Health Longitudinal Technology Application (Electronic Health Record)
AOD	Administrative Officer of the Day
CAC	Clinical Applications Coordinator
CBO	Chief Business Office
CC	Community Care
CID	Clinical Indication Date
CHCS	Composite Healthcare System
CPRS	Computerized Patient Record System
CTB	Consult Toolbox
DOA	Delegation of Authority
DOB	Date of Birth
DoD	Department of Defense
EE	Eligibility and Enrollment
EOC	Episode of Care
FBCS	Fee Basis Claims System
IDT	Interdisciplinary Team
IFC	Inter-Facility Consults
JLV	Joint Legacy Viewer

LOP	Local Operation Procedures
MTF	Military Treatment Facility
OHI	Other Health Insurance

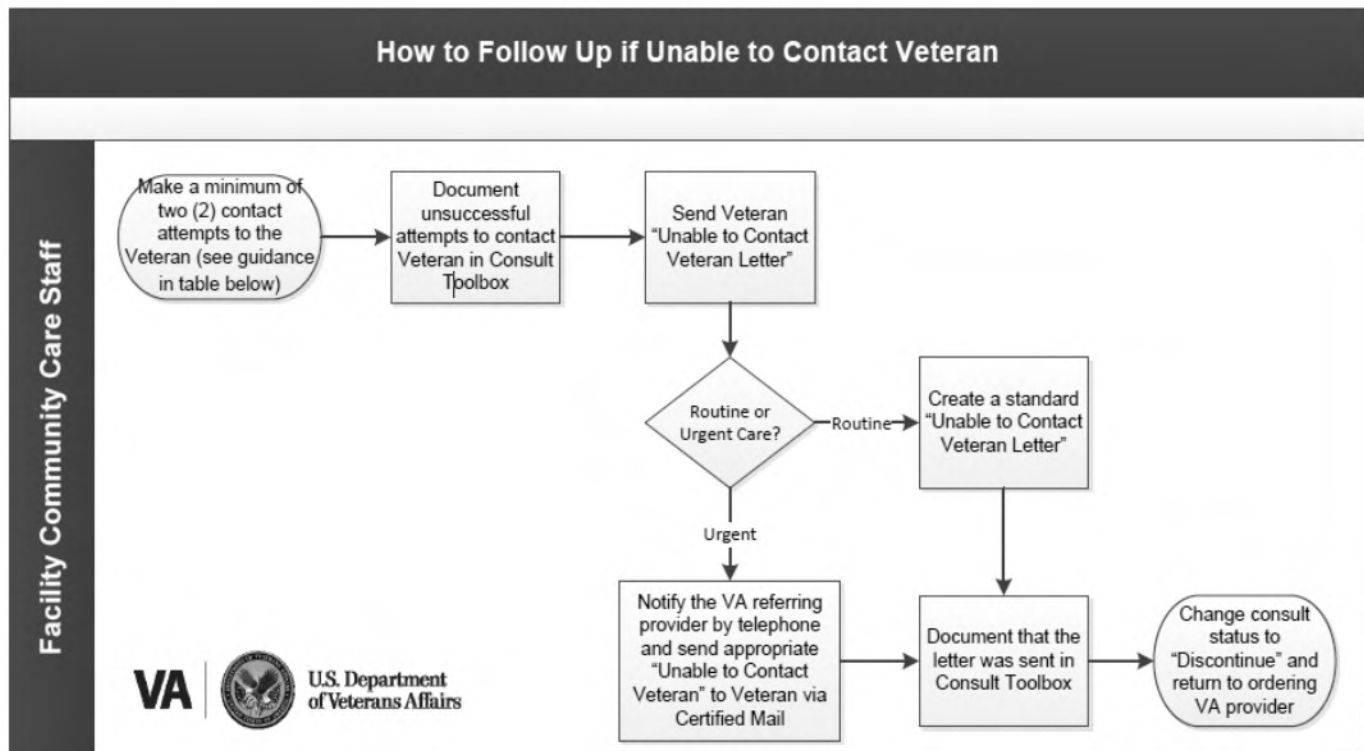
RFS	Request for Services
SAR	Secondary Authorization Request
SEOC	Standardized Episode of Care
SOP	Standard Operating Procedures
FGB	Field Guidebook
VA	Department of Veterans Affairs
VHA	Veteran's Health Administration
VistA	Veteran's Health Information Systems and Technology Architecture
VSE	VistA Scheduling Enhancements

Resources

Resource	Resource Links
Field Guidebook (FGB)	Office of Community Care Field Guidebook
BoilerPlate Text Option	Hospital Notification Support Documents: How to Utilize BoilerPlate Text Option
CC Advanced Payment DoD SharePoint	https://dvagov.sharepoint.com/sites/vacovha/DUSHCC/DC/DO/CI/VA_DOD_Adv_Pay/default.aspx
Community Care Hub	Community Care Hub
Community Care DoD Consult and Hospital Notification Training	https://vaww.va.gov/COMMUNITYCARE/cchub/training/care-coordination.asp
1601A.02 Eligibility	1601A.02 Eligibility Directive

3.13 Contact Veteran and Fulfill Minimum Contact Requirements

(Pre/Post CCN)



PROCEDURES

General Considerations:

Note: Facility community care staff will contact the Veteran and obtain Veteran preference information in instances where it is not captured at the point-of-service or in the specialty clinics at the facility.

- For more information regarding VHA scheduling requirements, please refer to: VHA Directive 1230: Outpatient Scheduling Processes and Procedure

STEP	ACTIVITY
1	<p>Document Veteran Contact in the Consult Toolbox (CTB)</p> <p>For Mental Health services</p> <ul style="list-style-type: none"> A minimum of four (4) contact attempts must be made to the Veteran. <p>Note: A minimum of three (3) phone call attempts are required to be made on separate days. The contact letter <i>may</i> be mailed on the same day as the first phone call.</p> <p>For all remaining categories of care</p> <ul style="list-style-type: none"> A minimum of two (2) contact attempts must be made to the Veteran.

	<p>Note: A minimum of one (1) phone call attempt and one (1) contact letter, may occur on the same day, to fill this requirement.</p> <p>Document “unsuccessful” attempts to contact Veteran using the CTB.</p> <p>Navigate to “<i>MSA Pt Contacts</i>” tab and select action completed: Choose either “First Call to Veteran” or “Second Call to Veteran”.</p> <p>References:</p> <p><u>VHA Notice 2019-09 (2) Minimum Scheduling Efforts Required Outpatient Appointments Updates to VHA Dir 1230 and VHA Directive 1232 (1), VHA Directive 1230: Outpatient Scheduling Processes and Procedure and the Consult Toolbox SharePoint Site.</u></p>
2	<p>If unable to contact the Veteran, send an "<u>Unable to Contact Veteran Letter</u>" and document using the Consult Toolbox.</p> <p>For STAT consults with time sensitive requirements, if the Veteran does not respond to the telephone contact attempts within 24 hours, notify the ordering VA Provider by telephone and send appropriate "Unable to Contact Veteran" letter to the Veteran.</p> <p>Document letter was sent using the CTB.</p>
3	<p>If the Veteran does not respond to the "Unable to Contact Veteran Letter" after (14) calendar days of the date of the letter, change consult status to “Cancel” and return to ordering VA Provider with the appropriate comment.</p>
4	<p>Monitor the <u>Community Care Contact Attempts Report</u> to review consults with minimum contact attempts and 14 day letters.</p>

3.14 How to Schedule Care Under Community Care Network (CCN)

Post CCN)



Under the CCN, VA facilities will have the option to work directly with Veterans and community providers to schedule care, with the goal of improving scheduling and appointment timeliness and Veteran satisfaction with community care. Scheduling can occur in various ways, depending on VA facility operations and the Veteran preference: scheduling by VA staff, scheduling by the Veteran, scheduling by the community provider, scheduling by the CCN contractor, or a combination of these various ways.

Key differences between the scheduling process using CCN compared to the PC3 contract include the following:

- Referrals are required for all episodes of care, including grandfathered Distance-Eligible Veterans (DEVs).
- Scheduling will be managed through the Facility Community Care Office, except for sites that exclusively manage their scheduling through optional Task #1.
- New technologies will support scheduling operations to enhance coordination with CCN contractors, Community Providers, and Veterans (i.e. VA Online Scheduling (mobile app) and HealthShare Referral Manager, etc.
- Eligible Veterans will have the option to self-schedule

Note: Per the Facility Community Care Ordering Officer Delegation Rescinded Announcement released September 3, 2019, as of August 13, 2019, ordering officer delegation is no longer required to order care under CCN.

For further details on previous ordering officer guidance, reference the Facility Community Care Ordering Officers Memorandum dated November 13, 2018.

HSRM Task List Management

HSRM's task management system helps facility community care staff manage all aspects of care coordination for each episode of care. The Task List also streamlines communication between facility community care staff and community providers that use HSRM. In addition, users can utilize tasks to review Veteran and referral information, create, assign and track care coordination activities, as well as set reminders and alerts to promote efficient and timely referral processing. Furthermore, they can sort and filter tasks by patient, referral number and other factors for each episode of care. The primary uses of the Task List include the following:

- Review and complete tasks from the Task List
- Create tasks with auto-triggered time windows (compliant with contract requirements and recommended business processes) for both VA facility community care staff and community provider staff to respond or take action
- Review and identify tasks for assigned users and user groups
- Perform and complete manual and automated tasks
- Track workflow and status of tasks and actions required in HSRM

The HSRM *Task List* assists facility community care staff managing referrals and in providing care coordination activities throughout the Veteran's episode of care in the community. The tasks in the *Task List* will assist the staff member with coordinating the care for the veteran and to effectively manage their workflow.

Community Provider/Facility is a Required field on referrals in HSRM

As of November 23, 2020, the Community Provider/Facility on the Referral Details Screen is a required field in HSRM for all referrals. A user may find the appropriate Community Provider/Facility by using the PPMS Provider Search link.

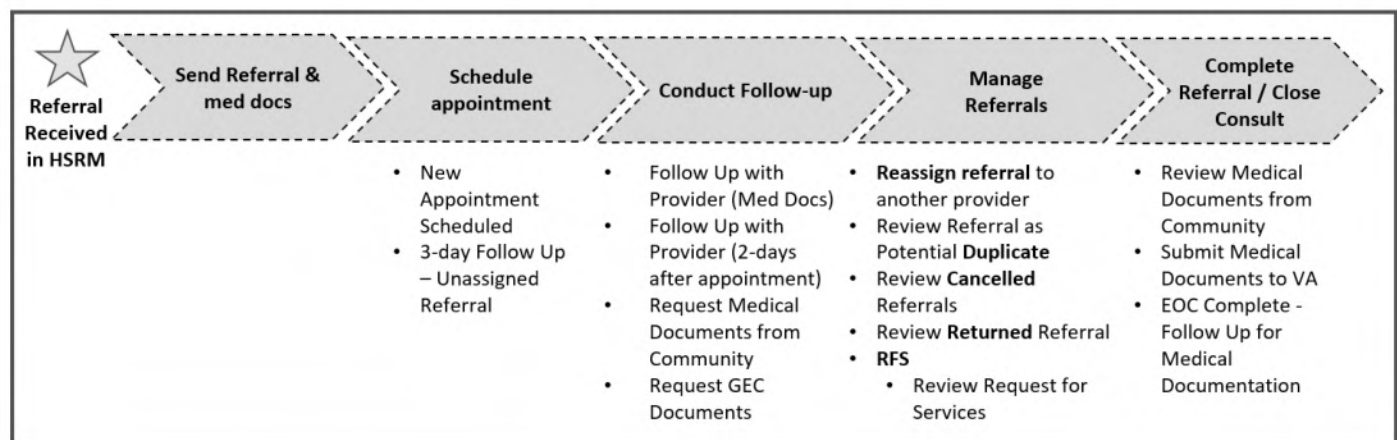
- **All users must enter a Community Provider/Facility** unless there is an Optional Task selected on referral
- **Users will not be able** to generate an Offline Referral Form if there is no Community Provider/Facility assigned
 - **A message will generate and be displayed on the Offline Referral Form** instructing the user to add a Community Provider/Facility (example message below)

U.S. Department
of Veterans Affairs

**VA Form 10-7080 - Approved Referral For
Medical Care**

A program authority AND provider must be selected in order to generate the Offline Referral Form or the Billing and Other Referral Information Form.

Care Coordination Workflow in HSRM



Priority Level on Referral List in HSRM

Using the *Find Referrals* option, users may specifically search for referrals by the *Priority* level identified by the referring provider in the consult. The *Priority* levels indicate how soon the Veteran needs to be seen by the community provider. The *Priority* levels for referrals are:

- Within 1 Week
- Today
- Tomorrow AM
- Within 1 Month
- STAT (Urgent)
- Within 24 Hours
- Routine
- Within 72 Hours

Note: The *Priority* fields on the Referral List are different from the *Priority* levels on the Task List. The *Priority* field on the Task List has been repurposed to be the level of care coordination identified by the Screening/Triage Tool.

Priority Field on Task List

Clinical and administrative staff can prioritize their Task List by filtering or sorting the *Priority* level of the task. The *Priority* field on the Task List has been changed to be the level of care coordination identified by the Screening/Triage Tool. It is recommended that users prioritize their day-to-day tasks based on the level of care coordination. For instance, users should first address tasks which are Urgent or Complex, then address tasks associated with Moderate and Basic levels of care coordination.

HSRM Tasks Associated with Scheduling Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
New Appointment Scheduled	When an appointment is scheduled, by community provider staff, at a location that is different from the initial provider.	No action is needed	Facility community care staff

HSRM Tasks Associated with Managing Referral Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
Review Returned Referral	When a community provider rejects a referral.	<ol style="list-style-type: none"> 1. Review the returned referral 2. Identify a new community provider, send the referral packet to the new community provider and notify the Veteran of the community provider change 3. Mark the task as complete 	Facility community care staff
Reassign Referral to Another Provider	When a community provider has been made inactive (i.e., end dated) and is associated with a referral in the Sent, First Appointment Made, Initial Care Given or Accepted status .	<ol style="list-style-type: none"> 1. Open PPMS to find another community provider 2. Contact the Veteran to confirm community provider preferences and select a High Performing Provider (HPP) if possible 3. Update the referral with the new community provider's information and send the referral to the new community provider 4. Mark the task as complete 	Facility community care clinical staff
Review Cancelled Referral	When a referral status is changed to Cancelled .	<ol style="list-style-type: none"> 1. Review the cancelled referral to determine if any appointments have been scheduled or attended for this referral 2. Take actions to cancel any appointments in HSRM and notify the Veteran and TPA of the appointment cancellation 3. Schedule a new appointment for the Veteran and reference the How to Schedule process per the Field Guidebook 2.0, Chapter 3, Sections 3.9 – 3.14 if needed 4. Document the contact in the CC-CCP Note 5. Mark the task as complete 	Facility community care staff and TPA
Review RFS Document	When a Request for Service (RFS) document has been uploaded to a referral. Note: RFS was formerly known as Secondary Authorization Request (SAR)	<ol style="list-style-type: none"> 1. Review the RFS form 2. Send the RFS form for clinical review, if required 3. Enter a new consult if services are approved 4. Mark the task as complete 	Facility community care staff based on level of care coordination assigned

It is recommended that facility community care staff highly prioritize reviewing returned referrals so that the referral can be sent back to the same provider or another community provider. The staff need to follow their facilities internal processes prior to sending the referral back to a community provider. Once a new provider has been selected, they will manually change the status of the referral to Sent and save the changes to the referral. This will send the referral back to the community provider or a new community provider.

Review Canceled Referrals

This is an automated task generated by HSRM. When there is a community provider found that has been recently deactivated and there is a pending Veteran's appointment, facility community care staff must take actions to cancel any appointments in HSRM.

Also, staff must notify the Veteran and notify the vendor of the appointment cancellation. Then, staff must provide the Veteran with a current list of available in-network community providers and must follow scheduling guidelines.

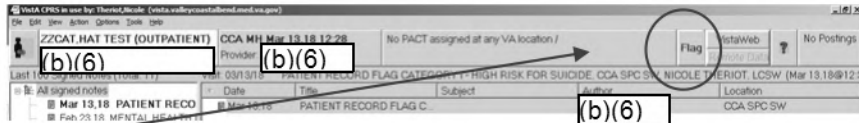
3.15 How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran

PROCEDURES

General Considerations:

- Facility community care office staff will receive notification to schedule the approved community care consult (consult in Active status) via CPRS alert.
- Scheduling activity should commence as soon as the consult is received, otherwise using the guidelines below:

CPRS Instructions	Admin Staff to contact Veteran
Routine appointment or No Later Than (NLT) date > 20/28 days	Within 2 business days of notification
NLT date < 20/28 days	Within 1 business day of notification
Urgent/emergent consult/STAT	Schedule immediately or as instructed during warm handoff from VHA clinic

STEP	ACTIVITY
1	<p>If the Veteran has an active Behavioral Patient Record Flag (BPRF), elevate the consult to the facility community care clinical staff for review prior to scheduling. The facility community care clinical staff should contact the facility's Disruptive Behavior Committee (DBC) chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with community providers. DBC Chair contact information can be found at: Workplace Violence Prevention Program (WVPP) Point of Contact (POC) Search Page; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If applicable, engage the DBC chair with the community provider to discuss any safety implications. <i>Note: This process is only required for the BPRF, not for other PRFs, such as the High-Risk Suicide (HRS) PRF.</i></p>  <p>Note: If a Veteran has an active PRF, the Veteran's record in the Computerized Patient Record System (CPRS) will appear with a red "Flag" note, like follows:</p> <p>When a flag is active and a record is accessed, a screen will automatically open first indicating the Veteran has a PRF. The screen includes the instructions for how to manage the patient based on the PRF. Here is what an example pop-up looks like for HRS PRF.</p>

Vista CPMS in use by: Theriot, Nicole (vista.valleycrosshailhead.sand.va.gov)

ZZCAT.HAT TEST (OUTPATIENT) Visit Not Selected No PACT assigned at any VA location /

Provider: (b)(6)

Flag: VistaWeb Remote Data No Postings

Category I Flags: 1 Item(s)

HIGH RISK FOR SUICIDE

Category II Flags

Flag Name: HIGH RISK FOR SUICIDE

Assignment Narrative:
This Veteran has been assessed as being at high risk for suicidal behavior/self-directed violence.

NON-CLINICAL STAFF:
- Please pay attention to the Veteran's emotional state at check-in and notify a Provider if you have concerns.
- If this patient no-shows or cancels any appointments without rescheduling, please alert the Provider and the Suicide Prevention Coordinator.
Please verify contact information and emergency contact information AT EVERY VISIT.

CLINICAL STAFF:
For CPMS users: Patient Record Category I Flag Name as

Signed, Linked Notes of Title: PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE

Date	Action	Author

Cover Sheet | Problems | Meds

Close

Patient Record Flags

Category I Flags: 1 Item(s)

HIGH RISK FOR SUICIDE

Category II Flags

Flag Type: CLINICAL

Flag Category: I (NATIONAL)

Assignment Status: Active

Initial Assigned Date: MAR 13, 2018@11:40:28

Approved by: (b)(6)

Next Review Date: APR 13, 2018

Owner Site: HARLINGEN VA CLINIC (HARLINGEN VA CLINIC)

Originating Site: HARLINGEN VA CLINIC (HARLINGEN VA CLINIC)

Signed, Linked Notes of Title: PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE

Date	Action	Author
MAR 13, 2018@12:32	NEW ASSIGNMENT	(b)(6)

Discuss appointment and provider preferences

- Use PPMS to review community care provider options with Veteran by network adequacy and High Performing Provider (HPP) designation.
- Encourage Veteran to schedule with CCN providers designated as high performing when Veteran does not have a Preferred Provider, if possible.
- For scripts for scheduling appointments with HPP, please refer to the Utilization Management High Performing Providers (UM HPP) Scheduling Appointments with HPP within the Community Care Network (CCN).
- For quick reference about the HPP designation, please refer to the HPP Designation Reference Sheet.

*HPP Designation:

An HPP is a community healthcare provider who has met or exceeded identified quality and cost-efficiency criteria and with whom scheduling a Veteran health

care appointment is recommended. The HPP designation means a provider has been formally evaluated using nationally recognized quality measures such as Healthcare Effectiveness Data & Information Set (HEDIS) and Physician Quality Reporting System (PQRS) measures.

HPP Designation Types:

There are three HPP designations: Yes, No, or Unknown.

1. **Y (Yes)**: Provider meets the CCN HPP designation based on the quality and cost-efficient care criteria
2. **N (No)**: Provider does not meet the CCN HPP designation based on the quality and cost-efficient care criteria
3. **U (Unknown)**: This is the default value and indicates that a CCN provider's HPP designation has not been submitted to VA's Provider Profile Management System (PPMS)

NOTE: There are several reasons for receiving the "U" designation: the provider is not part of CCN; the CCN provider's specialty is not evaluated as part of the HPP designation; CCN provider may not have enough claims data for HPP designation evaluation; CCN provider's HPP designation evaluation may be in process; or CCN contractor has not designated provider's HPP designation status. HPP designations are also subject to change depending on the provider's performance. For example, a provider who received an "N" can undergo the evaluation process again and receive a "Y" with improved performance, and similarly for providers who begin with a "Y".

- 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**.

HPP Designation Process:

The CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM.

Individual providers are evaluated on quality and cost-efficiency measures determined by VA and CCN Contractor which will result in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor will determine scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers will result in either a Yes, No, or Unknown HPP designation.

NOTE: The HPP designation scoring process may vary across CCN regions. The information above may only apply to CCN Regions 1, 2, 3 and 4. The HPP designation scoring process for CCN Regions 5 and 6 is pending.

The Difference Between Preferred Providers and HPPs:

Preferred Provider: A provider from whom a Veteran chooses to seek care	HPP: A CCN provider who meets pre-determined VA and CCN Regional Contractor designated quality criteria
<ul style="list-style-type: none"> • Veteran's preferred provider could be associated with any provider contract type (e.g., Veterans Care Agreement [VCA], CCN, etc.) or may not be associated with a contract • Veteran's preferred provider supersedes HPPs when scheduling appointments in the community • Veteran's preferred provider may be eligible for the HPP designation, depending on CCN Region • Veterans may not have a preferred provider • Veterans' provider preference is collected in Consult Toolbox (CTB) • Example: If an eligible Veteran seeks care in the community and has a preferred provider, then the Veteran will most likely schedule an appointment with that preferred provider 	<ul style="list-style-type: none"> • Deployment of the HPP Designation coincides with the CCN Region deployment (staggered) • Facility community care staff can identify HPPs at the point of scheduling (PPMS or HSRM) • Veterans are not required to seek care from HPPs • CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM • HPP designations are not collected in CTB • Example: If an eligible Veteran seeks care in the community and does not have a preferred provider, facility community care staff will communicate to Veterans the availability of appointments with HPPs

There are several key differences between a Preferred Provider and an HPP. The table below outlines the differences between the two provider types:

Discuss appointment and provider preferences

- Use PPMS to review community care provider options with Veteran by network adequacy and High Performing Provider (HPP) designation.
- Encourage Veteran to schedule with CCN providers designated as high performing when Veteran does not have a Preferred Provider, if possible.
- For scripts for scheduling appointments with HPP, please refer to the Utilization Management High Performing Providers (UM HPP) Scheduling Appointments with HPP within the Community Care Network (CCN).
- For quick reference about the HPP designation, please refer to the HPP Designation Reference Sheet.

*HPP Designation:

An HPP is a community healthcare provider who has met or exceeded identified quality and cost-efficiency criteria and with whom scheduling a Veteran health care appointment is recommended. The HPP designation means a provider has been formally evaluated using nationally recognized quality measures such as

Healthcare Effectiveness Data & Information Set (HEDIS) and Physician Quality Reporting System (PQRS) measures.

HPP Designation Types:

There are three HPP designations: Yes, No, or Unknown.

4. **Y (Yes):** Provider meets the CCN HPP designation based on the quality and cost-efficient care criteria
5. **N (No):** Provider does not meet the CCN HPP designation based on the quality and cost-efficient care criteria
6. **U (Unknown):** This is the default value and indicates that a CCN provider's HPP designation has not been submitted to VA's Provider Profile Management System (PPMS)

NOTE: There are several reasons for receiving the "U" designation: the provider is not part of CCN; the CCN provider's specialty is not evaluated as part of the HPP designation; CCN provider may not have enough claims data for HPP designation evaluation; CCN provider's HPP designation evaluation may be in process; or CCN contractor has not designated provider's HPP designation status. HPP designations are also subject to change depending on the provider's performance. For example, a provider who received an "N" can undergo the evaluation process again and receive a "Y" with improved performance, and similarly for providers who begin with a "Y".

- 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**.

HPP Designation Process:

The CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM.

Individual providers are evaluated on quality and cost-efficiency measures determined by VA and CCN Contractor which will result in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor will determine scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers will result in either a Yes, No, or Unknown HPP designation.

NOTE: The HPP designation scoring process may vary across CCN regions. The information above may only apply to CCN Regions 1, 2, 3 and 4. The HPP designation scoring process for CCN Regions 5 and 6 is pending.

The Difference Between Preferred Providers and HPPs:

Preferred Provider: A provider from whom a Veteran chooses to seek care	HPP: A CCN provider who meets pre-determined VA and CCN Regional Contractor designated quality criteria
<ul style="list-style-type: none"> • Veteran's preferred provider could be associated with any provider contract type (e.g., Veterans Care Agreement [VCA], CCN, etc.) or may not be associated with a contract • Veteran's preferred provider supersedes HPPs when scheduling appointments in the community • Veteran's preferred provider may be eligible for the HPP designation, depending on CCN Region • Veterans may not have a preferred provider • Veterans' provider preference is collected in Consult Toolbox (CTB) • Example: If an eligible Veteran seeks care in the community and has a preferred provider, then the Veteran will most likely schedule an appointment with that preferred provider 	<ul style="list-style-type: none"> • Deployment of the HPP Designation coincides with the CCN Region deployment (staggered) • Facility community care staff can identify HPPs at the point of scheduling (PPMS or HSRM) • Veterans are not required to seek care from HPPs • CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM • HPP designations are not collected in CTB • Example: If an eligible Veteran seeks care in the community and does not have a preferred provider, facility community care staff will communicate to Veterans the availability of appointments with HPPs

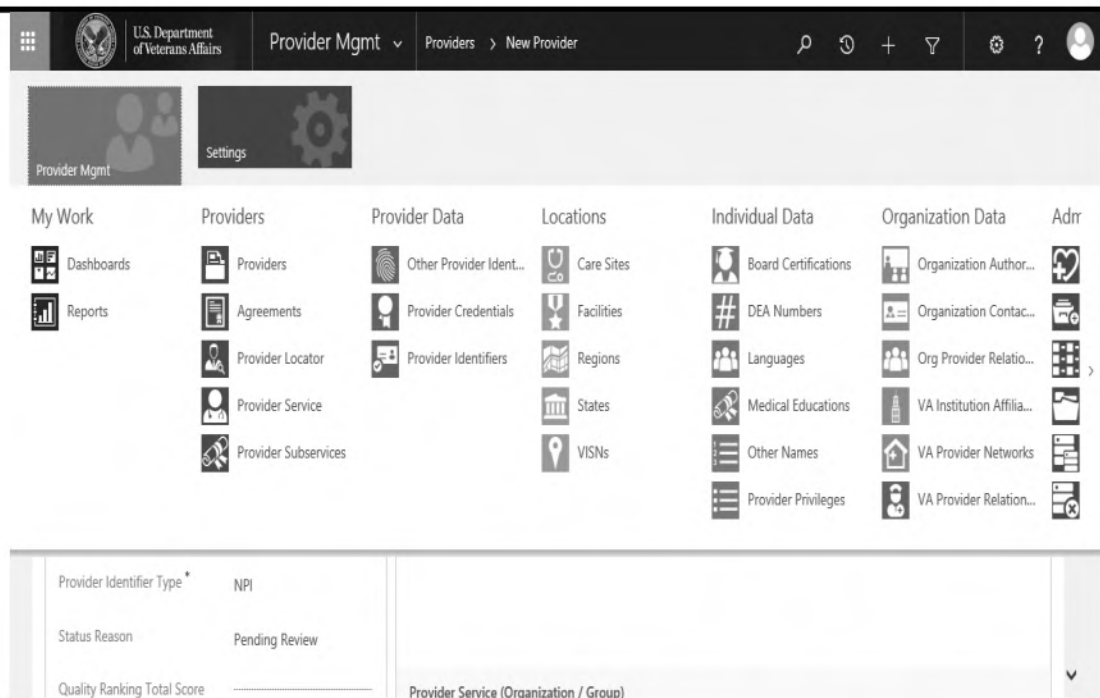
There are several key differences between a Preferred Provider and an HPP. The table below outlines the differences between the two provider types:

How to Locate HPPs During Scheduling:

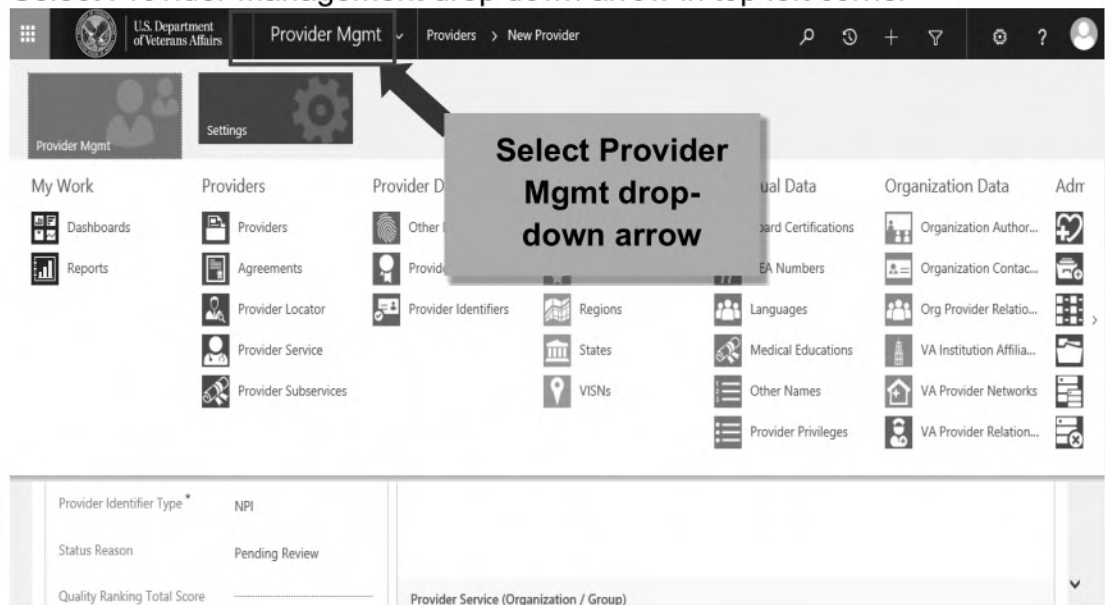
Search functions are included in both PPMS and HSRM to help locate the HPP designation when scheduling Veterans with community providers.

How to Locate the HPP Designation in PPMS:

1. Open PPMS



2. Select Provider Management drop down arrow in top left corner

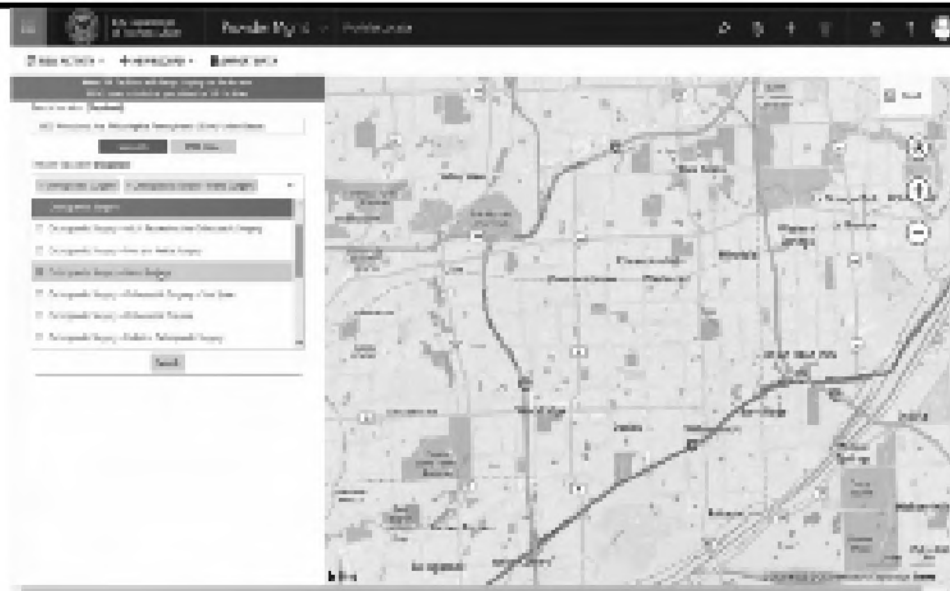


3. Select the Provider Locator under the Providers section

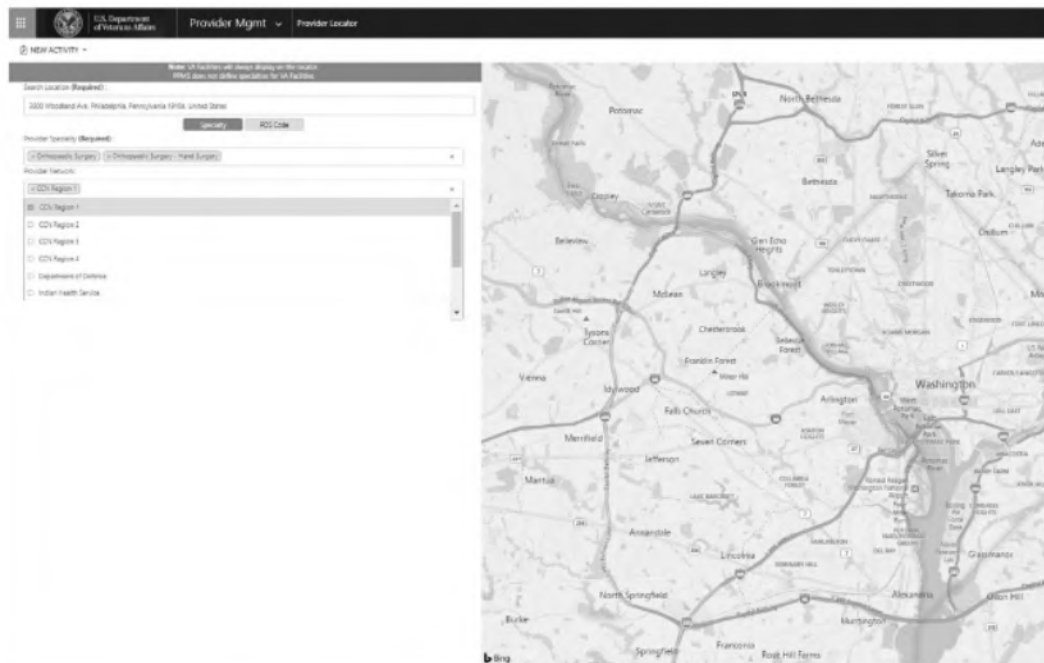


4. Copy and Paste Veteran's address from CPRS or type the Veteran's address into the search location field

5. Type in the provider's specialty the Veteran needs and make selection from list displayed (Note: You may select multiple specialties)



6. Search for and select the appropriate provider network (e.g., CCN Region 1)



7. Once all fields have been completed, click the search button (Note: The radius and distance fields are automatically set to default values. You may decrease/expand the value as needed.)

U.S. Department of Veterans Affairs | Provider Mgmt | Provider Locator

NEW ACTIVITY | NEW RECORD | IMPORT DATA

Note: VA facilities will always display on the location. HSRM does not display locations for VA facilities.

Search Location (Required):
3800 Woodland Ave, Philadelphia, Pennsylvania 19104, United States

Specialty: POS Code

Provider Specialty (Required):
Orthopaedic Surgery | Orthopaedic Surgery - Hand Surgery

Provider Network:
CCN Region 1

Provider Details:

Radius: Drive Time
Radius (Max 500 Miles): 25 | Sort By: Distance

Search

Select search to continue

8. In the search results, locate the HPP designation under the provider's National Provider Identifier (NPI) (HPP-Y/ HPP-N/ HPP-U)

U.S. Department of Veterans Affairs | Provider Mgmt | Provider Locator

NEW ACTIVITY | NEW RECORD | IMPORT DATA

Note: VA facilities will always display on the location. HSRM does not display locations for VA facilities.

Search Location (Required):
3800 Woodland Ave, Philadelphia, Pennsylvania 19104, United States

Specialty: POS Code

Provider Specialty (Required):
Orthopaedic Surgery | Orthopaedic Surgery - Hand Surgery

Provider Network:
CCN Region 1

Provider Details:

Radius: Drive Time
Radius (Max 500 Miles): 25 | Sort By: Distance

Search

(b)(6)

2	Directions 0.25 mi 1 min	Orthopaedic Surgery/CCN Region 1	1417357346 HPP-Y
3	Directions 0.25 mi 1 min	Orthopaedic Surgery/CCN Region 1	158051345 HPP-U

How to Locate the HPP Designation in HSRM:

1. Open HSRM and login
2. On the referral screen, select or search for the referral

Referral List

> Referrals

Assigned User	Referring Facility	Last Name	First Name	Date of Birth	SSN	Service	Priority	Optional Location	Date Added	Referral Number	Category of Care	Status	Community Provider / Facility	Appt Date
	Beth VA Medical Center	(b)(6)				(b)(3):38 U.S.C. 5701								
	Beth VA Medical Center	HSRMF91												
	Beth VA Medical Center	HSRMF92												
	Beth VA Medical Center	HSRMF93												
	Beth VA Medical Center	HSRMF94												
	Beth VA Medical Center	HSRMF95												
	Beth VA Medical Center	HSRMF96												
	Beth VA Medical Center	HSRMF97												
	Beth VA Medical Center	HSRMF98												
	Beth VA Medical Center	HSRMF99												
	Beth VA Medical Center	HSRMF100												
	Beth VA Medical Center	HSRMF101												
	Beth VA Medical Center	HSRMF102												
	Beth VA Medical Center	HSRMF103												
	Beth VA Medical Center	HSRMF104												
	Beth VA Medical Center	HSRMF105												
	Beth VA Medical Center	HSRMF106												
	Beth VA Medical Center	HSRMF107												
	Beth VA Medical Center	HSRMF108												
	Beth VA Medical Center	HSRMF109												
	Beth VA Medical Center	HSRMF110												

3. Check the referral status and ensure that it is approved

Referral List

> Referrals

Assigned User	Referring Facility	Last Name	First Name	Date of Birth	SSN	Service	Priority	Optional Location	Date Added	Referral Number	Category of Care	Status	Community Provider / Facility	Appt Date
	Beth VA Medical Center	(b)(6)				(b)(3):38 U.S.C. 5701								
	Beth VA Medical Center	HSRMF91												
	Beth VA Medical Center	HSRMF92												
	Beth VA Medical Center	HSRMF93												
	Beth VA Medical Center	HSRMF94												
	Beth VA Medical Center	HSRMF95												
	Beth VA Medical Center	HSRMF96												
	Beth VA Medical Center	HSRMF97												
	Beth VA Medical Center	HSRMF98												
	Beth VA Medical Center	HSRMF99												
	Beth VA Medical Center	HSRMF100												
	Beth VA Medical Center	HSRMF101												
	Beth VA Medical Center	HSRMF102												
	Beth VA Medical Center	HSRMF103												
	Beth VA Medical Center	HSRMF104												
	Beth VA Medical Center	HSRMF105												
	Beth VA Medical Center	HSRMF106												
	Beth VA Medical Center	HSRMF107												
	Beth VA Medical Center	HSRMF108												
	Beth VA Medical Center	HSRMF109												
	Beth VA Medical Center	HSRMF110												

4. Select the needed referral to go to the referral detail screen

HSRMPAT (b)(6)

Please refer to the using VA's internal network information for details on the prescription requirements related to this approved referral and vision.

Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703 Estimated Cost of Care: 2,645.17

Insurance Details: VA Payer Status: VA - Primary Payer

Referral Processing Information:

Referral Number: VN000000121	Source of Referral: Interfaced from VA	Date Added: 06/15/2019
* Status: Approved	Comments:	Update Date: 09/15/2019
Referral Return Reason:	Assigned User:	Update Time: 12:37
Unique Consult ID: 590_2051		Update User: Integration Account
* Network: Not Allocated		Update Facility: Beth VA Medical Center
Optional Task(s):		Ordering Officer:
Audit Trail		

Initial Community Provider/Facility Information:

Treating Specialty: Cardiac Surgery	Community Provider / Facility:	APWS Provider Search:
	Provider Location:	Allocated Date:
	Provider Name:	Appointment Date:
	Abilities:	Provider Details:

5. Complete program authority field

(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)

(b)(6)

Please refer to the Using and Utilizing Information for details on the pre-certification requirements related to this approved referral and veteran.

▼ Authority

*Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703 Q

Estimated Cost of Care: 2,646.17

▼ Insurance Details

VA Payer Status: VA - Primary Payer Q

▼ Referral Processing Information

Referral Number: VA000000121

* Status: Approved Q

Referral Return Reason: Q

Unique Consult ID: 506_2051

* Network: Not Allocated

Optional Task(s):

Audit Trail

Source of Referral: Interfaced from VA

Comments:

Assigned User: Q

Data Added: 06/15/2019

Update Date: 05/15/2019

Update Time: 12:37

Update User: Integration Account

Update Facility: Bath VA Medical Center

Ordering Officer:

▼ Initial Community Provider/Facility Information

Treating Specialty: Cardiac Surgery

PPMS Provider Search

Community Provider / Facility:

Provider Location:

Provider Name:

Affiliation: Q

Allocated Date:

Appointment Date:

Provider Details:

6. Go to PPMS provider search section and click "PPMS Provider Search"

(b)(6)

Please refer to the Using and Utilizing Information for details on the pre-certification requirements related to this approved referral and veteran.

▼ Authority

*Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703 Q

Estimated Cost of Care: 2,646.17

▼ Insurance Details

VA Payer Status: VA - Primary Payer Q

▼ Referral Processing Information

Referral Number: VA000000121

* Status: Approved Q

Referral Return Reason: Q

Unique Consult ID: 506_2051

* Network: Not Allocated

Optional Task(s):

Audit Trail

Source of Referral: Interfaced from VA

Comments:

Assigned User: Q

Data Added: 06/15/2019

Update Date: 05/15/2019

Update Time: 12:37

Update User: Integration Account

Update Facility: Bath VA Medical Center

Ordering Officer:

▼ Initial Community Provider/Facility Information

Treating Specialty: Cardiac Surgery

PPMS Provider Search

Community Provider / Facility:

Provider Location:

Provider Name:

Affiliation: Q

Allocated Date:

Appointment Date:

Provider Details:

7. Fill in provider's NPI (from PPMS) and select enter

(b)(6)

PPMS Provider Search

To find a provider, enter a valid NPI:

*NPI:

Specialty	Care Provider	Affiliation	Phone	Care Site	Address	Drive Time	Distance

8. View HPP designation in the right-hand corner (Yes/No/Unknown)

(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)(b)(3):38
U.S.C. 5701;
(b)(6)

	<div>PPMS Provider Search</div> <div>To find a provider, enter a valid NPI</div> <div>*NPI <input type="text" value="109916202"/></div> <div>Records found: 6 (16)</div> <table><thead><tr><th>Specialty</th><th>Care Provider</th><th>Affiliation</th><th>Phone</th><th>Care Site</th><th>Address</th><th>Drive Time</th><th>Distance</th><th>Phone NPI</th><th>High Performing Provider</th></tr></thead><tbody><tr><td>Internal Medicine - Interventional Cardiology</td><td>(b)(6)</td><td>CCO</td><td>(b)(6)</td><td>(b)(6)</td><td>(b)(6)</td><td></td><td></td><td>109916202</td><td>Yes</td></tr><tr><td>Internal Medicine - Interventional Cardiology</td><td></td><td>CCO</td><td></td><td></td><td></td><td></td><td></td><td>109916202</td><td>Yes</td></tr><tr><td>Internal Medicine - Interventional Cardiology</td><td></td><td>CCO</td><td></td><td></td><td></td><td></td><td></td><td>109916202</td><td>Yes</td></tr><tr><td>Internal Medicine - Interventional Cardiology</td><td></td><td>CCO</td><td></td><td></td><td></td><td></td><td></td><td>109916202</td><td>Yes</td></tr><tr><td>Internal Medicine - Interventional Cardiology</td><td></td><td>CCO</td><td></td><td></td><td></td><td></td><td></td><td>109916202</td><td>Yes</td></tr><tr><td>Internal Medicine - Interventional Cardiology</td><td></td><td>CCO</td><td></td><td></td><td></td><td></td><td></td><td>109916202</td><td>Yes</td></tr></tbody></table>	Specialty	Care Provider	Affiliation	Phone	Care Site	Address	Drive Time	Distance	Phone NPI	High Performing Provider	Internal Medicine - Interventional Cardiology	(b)(6)	CCO	(b)(6)	(b)(6)	(b)(6)			109916202	Yes	Internal Medicine - Interventional Cardiology		CCO						109916202	Yes	Internal Medicine - Interventional Cardiology		CCO						109916202	Yes	Internal Medicine - Interventional Cardiology		CCO						109916202	Yes	Internal Medicine - Interventional Cardiology		CCO						109916202	Yes	Internal Medicine - Interventional Cardiology		CCO						109916202	Yes
Specialty	Care Provider	Affiliation	Phone	Care Site	Address	Drive Time	Distance	Phone NPI	High Performing Provider																																																														
Internal Medicine - Interventional Cardiology	(b)(6)	CCO	(b)(6)	(b)(6)	(b)(6)			109916202	Yes																																																														
Internal Medicine - Interventional Cardiology		CCO						109916202	Yes																																																														
Internal Medicine - Interventional Cardiology		CCO						109916202	Yes																																																														
Internal Medicine - Interventional Cardiology		CCO						109916202	Yes																																																														
Internal Medicine - Interventional Cardiology		CCO						109916202	Yes																																																														
Internal Medicine - Interventional Cardiology		CCO						109916202	Yes																																																														
2	<p>Contact the community provider to determine if he/she has accepted the referral.</p> <ul style="list-style-type: none">• If yes,<ul style="list-style-type: none">○ For Veterans with an active HRS PRF, engage the facility community care clinical staff to ensure the completed progress note for the PRF, which includes the contact information for the Veteran's Mental Health Treatment Coordinator/Provider or Suicide Prevention Coordinator, is included in the referral package to assist with care coordination and/or consultation about the Veteran's suicide risk. Facility community care staff should ensure the HRS PRF note is clearly visible to the community provider, to ensure awareness of the Veteran's suicide risk.○ For Veterans with an active BPRF, facility community care clinical staff should ensure the DBC Chair engaged with the community provider <i>prior to scheduling</i>, if applicable, based on Step 1. Community care staff should ensure the completed progress note, which includes the contact information for the DBC chair, is included in the referral package to assist with care coordination and/or consultation about the Veteran's behavioral risks.○ Note: The completed progress note for a Veteran with an active PRF should be included in the referral package. This is an example of the completed progress note:																																																																						

The screenshot shows the VistA CPRS interface. The top bar indicates the user is logged in as (b)(6). The main window displays patient information for 'ZZCAT HAT TEST (OUTPATIENT)' with a date of March 13, 2018. The patient's location is 'CCA MH' and the provider is '(b)(6)'. The patient record flag category is 'I - HIGH RISK FOR SUICIDE, CCA SPC SW'. The left sidebar lists signed notes, including 'Mar 13, 18 PATIENT RECO', 'Feb 23, 18 MENTAL HEALTH I', 'Feb 05, 18 PRIMARY CARE IN', 'Jan 24, 18 PRIOR AUTHORIZ', 'Oct 16, 17 2017 FLU SEASON', 'Sep 21, 17 CONTRACT ADULT', 'Aug 01, 17 IMED PATIENT ED', 'Aug 01, 17 IMED PATIENT ED', 'Jul 05, 17 GEC REFERRAL PH', and 'Feb 24, 17 NURSING TELEPH'. The main window also shows a list of signed notes, including 'Mar 13, 18 PATIENT RECO', 'Feb 23, 18 MENTAL HEALTH I', 'Feb 05, 18 PRIMARY CARE IN', 'Jan 24, 18 PRIOR AUTHORIZ', 'Oct 16, 17 2017 FLU SEASON', 'Sep 21, 17 CONTRACT ADULT', 'Aug 01, 17 IMED PATIENT ED', 'Aug 01, 17 IMED PATIENT ED', 'Jul 05, 17 GEC REFERRAL PH', and 'Feb 24, 17 NURSING TELEPH'. The bottom navigation bar includes links for 'Cover Sheet', 'Problems', 'Meds', 'Orders', 'Notes', 'Consults', 'Surgery', 'DIC:Summ', 'Labs', and 'Reports'.

○ proceed to Step 3

- If no, and these were the Veteran's preferred providers, contact the Veteran to inform him/her of the declinations and select another three community providers (determined by the Veteran) and proceed back to Step 1.
- If no, and there was no preferred provider(s) identified by the Veteran, select a new provider, and proceed back to Step 1.
- Document the new provider in HSRM and CPRS.

3

Schedule the appointment with the community provider and document the date and time of the appointment in HSRM (or VSE/Vista). The consult status will change to "Scheduled".

HSRM Build 6 Patch Fact Sheet

For further details on how to document Veteran appointment in HSRM, please refer to the [HealthShare Referral Management VA SharePoint page](#) for additional information in the [HSRM User Guide](#).

For further details on how to conduct a provider search in HSRM, please refer to the [HealthShare Referral Management VA SharePoint page](#) for information on the [HSRM VA Employee User Guide and Provider searches in HSRM](#).

PPMS Guidance – Finding Specific Provider in HSRM Provides PPMS end users with guidance on the trouble shooting steps to follow when unable to find specific providers within HSRM. VA staff may have the ability to modify the Provider information troubleshoot their issue.

Note: In HSRM the user may need to reselect the provider's affiliation again on the appointment screen for the affiliation to reflect in the offline referral form.

	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
4	Create and send the Community Care Information Packet to the Veteran via preferred method (email or standard mail) using the Consult Toolbox , document that the packet was sent to the Veteran.

PROCEDURES

General Considerations:

- Facility community care office staff will receive notification to schedule the approved community care consult (consult in Active status) via CPRS alert.
- Scheduling activity should commence as soon as the consult is received, otherwise using the guidelines below:

CPRS Instructions	Admin Staff to contact Veteran
Routine appointment or No Later Than (NLT) date > 20/28 days	Within 2 business days of notification
NLT date < 20/28 days	Within 1 business day of notification
Urgent/emergent consult/STAT	Schedule immediately or as instructed during warm handoff from VHA clinic

STEP	ACTIVITY
1	<p>Discuss appointment and provider preferences</p> <ul style="list-style-type: none"> Use PPMS to review community care provider options with Veteran by network adequacy and High Performing Provider (HPP) designation. Encourage Veteran to schedule with CCN providers designated as high performing when Veteran does not have a Preferred Provider, if possible. For scripts for scheduling appointments with HPP, please refer to the Utilization Management High Performing Providers (UM HPP) Scheduling Appointments with HPP within the Community Care Network (CCN). For quick reference about the HPP designation, please refer to the HPP Designation Reference Sheet. <p>*HPP Designation:</p> <p>An HPP is a community healthcare provider who has met or exceeded identified quality and cost-efficiency criteria and with whom scheduling a Veteran health care appointment is recommended. The HPP designation means a provider has been formally evaluated using nationally recognized quality measures such as Healthcare Effectiveness Data & Information Set (HEDIS) and Physician Quality Reporting System (PQRS) measures.</p>

HPP Designation Types:

There are three HPP designations: Yes, No, or Unknown.

7. Y (Yes): Provider meets the CCN HPP designation based on the quality and cost-efficient care criteria
8. N (No): Provider does not meet the CCN HPP designation based on the quality and cost-efficient care criteria
9. U (Unknown): This is the default value and indicates that a CCN provider's HPP designation has not been submitted to VA's Provider Profile Management System (PPMS)

NOTE: There are several reasons for receiving the "U" designation: the provider is not part of CCN; the CCN provider's specialty is not evaluated as part of the HPP designation; CCN provider may not have enough claims data for HPP designation evaluation; CCN provider's HPP designation evaluation may be in process; or CCN contractor has not designated provider's HPP designation status. HPP designations are also subject to change depending on the provider's performance. For example, a provider who received an "N" can undergo the evaluation process again and receive a "Y" with improved performance, and similarly for providers who begin with a "Y".

- 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**.

HPP Designation Process:

The CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM.

Individual providers are evaluated on quality and cost-efficiency measures determined by VA and CCN Contractor which will result in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor will determine scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers will result in either a Yes, No, or Unknown HPP designation.

NOTE: The HPP designation scoring process may vary across CCN regions. The information above may only apply to CCN Regions 1, 2, 3 and 4. The HPP designation scoring process for CCN Regions 5 and 6 is pending.

The Difference Between Preferred Providers and HPPs:

Preferred Provider: A provider from whom a Veteran chooses to seek care	HPP: A CCN provider who meets pre-determined VA and CCN Regional Contractor designated quality criteria
<ul style="list-style-type: none"> • Veteran's preferred provider could be associated with any provider contract type (e.g., Veterans Care Agreement [VCA], CCN, etc.) or may not be associated with a contract • Veteran's preferred provider supersedes HPPs when scheduling appointments in the community • Veteran's preferred provider may be eligible for the HPP designation, depending on CCN Region • Veterans may not have a preferred provider • Veterans' provider preference is collected in Consult Toolbox (CTB) • Example: If an eligible Veteran seeks care in the community and has a preferred provider, then the Veteran will most likely schedule an appointment with that preferred provider 	<ul style="list-style-type: none"> • Deployment of the HPP Designation coincides with the CCN Region deployment (staggered) • Facility community care staff can identify HPPs at the point of scheduling (PPMS or HSRM) • Veterans are not required to seek care from HPPs • CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM • HPP designations are not collected in CTB • Example: If an eligible Veteran seeks care in the community and does not have a preferred provider, facility community care staff will communicate to Veterans the availability of appointments with HPPs

There are several key differences between a Preferred Provider and an HPP. The table below outlines the differences between the two provider types:

Discuss appointment and provider preferences

- Use PPMS to review community care provider options with Veteran by network adequacy and High Performing Provider (HPP) designation.
- Encourage Veteran to schedule with CCN providers designated as high performing when Veteran does not have a Preferred Provider, if possible.
- For scripts for scheduling appointments with HPP, please refer to the Utilization Management High Performing Providers (UM HPP) Scheduling Appointments with HPP within the Community Care Network (CCN).
- For quick reference about the HPP designation, please refer to the HPP Designation Reference Sheet.

*HPP Designation:

An HPP is a community healthcare provider who has met or exceeded identified quality and cost-efficiency criteria and with whom scheduling a Veteran health care appointment is recommended. The HPP designation means a provider has been formally evaluated using nationally recognized quality measures such as Healthcare Effectiveness Data & Information Set (HEDIS) and Physician Quality Reporting System (PQRS) measures.

HPP Designation Types:

There are three HPP designations: Yes, No, or Unknown.

10. Y (Yes): Provider meets the CCN HPP designation based on the quality and cost-efficient care criteria
11. N (No): Provider does not meet the CCN HPP designation based on the quality and cost-efficient care criteria
12. U (Unknown): This is the default value and indicates that a CCN provider's HPP designation has not been submitted to VA's Provider Profile Management System (PPMS)

NOTE: There are several reasons for receiving the "U" designation: the provider is not part of CCN; the CCN provider's specialty is not evaluated as part of the HPP designation; CCN provider may not have enough claims data for HPP designation evaluation; CCN provider's HPP designation evaluation may be in process; or CCN contractor has not designated provider's HPP designation status. HPP designations are also subject to change depending on the provider's performance. For example, a provider who received an "N" can undergo the evaluation process again and receive a "Y" with improved performance, and similarly for providers who begin with a "Y".

- 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**.

HPP Designation Process:

The CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM.

Individual providers are evaluated on quality and cost-efficiency measures determined by VA and CCN Contractor which will result in a score. Group provider scores are individual provider results rolled-up into a single score. The CCN Contractor will determine scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers will result in either a Yes, No, or Unknown HPP designation.

NOTE: The HPP designation scoring process may vary across CCN regions. The information above may only apply to CCN Regions 1, 2, 3 and 4. The HPP designation scoring process for CCN Regions 5 and 6 is pending.

The Difference Between Preferred Providers and HPPs:

Preferred Provider: A provider from whom a Veteran chooses to seek care	HPP: A CCN provider who meets pre-determined VA and CCN Regional Contractor designated quality criteria
<ul style="list-style-type: none"> • Veteran's preferred provider could be associated with any provider contract type (e.g., Veterans Care Agreement [VCA], CCN, etc.) or may not be associated with a contract • Veteran's preferred provider supersedes HPPs when scheduling appointments in the community • Veteran's preferred provider may be eligible for the HPP designation, depending on CCN Region • Veterans may not have a preferred provider • Veterans' provider preference is collected in Consult Toolbox (CTB) • Example: If an eligible Veteran seeks care in the community and has a preferred provider, then the Veteran will most likely schedule an appointment with that preferred provider 	<ul style="list-style-type: none"> • Deployment of the HPP Designation coincides with the CCN Region deployment (staggered) • Facility community care staff can identify HPPs at the point of scheduling (PPMS or HSRM) • Veterans are not required to seek care from HPPs • CCN Contractor processes HPP metrics, conducts the HPP algorithm and submits the HPP designation, Y/N/U, via the provider file in PPMS which will then transmit to HSRM • HPP designations are not collected in CTB • Example: If an eligible Veteran seeks care in the community and does not have a preferred provider, facility community care staff will communicate to Veterans the availability of appointments with HPPs

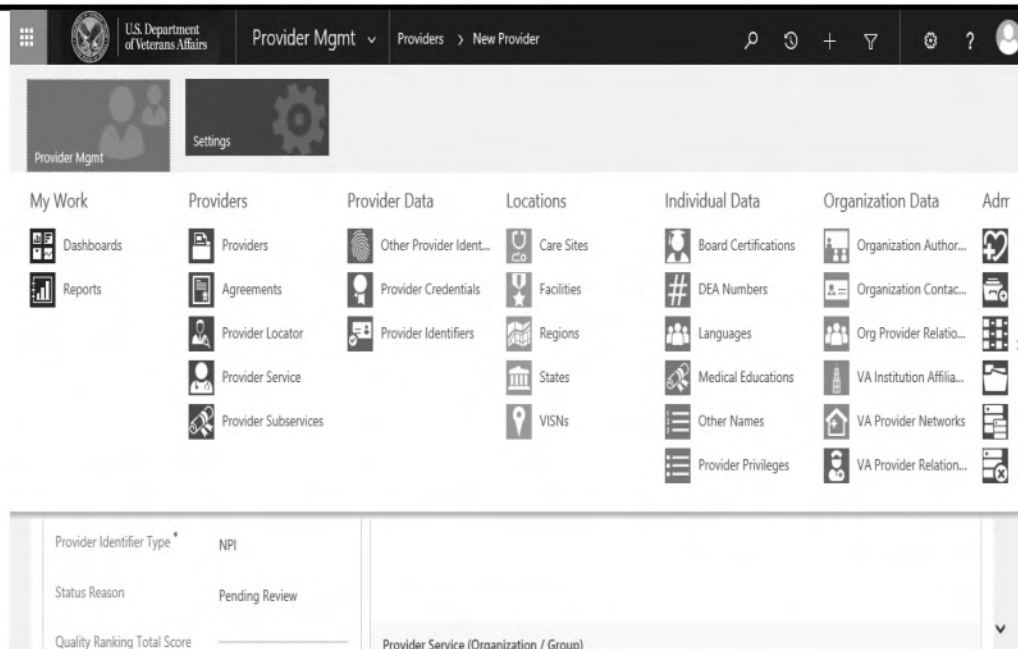
There are several key differences between a Preferred Provider and an HPP. The table below outlines the differences between the two provider types:

How to Locate HPPs During Scheduling:

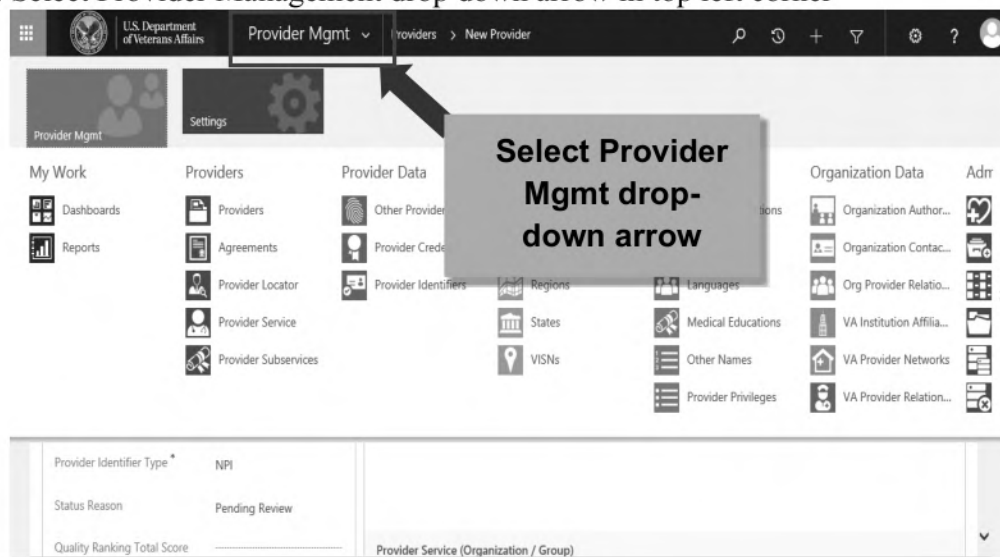
Search functions are included in both PPMS and HSRM to help locate the HPP designation when scheduling Veterans with community providers.

How to Locate the HPP Designation in PPMS:

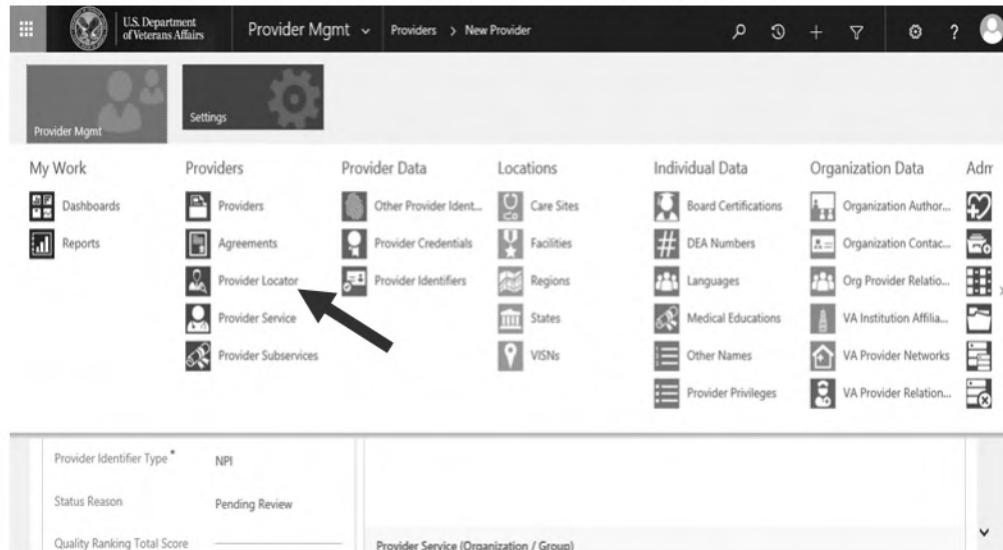
9. Open PPMS



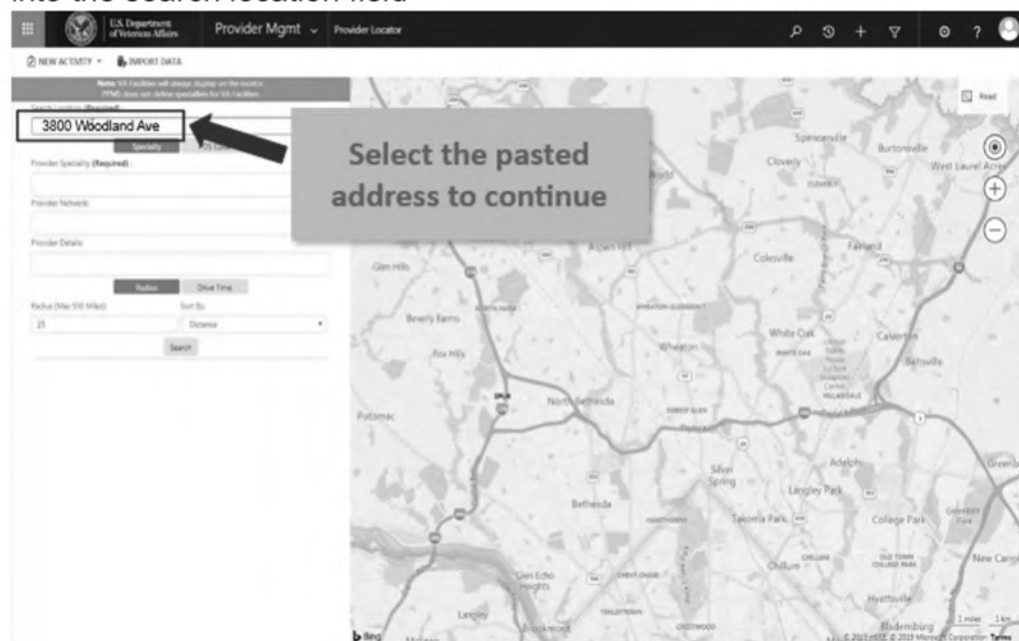
10. Select Provider Management drop down arrow in top left corner



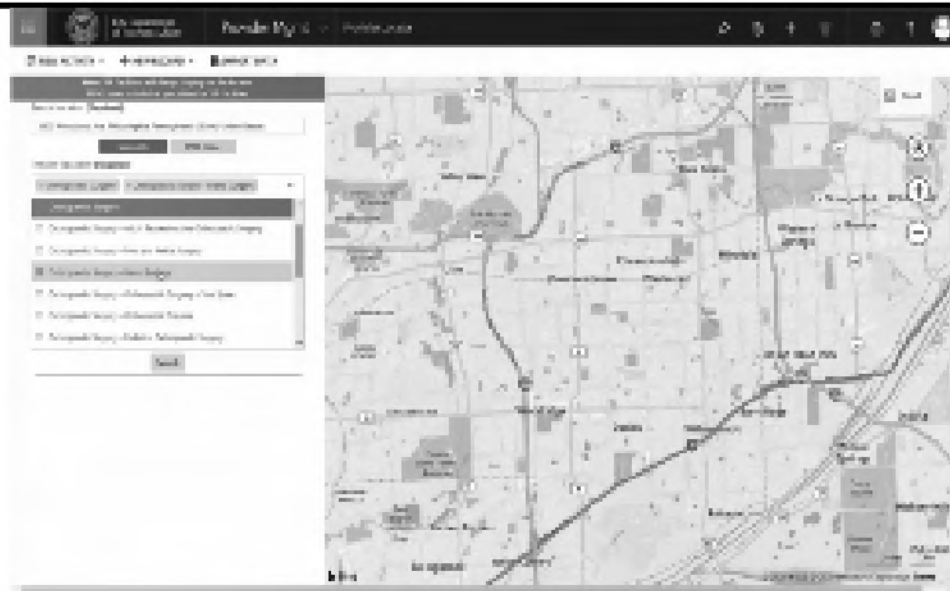
11. Select the Provider Locator under the Providers section



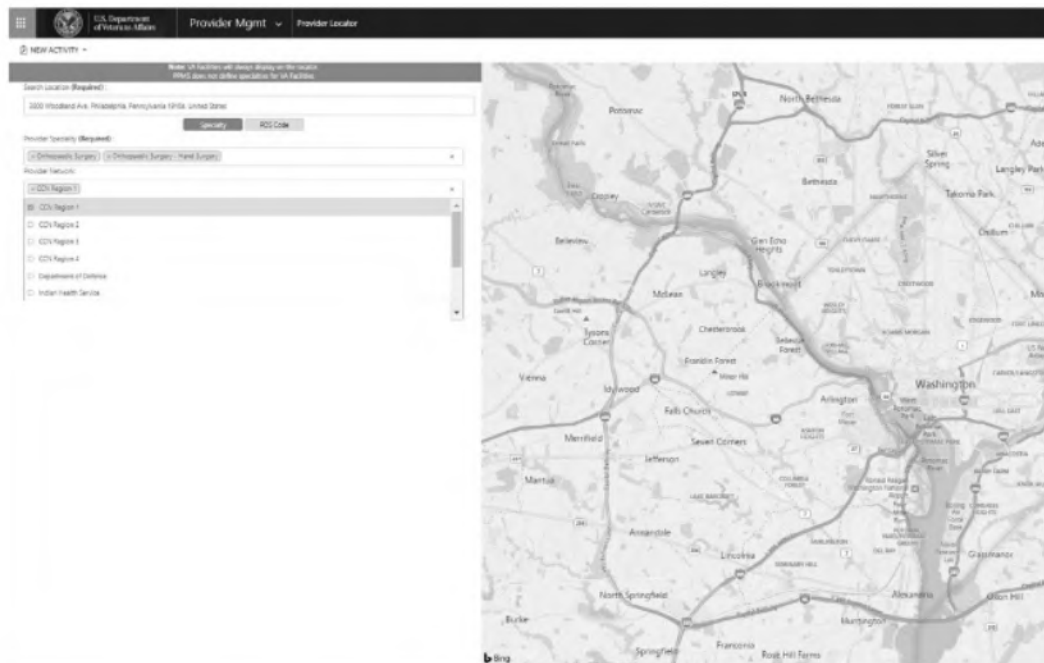
12. Copy and Paste Veteran's address from CPRS or type the Veteran's address into the search location field



13. Type in the provider's specialty the Veteran needs and make selection from list displayed (Note: You may select multiple specialties)



14. Search for and select the appropriate provider network (e.g., CCN Region 1)



15. Once all fields have been completed, click the search button (Note: The radius and distance fields are automatically set to default values. You may decrease/expand the value as needed.)

U.S. Department of Veterans Affairs | Provider Mgmt | Provider Locator

NEW ACTIVITY | NEW RECORD | IMPORT DATA

Note: VA Facilities will always display on the location. HSRM does not display locations for VA Facilities.

Search Location (Required): 3800 Woodland Ave, Philadelphia, Pennsylvania 19104, United States

Provider Specialty (Required): Orthopaedic Surgery

Provider Network: CCN Region 1

Radius (Max 500 Miles): 25

Sort By: Distance

Search

Select search to continue

16. In the search results, locate the HPP designation under the provider's National Provider Identifier (NPI) (HPP-Y/ HPP-N/ HPP-U)

U.S. Department of Veterans Affairs | Provider Mgmt | Provider Locator

NEW ACTIVITY | NEW RECORD | IMPORT DATA

Note: VA Facilities will always display on the location. HSRM does not display locations for VA Facilities.

Search Location (Required): 3800 Woodland Ave, Philadelphia, Pennsylvania 19104, United States

Provider Specialty (Required): Orthopaedic Surgery

Provider Network: CCN Region 1

Radius (Max 500 Miles): 25

Sort By: Distance

Search

Rank	Directions	Orthopaedic Surgery (CCN Region 1)	NPI
2	Directions 0.25 mi 1 min	Orthopaedic Surgery (CCN Region 1)	1417357346 HPP-Y
3	Directions 0.25 mi 1 min	Orthopaedic Surgery (CCN Region 1)	1508053365 HPP-U

How to Locate the HPP Designation in HSRM:

9. Open HSRM and login
10. On the referral screen, select or search for the referral

HSRMPAT (b)(6)

Please refer to the Using and Understanding Information tool for details on the precertification requirements related to this approved referral and veteran.

Authority

*Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703 Q Estimated Cost of Care: 2,646.17

Insurance Details

VA Payer Status: VA - Primary Payer Q

Referral Processing Information

Referral Number: VA000000121
 *Status: Approved Q
 Referral Return Reason: Q
 Unique Consult ID: 506_2851
 *Network: Not Allocated
 Optional Task(s):
 Audit Trail

Source of Referral: Interfaced from VA
 Comments: Q
 Assigned User: Q

Date Added: 06/15/2019
 Update Date: 06/15/2019
 Update Time: 12:37
 Update User: Integration Account
 Update Facility: Bath VA Medical Center
 Ordering Officer: Q

Initial Community Provider/Facility Information

Treating Specialty: Cardiac Surgery

PPMS Provider Search

Community Provider / Facility: Q
 Provider Location: Q
 Provider Name: Q
 Affiliation: Q

Allocated Date: Q
 Appointment Date: Q
 Provider Details: Q

14. Go to PPMS provider search section and click "PPMS Provider Search"

HSRMPAT (b)(6)

Please refer to the Using and Understanding Information tool for details on the precertification requirements related to this approved referral and veteran.

Authority

*Program Authority: Authorized/Pre-authorized VA Referral (not otherwise specified) - 1703 Q Estimated Cost of Care: 2,646.17

Insurance Details

VA Payer Status: VA - Primary Payer Q

Referral Processing Information

Referral Number: VA000000121
 *Status: Approved Q
 Referral Return Reason: Q
 Unique Consult ID: 506_2851
 *Network: Not Allocated
 Optional Task(s):
 Audit Trail

Source of Referral: Interfaced from VA
 Comments: Q
 Assigned User: Q

Date Added: 06/15/2019
 Update Date: 06/15/2019
 Update Time: 12:37
 Update User: Integration Account
 Update Facility: Bath VA Medical Center
 Ordering Officer: Q

Initial Community Provider/Facility Information

Treating Specialty: Cardiac Surgery

PPMS Provider Search

Community Provider / Facility: Q
 Provider Location: Q
 Provider Name: Q
 Affiliation: Q

Allocated Date: Q
 Appointment Date: Q
 Provider Details: Q

15. Fill in provider's NPI (from PPMS) and select enter

HSRMPAT (b)(6)


PPMS Provider Search

To find a provider, enter a valid NPI

*NPI: Q

Specialty	Care Provider	Affiliation	Phone	Care Site	Address	Drive Time	Distance

16. View HPP designation in the right-hand corner (Yes/No/Unknown)

	
2	<p>Contact the community provider to determine if he/she has accepted the referral.</p> <ul style="list-style-type: none"> • If yes, proceed to Step 3 • If no, and these were the Veteran's preferred providers, contact the Veteran to inform him/her of the declinations and select another three community providers (determined by the Veteran) and proceed back to Step 1. • If no, and there was no preferred provider(s) identified by the Veteran, select a new provider, and proceed back to Step 1. • Document the new provider in HSRM and CPRS.
3	<p>Schedule the appointment with the community provider and document the date and time of the appointment in HSRM (or VSE/VistA). The consult status will change to "Scheduled".</p> <p>HSRM Build 6 Patch Fact Sheet</p> <p>For further details on how to document Veteran appointment in HSRM, please refer to the HealthShare Referral Management VA SharePoint page for additional information in the HSRM User Guide.</p> <p>For further details on how to conduct a provider search in HSRM, please refer to the HealthShare Referral Management VA SharePoint page for information on the HSRM VA Employee User Guide and Provider searches in HSRM.</p> <p><u>PPMS Guidance – Finding Specific Provider in HSRM</u> Provides PPMS end users with guidance on the trouble shooting steps to follow when unable to find specific providers within HSRM. VA staff may have the ability to modify the Provider information troubleshoot their issue.</p> <p>Note: In HSRM the user may need to reselect the provider's affiliation again on the appointment screen for the affiliation to reflect in the offline referral form.</p> <p>For additional instructions on documenting the appointment in VistA/VSE, refer to appropriate artifact below:</p> <p>If using Vista - Appointment Management Tutorial</p> <p>If using VSE - VistA Scheduling Enhancements (VSE) User Guide</p>
4	<p>Create and send the Community Care Information Packet to the Veteran via preferred method (email or standard mail) using the Consult Toolbox, document that the packet was sent to the Veteran.</p>

For detailed information regarding Locating Rurality in HSRM please review the step-by-step guidance.

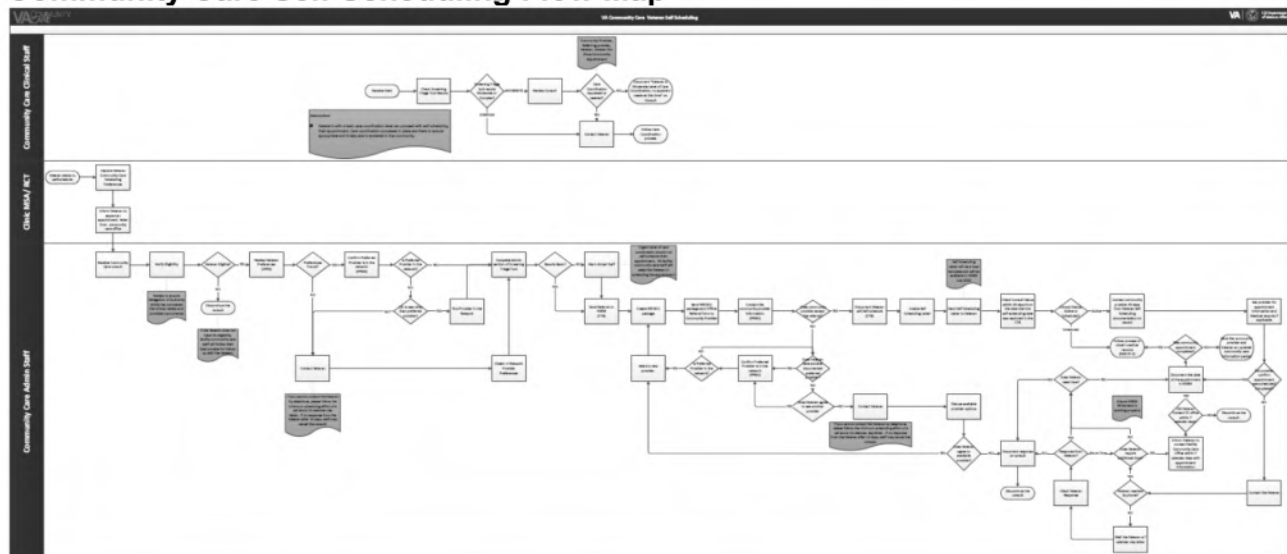
3.16 Community Care Veteran Self Scheduling Process

Overview

To maintain Veteran-centric care and allow Veterans to be active participants in their own care delivery, The Office of Community Care has created a process for Veteran's to schedule directly with community care providers by using the community care self-scheduling process.

In the VSS process, the VA provides administrative support so Veterans and community providers can work together to schedule appointments. The VA does not schedule the community care appointment directly with the community provider unless scheduling assistance is determined to be necessary by community care clinical staff. For more detailed information on the VSS process, please review the [Veteran Self Scheduling SOP](#)

Community Care Self Scheduling Flow Map



VSS begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider. NOTE: Self-scheduling may not be appropriate for some Veterans with active BPRFs, based on the Veteran's, individual needs. If the Veteran has an active BPRF, elevate the request to the facility community care clinical staff to contact the facility's DBC chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with community providers. DBC Chair contact information can be found at: WVPP POC Search Page; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If there are safety implications, VA staff should schedule the Veteran following the process outlined in 3.16 How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran. The Veteran can provide this preference to self-schedule to the clinic Medical Support Assistant (MSA), Referral Coordination Team (RCT) or the facility community care staff. It is highly encouraged that these preferences be captured at the clinic MSA and RCT levels. The community care Veterans Self-Scheduling

process is encouraged, but not mandated. VSS allows Veterans to schedule directly with community providers. When VSS is selected, staff must capture this scheduling preference using the Consult Toolbox (CTB) Consult Review Tab. These consults will be excluded from the scheduling timeliness metric but will be included as a subset for tracking/reporting purposes.

Consults where the Veterans has opted to self-schedule must be completed within 90 days metric as shown in the OCC Top Metrics report. Training materials are available in the OCC FGB Ch. 3. Section 3.16.¹

It is important to note for care that is available within the VA, the Veteran's preference to self-schedule for community care should be captured after a member of the RCT has discussed all care options with the Veteran (virtual care, face to face, and community care) and the Veteran has opted-in for community care. Once it is identified that the Veteran has elected to self-schedule his/her community appointment, the Veteran must be informed that he/she will receive a self-scheduling letter in the mail with the approved community provider information so he/she can contact the community provider to schedule the community appointment.

Veteran Preferences to be Documented:

Veteran preferences for scheduling community care appointments will be documented at the following points in time:

- Prior to an internal consult being forwarded to community care
- At the time of check-out for consults ordered directly to community care for services not available at the medical center
- By the facility community care staff if no community care preferences are captured on the consult prior to being received by the facility community care office

REMINDER: If the Veteran has an active BPRF, a clinical member of the facility community care office must contact the DBC Chair to ensure there are no safety implications with the Veteran self-scheduling in the community. If there are safety implications, VA staff should schedule the Veteran following the process outlined in 3.16 How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran.

More guidance on the process for capturing Veteran's community care scheduling preferences can be found in chapter 2, section 2.19.

Process

The Veteran Community Care Self-Scheduling Process begins once the Veteran has opted-in and elected to self-schedule his/her own community appointment and the RCT has captured community care scheduling preferences and has informed the Veteran that he/she will receive a self-scheduling letter in the mail with community provider information to self-schedule the community appointment.

¹<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>

After the consult has been forwarded to community care or the consult was sent directly to community care, the facility community care administrative (or possibly clinical) staff will:

- Receive the consult
- Review the documented eligibility for community care to ensure the Veteran meets administrative eligibility for community care (Veteran is enrolled, and community care eligibility is documented)

Note: If the Veteran does not have VA eligibility, facility community care staff will follow their local process for follow-up with the Veteran.

- Review to ensure Delegation of Authority (DOA) has completed the clinical review and provided concurrence.
- If the Veteran is NOT eligible for community care, the consult will be cancelled. The ordering provider will receive a view alert and can take any follow-up action if needed.
- If the Veteran IS eligible for community care, review the consult to determine if preferences for a community care provider are documented or if indication of no preference.
- If the community care scheduling preferences were documented in the consult comments, confirm the preferred provider is in the network by searching PPMS
- If the community care scheduling preferences were not documented in the consult comments, contact the Veteran to document the community care scheduling preferences

NOTE: If preferences are not documented, the facility community care staff will contact the Veteran for preferences. Consults will NOT be cancelled, discontinued or forwarded back to the internal service to document preferences.

NOTE: If you cannot contact the Veteran by telephone, please follow the minimum scheduling effort of a call and a 14-calendar day letter. If no response from the Veteran after 14 days, staff may cancel the consult.

- If the documented provider is in the network, continue with the VSS process
- If the documented provider is not in the network, check to see if a comment is on the consult stating the Veteran is willing to see another provider. If it is not documented on the consult, contact the Veteran to discuss community provider options. If the Veteran cannot be contacted by telephone, follow the minimum scheduling effort guidance [VHA Notice 2019-09 Minimum Scheduling Efforts Required Outpatient Appts Updates to VHA Directives 1230 and 1232 1](#), [VHA Directive 1230: Outpatient Scheduling Processes and Procedure](#)
- If it is documented on the consult that the Veteran is willing to see another provider, search PPMS for a network provider closest to the Veteran's address and document the provider in the comment of the consult using the CTB and continue with the VSS process.

Process for Basic Level of Care Coordination

Administrative staff (or clinical staff based off local processes) will complete the admin section of the screening/triage tool.

Screening/Triage Tool SOP (Department of Veterans Affairs Screening Triage Tool SOP)

- If the results of the screening/triage tool are **BASIC** level of care coordination, send the referral to HSRM using the CTB and then create the REFDOC package and continue with the self-scheduling process
- If the results of the screening/triage tool are either **URGENT, MODERATE or COMPLEX** level of care coordination:

URGENT level of care coordination Veterans should not self-schedule their appointment. VA facility community care staff will assist the Veteran in scheduling the appointment

- An alert goes to the clinical staff to complete the clinical part of the screening/triage tool. ***
- Send the referral to HSRM using the CTB and then create the REFDOC package and continue with the self-scheduling process.

---Proceed with this step when screening/triage tool results are MODERATE OR COMPLEX

- Clinical staff receive the view alert and complete the clinical part of the screening/triage tool.
- For **MODERATE** level of care coordination, review the consult to determine if care coordination was needed or requested by the referring provider, community provider, the Veteran, or if the Veteran no-showed the appointment.
- If care coordination is needed, contact the Veteran and provide the needed care coordination.
- If care coordination is not needed, document in the comments of the consult "Veteran is moderate level of care coordination and no apparent needs at this time".

For **COMPLEX** level of care coordination, contact the Veteran to provide the needed care coordination.

The REFDOC package is sent to the community provider for review and acceptance. The REFDOC package should include:

- Provider Referral Fax Cover Sheet Template
- Offline referral form
- Referral/consult
- Medical documentation
- Fax cover sheet (to return the date of the appointment and/or medical documentation)

The facility community care staff will contact the community provider to determine if the referral has been accepted

- If yes,
 - For Veterans with an active HRS PRF, engage the facility community care clinical staff to ensure the completed progress note for the PRF, which includes the contact information for the Veteran's Mental Health Treatment Coordinator/Provider or Suicide Prevention Coordinator, is included in the referral package to assist with care coordination and/or consultation about the Veteran's suicide risk. Community care staff should ensure the HRS PRF note is clearly visible to the community provider, to ensure awareness of the Veteran's suicide risk.
 - For Veterans with an active BPRF, engage the facility community care clinical staff to ensure the completed progress note for the PRF, which includes the contact information for the DBC chair, is included in their referral package to assist with care coordination and/or consultation about the Veteran's behavioral risks.
 - Note: The completed progress note for a Veteran with an active PRF should be included in the referral package. This is an example of the completed progress note:

The screenshot displays a VistA CPCS interface for a patient named 'ZZCAT.HAT TEST (OUTPATIENT)'. The patient's record is marked with several flags, including 'PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE' and 'CCA SPC SW'. The interface shows a list of signed notes on the left, with the most recent note dated 'Mar 13, 18' titled 'PATIENT RECO'. The main window displays the details of this note, including the local title 'PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE', the standard title 'MENTAL HEALTH PATIENT RECORD FLAG', and the date of note 'MAR 13, 2018 12:40:15'. The note content includes a comment '(b)(3):38 U.S.C. 5701; (b)(6)' and a list of medical providers '(b)(3):38 U.S.C. 5701; (b)(6)'. The interface also shows a 'Health Factors' section with 'SUICIDE HIGH RISK PRF PLACED ON CHART'.



CTB Version 1.9.0078

- The facility community care staff will document **that the Veteran is self-scheduling by** using the Consult Toolbox Consult (CTB) Review Tab. Select self-scheduling on the drop down in the section titled "Is Responsible for Scheduling". This will be captured on the comment of the consult. Facility community care staff will then create and mail the Veteran self-scheduling letter to the Veteran.



CTB Version 2.0

- The facility community care staff will document **that the Veteran is self-scheduling by** using the Consult Toolbox "Patient Preferences" workflow. Select the "Veteran self-scheduling" radio button under the "Veteran's Scheduling Preference" header. This will

be captured on the comment of the consult. Facility community care staff will then create and mail the Veteran self-scheduling letter to the Veteran.

CTB Version 1.9.0078 & CTB Version 2.0

- If the community provider did NOT accept the referral, the facility community care staff will review the consult to determine if additional preferred providers have been documented.
- Were other preferred providers documented in the comment of the consult?
 - If yes, staff will confirm that the preferred provider is in the network using PPMS.
- If the provider is in the network, document the new provider in HSRM and send REFDOC package
- If the provider is NOT in the network, did the Veteran agree to see another provider?
- If yes, document the new provider in HSRM and send the REFDOC package
- If no, contact the Veteran by telephone to discuss community provider options. Minimum scheduling effort guidance applies.
- Does the Veteran agree to see a network provider?
- If yes, document the new provider in HSRM and send REFDOC package
- If no, document the discussion with the Veteran in the comment of the consult and cancel the consult.
- If no, did the Veteran agree to see another provider?
- If yes, document the new provider in HSRM and send REFDOC package
- If no, contact the Veteran by telephone to discuss community provider options. Minimum scheduling effort guidance applies.
- Does the Veteran agree to see a network provider?
- If yes, document the new provider in HSRM and send the REFDOC package
- If no, document the discussion with the Veteran in the comment of the consult and cancel the consult.

At this point in the process, the community provider has accepted the referral and the Veteran has been mailed the Veteran Self Scheduling Letter.

- *Note: When possible, include a facility community care office extension number on the Veterans Self Scheduling Letter that will allow the Veteran to leave the appointment information on voicemail if a staff member is not available.*

The letter will instruct the Veteran to contact the facility community care office with the date and time of the community appointment. In instances where the Veteran does not contact the facility community care office with the date and time of the community appointment, the facility community care office will NOT be required to contact the Veteran to document the date of the community appointment. Rather, 30 days from the date that the self-scheduling preference was documented using the CTB, the facility community care staff will contact the community provider identified in the referral in HSRM for the appointment information and medical documentation (if the date of the appointment has passed). Consults with the self-scheduling preference included in the consult comments will be excluded from the Active consults > 30 days metric on the Top Metric Report. However, the consult must still comply with the pending > 2 days metric and the scheduled > 90 days metric (all consults must still be completed within 90

days). The OCC has created a [Self-Scheduling report](#) to identify which consults have the self-scheduling preference documented and calculated 30 days from the date the comment was documented on the consult for staff to begin to take actions identified in the following steps.

Facility community care office staff will check the consult status within 30 days from the date the self-scheduling consult factor was documented in the comment of the consult. Utilizing the [Records Request Fax Cover Sheet Template](#), contact the community provider for the records based off the following:

- If the consult is in a scheduled status, follow the process in chapter 3 for obtaining medical documentation.
- If the consult is in an active status, contact the community provider and ask for the community appointment information and medical records if the date of the appointment has passed.
- Contact the community provider to confirm the community care appointment was scheduled and/or completed
- If yes, document the date of the appointment in HSRM. If the appointment has been completed, follow the process in chapter 3 for obtaining medical documents. If the appointment has NOT been completed, send the community provider and the Veteran an updated community care information packet.
- If the community provider could not confirm an appointment was made, the facility community care office staff will contact the Veteran to determine if the care is still needed and if a community appointment still needs to be scheduled.

Contact the Veteran by phone. If the Veteran has not yet scheduled their appointment and needs more time, Inform the Veteran that he/she must contact the facility community care office within seven (7) calendar days with the appointment information. If they do not contact the facility community care office within seven (7) calendar days, the consult will be cancelled. If the Veteran provides the appointment information document the appointment in HSRM. Send the community provider and Veteran an updated community care information packet. If the appointment was not confirmed, and the Veteran no longer needs the care, document the Veteran response in the comments section of the consult and cancel the consult. Send the [Provider Referral Termination Fax Cover Sheet Template](#) to the community provider notifying them the previously sent referral is now terminated.

If you are unable to contact the Veteran by phone, mail the [Veteran Self Scheduling No Contact Letter](#) (seven (7) calendar days).

- If the Veteran does not respond to the letter, document the no response in the comment on the consult and cancel the consult.
- If the Veteran responds to the letter, confirm the Veteran still needs the care
- If the Veteran no longer needs the care, document the Veteran's response in the comment of the consult and cancel the consult.
- If the Veteran still needs the care and provided the appointment information, schedule the appointment in HSRM.
- Send the community provider and Veteran an updated community care information packet.

- If the Veteran needs more time, contact the Veteran again in seven (7) calendar days to document the appointment date/time.

My HealtheVet for Communications

My HealtheVet is VA's award-winning online Personal Health Record. It offers Veterans anywhere, anytime Internet access to VA health care. Launched nationwide in 2003, My HealtheVet is the gateway to web-based tools that empower Veterans to become better partners in their health care. With My HealtheVet, America's Veterans access trusted, secure, and informed health and benefits information, at their convenience.

PROCEDURES	
<ul style="list-style-type: none"> • Secure messaging in any capacity for communication is a best practice as it is another trackable venue for providing excellent customer service. • My HealtheVet can also be used for Veteran outreach. To gather scheduling preferences and to inform Veterans of scheduled community care appointments. • Note: The provider must be in the CCN network; however, CC staff can advise Veteran and Provider on how to request to join the network if the inquiry requires. • Self-Scheduling Veterans can inform Community Care of their scheduled appointments in the Community. 	
STEP	ACTIVITY
1	Assigned staff go through a TMS modules, then are active in the My HealtheVet admin portal.
2	A Community Care Team must be created local Site Admin: <ul style="list-style-type: none"> • Triage Group: Community Care • VISN: • Facility: • Add Community Care staff that would respond to messages.
3	Veterans with Premium-Level My HealtheVet will see it as an option in their secure messaging.
4	Community Care staff assigned to the group must respond to Veteran inquiries within three business (3) days.
5	Resources / References My HealtheVet Home My HealtheVet Promotion and Communication My HealtheVet: Secure Messaging (SM) Administrative User Manual.

Guidance on Top Metrics Impact due to VSS

As part of the VSS process, the Office of Community Care consult timeliness metrics as reflected in the Top Metrics Report will be updated to allow for community care consults with a VSS comment to be excluded from the scheduling timeliness metric (scheduled within 30 days) and will only be measured for pending and completion timeliness. VSS consults must be completed within 90 days in order to meet the timeliness requirement. It is important to note that this change in the metrics only applies to consults where the Veteran has opted to self-schedule and the VSS comment is captured on the community care consult as an added comment. [Consult - Activity Measures - Power BI \(powerbigov.us\)](#)

Certify Completion on the Station Dashboard for VSS

Information on how to certify completion on the Station Dashboard for VSS is located here:

<https://dvagov.sharepoint.com/:b:/s/vacovha/DUSHCC/DC/DO/CI/FGB/EXT3VqwQRnJBsO9DT07QfBQBFzaFr8adKexqCKMBUSh5aA?e=nQzO80>

Link to Training

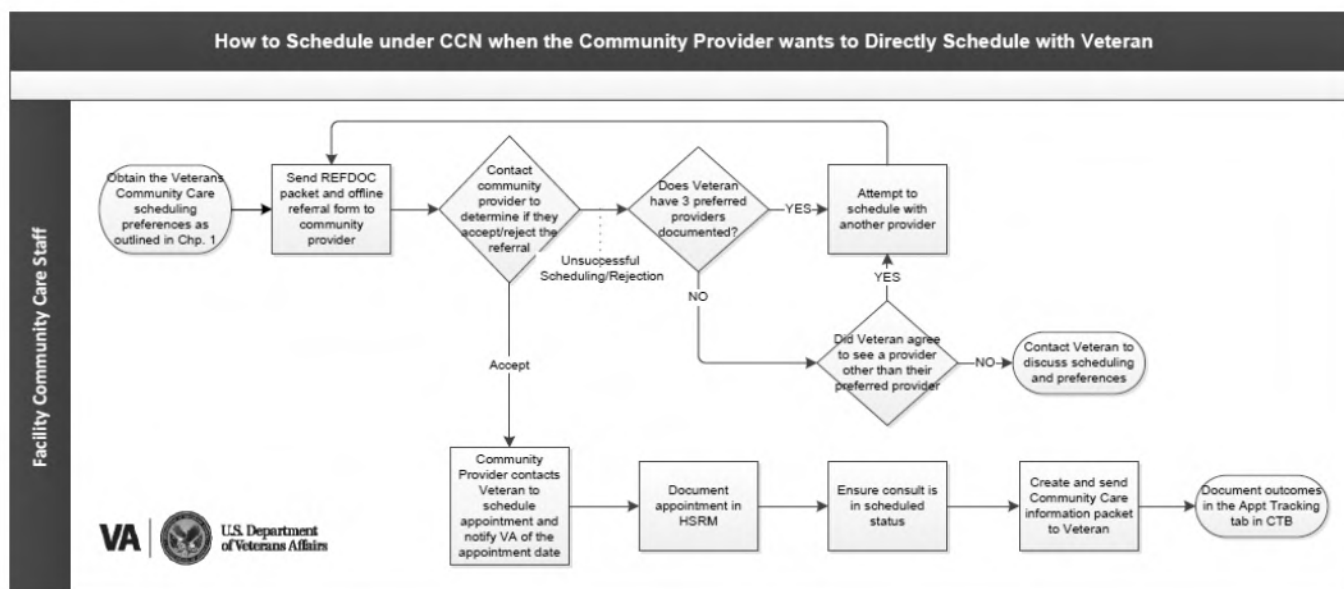
[Community Care Veteran Self-Scheduling Training](#)

HSRM Tasks available in HSRM related to Scheduling include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
New Appointment Scheduled	When an appointment is scheduled, by community provider staff, at a location that is different from the initial provider.	No action is needed	Facility community care staff

3.17 How to Schedule Under CCN When the Community Provider Contacts the Veteran to Schedule

(Post CCN)



PROCEDURES

General Considerations:

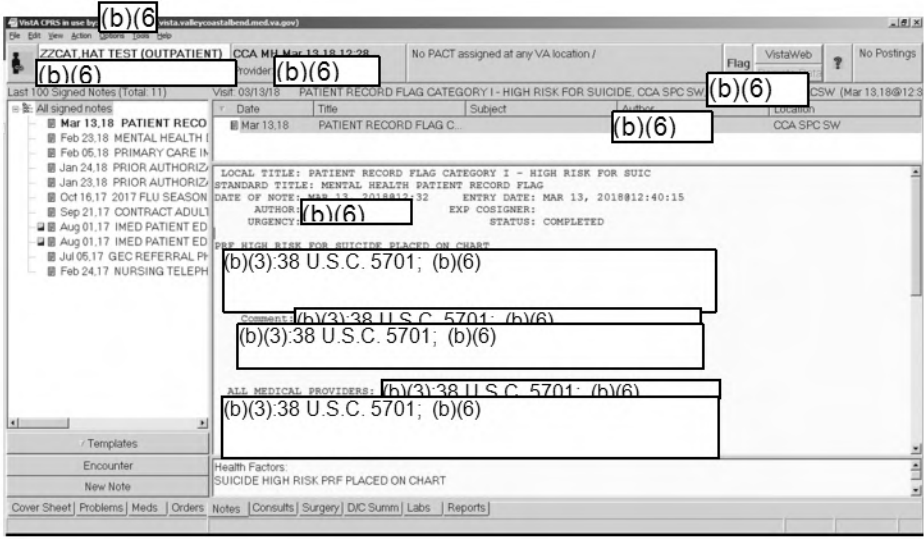
This process is a sub-process to VA scheduling. The Flow map above should be followed in the instances where the community provider would like to schedule directly with the Veteran.

STEP	ACTIVITY
1	<ul style="list-style-type: none"> Obtain the Veteran's Community Care scheduling <p>REMINDER: If the Veteran has an active BPRF, elevate the consult to the facility community care clinical staff to contact the facility's Disruptive Behavior Committee (DBC) chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with community providers. DBC Chair contact information can be found at: Workplace Violence Prevention Program (WVPP) Point of Contact (POC) Search Page; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If applicable, engage the DBC chair with the community provider to discuss any safety implications. <i>Note: This process is only required for the BPRF, not for other PRFs, such as the HRS PRF.</i></p>
2	<ul style="list-style-type: none"> Create and send the community provider the REFDOC package and authorization (offline referral form) for review and acceptance. <ul style="list-style-type: none"> For Veterans with an active HRS PRF, engage the facility community care clinical staff to ensure the completed progress note, which includes the contact information for the

PROCEDURES

General Considerations:

This process is a sub-process to VA scheduling. The Flow map above should be followed in the instances where the community provider would like to schedule directly with the Veteran.

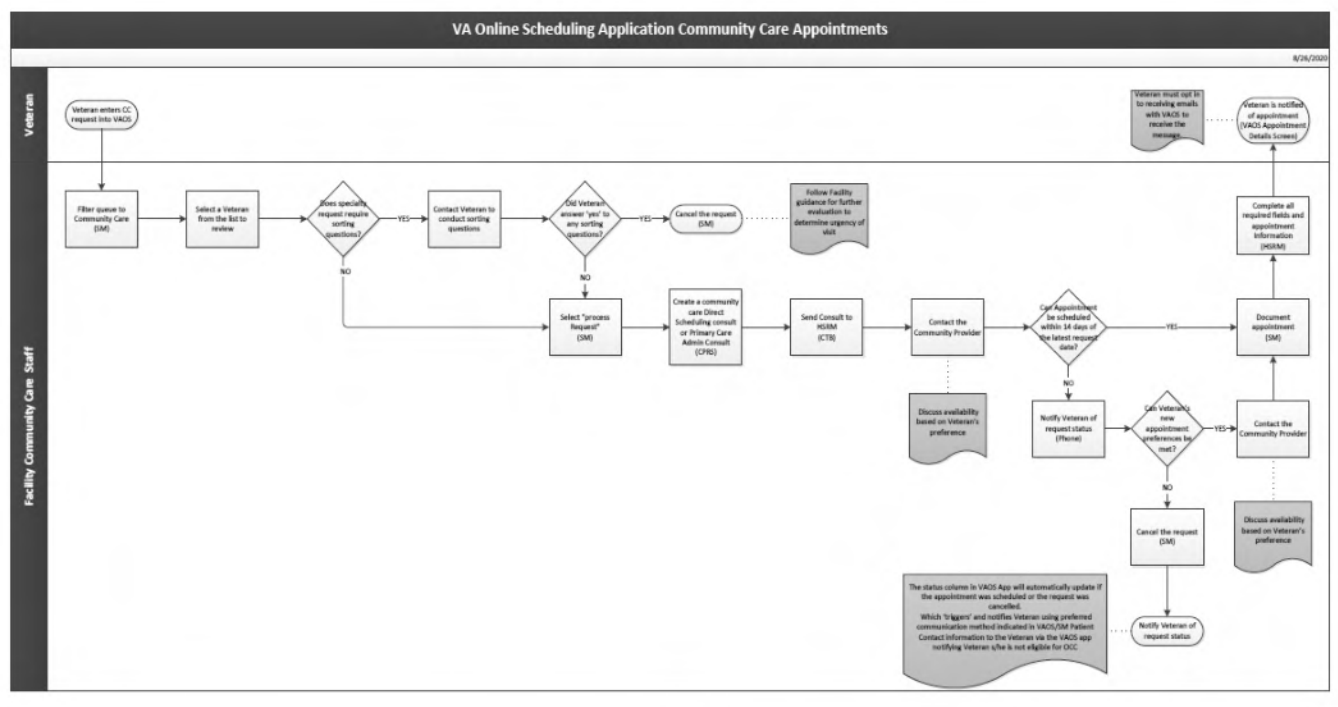
STEP	ACTIVITY
	<p>Veteran's Mental Health Treatment Coordinator/Provider or Suicide Prevention Coordinator, is included in the referral package to assist with care coordination and/or consultation about the Veteran's suicide risk. Community care staff should ensure the HRS PRF note is clearly visible to the community provider, to ensure awareness of the Veteran's suicide risk.</p> <ul style="list-style-type: none"> For Veterans with an active BPRF, engage the facility community care clinical staff to ensure the completed progress note, which includes the contact information for the DBC chair, is included in the referral package to assist with care coordination and/or consultation about the Veteran's behavioral risks. Note: The completed progress note for a Veteran with an active PRF should be included in the referral package. This is an example of the completed progress note:  <ul style="list-style-type: none"> The facility community care MSA may contact the community provider to verify receipt of the REFDOP package.
3	<p>Contact the community provider to determine if he/she accepts or declines the referral.</p> <ul style="list-style-type: none"> If yes, proceed to Step 3.

PROCEDURES

General Considerations:

This process is a sub-process to VA scheduling. The Flow map above should be followed in the instances where the community provider would like to schedule directly with the Veteran.

STEP	ACTIVITY
	<ul style="list-style-type: none"> • If no, and these were the Veteran's preferred providers, contact the Veteran to inform him/her of the declinations and select another three community providers (determined by the Veteran) and proceed back to Step 1. • If no, and there were no preferred providers identified by the Veteran, select a new provider, and proceed back to Step 1. • Document the new provider in HSRM and CPRS. <p>The community provider will contact the Veteran directly to schedule the appointment. Once the appointment is made, the expectation is that the community provider will provide the appointment information to the VA facility by an agreed upon method (fax, phone, etc.)</p>
4	<p>Contact the community provider for the appointment information if it is not received within three (3) business days from the date the community provider accepted the referral.</p> <p>To obtain a list of referrals that have not been updated to "First Appointment Made" status in 72 hours, please access the HSRM software.</p> <p>Choose the Report titled "Task Review Report" for the task "72 Hour Follow Up-Unassigned Referral" and click the "Preview" button for results.</p>
5	<p>The community provider will contact the Veteran directly to schedule the appointment. Once the appointment is made, the expectation is the community provider will provide the appointment information to the VA facility by an agreed upon method (fax, phone, etc.)</p>
6	<p>Document appointment in HSRM</p>
7	<p>Ensure the consult is in Scheduled status</p>
8	<p>Create and send the Community Care Information Packet to the Veteran via preferred method (email or standard mail).</p> <p>Using the Consult Toolbox, document that the packet was sent to the Veteran.</p>



PROCEDURES

General Considerations:

VA Online Scheduling (VAOS) is a mobile scheduling application that will allow Veterans who meet the following types of MISSION Act eligibilities to request community care appointments. This effort will enhance the scheduling process for Veterans. To be eligible to use VAOS for community care appointment requests, Veterans must meet one (1) of the MISSION Act criteria embedded in the VAOS application:

- Live in one of the following states – North Dakota, South Dakota, Montana, Alaska, or Wyoming, due to low Veteran population density
- Reside in a U.S. state or territory without a full-service VA Medical Center (Alaska, Hawaii, New Hampshire, and U.S. territories of Guam, American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands)
- Veterans who do not meet MISSION Act standards but have a “general best medical interest (BMI)” that allows them to obtain some or all their care in the community as opposed to a BMI that is for a specific episode of care.
 - o 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.
- Have an average drive time to a VA Medical Center (VAMC) of more than 30 minutes for primary care (*and not assigned to a primary care provider*), or more than 60 minutes for audiology, nutrition, optometry, or podiatry care.

Eligible Veterans can use VAOS (VAOS) to request the following types of community care appointments:

- Audiology – hearing aid support

- Audiology – routine exam
- Nutrition
- Optometry – routine exam
- Podiatry – routine exam
- Primary care – routine Initial appointment (if not assigned to a primary care provider)

VA staff will use the Scheduling Manager (SM) application to review and cancel requests for community care appointments and communicate with the Veteran.

Sites are to utilize the VAOS Community Care Comms Plan in order to provide information to Veterans.

STEP	ACTIVITY
1.	<ul style="list-style-type: none"> • Access Scheduling Manager and navigate to work queue. Filter for community care. • For additional guidance regarding VAOS and SM, please refer to the <u>VAOS SOP</u> and the <u>VAOS Flow Chart</u>. <p>Note: If the Veteran has an active BPRF, elevate the request to the facility community care clinical staff to contact the facility's DBC chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with community providers. DBC Chair contact information can be found at: <u>WVPP POC Search Page</u>; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If applicable, engage the DBC chair with the community provider to discuss any safety implications. <i>Note: This process is only required for the BPRF, not for other PRFs, such as the HRS PRF.</i></p>
2.	<p>Contact preferred community provider within three business days of gathering Veteran preferences to:</p> <ul style="list-style-type: none"> • Identify provider appointment availability and schedule the appointment • Obtain needs for medical documentation to be sent <ul style="list-style-type: none"> ○ For Veterans with an active HRS PRF, engage the facility community care clinical staff to ensure the completed progress note, which includes the contact information for the Veteran's Mental Health Treatment Coordinator/Provider or Suicide Prevention Coordinator, is included in the referral package to assist with care coordination and/or consultation about the Veteran's suicide risk. Community care staff should ensure the HRS PRF note is clearly visible to the community provider, to ensure awareness of the Veteran's suicide risk. ○ For Veterans with an active BPRF, engage community care office clinical staff to ensure the completed progress note, which includes the contact information for the DBC chair, is included in the referral package to assist with care coordination and/or consultation about the Veteran's behavioral risks.

- Note: The completed progress note for a Veteran with an active PRF should be included in the referral package. This is an example of the completed progress note:

The screenshot shows a VISTA progress note for a patient with a high-risk suicide flag. The note is dated March 13, 2018, and was written by a Licensed Clinical Social Worker (LCSW). The patient's name is redacted with (b)(6). The note title is "PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE, CCA SPC SW". The note content includes a local title, standard title, date of note, entry date, author, and a status of "COMPLETED". The note also mentions a "SUICIDE HIGH RISK PRF PLACED ON CHART". The patient's name is redacted with (b)(6) throughout the document.

3.

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 [HealthShare Referral Management VA SharePoint page](#) for additional information in the [HSRM User Guide](#).

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.

4.

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 the documents, as appropriate, in Step 3.

5.

Create the community care authorization in HSRM.

For further details on how to create the community care authorization in HSRM, please refer to the [HealthShare Referral Management VA SharePoint page](#) for additional information in the [HSRM User Guide](#).

6.	<p>Create Veteran patient referral packet using REFDOC. Packet contents should include:</p> <ul style="list-style-type: none"> • Community care authorization from HSRM • Community care consult • Standard Episode of Care (if applicable) • Required medical documentation • Veteran demographics <p>For additional information on how to create referral packet with the required contents using REFDOC, please reference REFDOC User Guide.</p>
7.	<p>Send referral packet to community care provider using HSRM, Fax, eFax, or provider's preferred method.</p> <p>Within HSRM, document that packet was sent to community care provider.</p> <p>For further details on how to send the referral packet to the community provider via HSRM, please refer to the HealthShare Referral Management VA SharePoint page for additional information in the HSRM User Guide.</p>
8.	<p>Create and send the Community Care Information Packet to the Veteran via preferred method (electronic or standard mail).</p> <p>Within HSRM, document that the packet was sent to the Veteran.</p> <p>For further details on how to document that packet was sent to the Veteran in HSRM, please refer to the HealthShare Referral Management VA SharePoint page for additional information in the HSRM User Guide.</p>

For additional information and artifacts regarding VAOS and community care appointments, please visit the [VA Online Scheduling \(VAOS\) SharePoint on the CI Solutions Page](#).

3.19 Optional Task #1 - Appointment Scheduling and Comprehensive Care Coordination under CCN

VA Medical Centers (VAMC) may decide to request the use of Optional Task #1, Appointment Scheduling and Comprehensive Care Coordination. VAMCs will have the option to complete and submit an Optional Task #1 business case to the Office of Community Care to request scheduling and care coordination support by the Regional Contractor. Business case submissions must be approved by the VISN Directors and Executive Leadership Council. The VISNs will be responsible for paying for Optional Task #1 under CCN using VISN 0140 funds.

After final approval from the Executive Leadership Council, the VAMC will be informed of the decision by their respective Regional Program Manager, who will also be the point of contact for engaging with the Regional Contractor for implementation of Optional Task #1.

The Clinical Integration team will provide education and training on the business process related to Optional Task #1. VISN leadership may also provide guidance on allotted volumes of referrals for Optional Task support.

Upon the completion of the contractor implementation, the facility community care staff may then begin sending Veteran referrals to the Regional Contractor. The process for sending to the contractor for Optional Task #1 support is as follows:

- As the facility community care staff receive consults for community care, they will confirm that the following appropriate actions were completed in the Consult Toolbox:
 1. Eligibility approved
 2. Veteran opted-in for community care
 3. Appropriate SEOC was selected
 4. Service is covered under CCN contract
 5. Reason for care is within medical benefits package
 6. Delegation of Authority approval is complete

If any of the above actions listed are incomplete or missing, alert the facility community care office staff responsible for completing the consult, to review and process prior to scheduling. **If the Veteran elected to self-schedule, do not send the Veteran on for Optional Task #1.**
- NOTE: Scheduling using Optional Task #1 may not be appropriate for some Veterans with active BPRFs. If the Veteran has an active BPRF, elevate the request to the facility community care clinical staff to contact the facility's DBC chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with community providers. DBC Chair contact information can be found at: WVPP POC Search Page; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If there are safety implications, VA staff should schedule the Veteran following the process outlined in 3.16 How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran.
- Once the above steps are completed, the facility community care staff will utilize the Screening Triage Tool to determine the Veteran's level of care coordination for this episode of care. If the Veteran is determined to have a "BASIC" level of care coordination, they are eligible to be sent as a referral to the contractor. For all other care coordination levels, please follow the Community Care scheduling process for VA scheduling.
- Community care staff must ensure appropriate authorization and prepare medical records before sending referrals to the CCN contractor for scheduling. The following steps should be completed to prepare the community care referral for the Regional Contractor:
 1. Locate the referral within HealthShare Referral Manager (HSRM) and upload to REFDOC package to HSRM by selecting a document type
 2. Choose program authority
 3. Choose affiliation
 4. Click apply
 5. Select Optional Task CLIN
 6. Click apply
- Once the referral has been submitted in HSRM to the CCN Contractor, complete the following steps in CPRS to document that the referral has been routed to the CCN Contractor for Optional Task #1 Services
 1. Select the appropriate consult in CPRS, select "Action," and "Add Comment"

2. Right-click within the comments box and select “Community Care Functions”
3. Select the “Consult Review” tab. Within the “Scheduling to be performed by” section select “Community Care Contractor”
4. By following these steps, a comment will be added to the consult for tracking purposes, which will identify that the referral has been routed to the CCN Contractor for scheduling

As the contractor manages the Veteran referral, they will document and update Veteran appointment information or any additional information related to appointment outcomes or requirements within HSRM. Site staff will utilize the Optional Task 1 Daily Scheduling Reports to track and enter newly scheduled and rescheduled appointments to VSE. Site staff will also utilize VSSC and HSRM reporting to address referrals that are returned by the CCN Contractor and to view Optional Task utilization. Please review the CCN Optional Task #1 SOP and for additional guidance. Contact (b)(6) @va.gov if you have questions.

3.20 How to Perform Clinical Review of Documentation and Coordinate Follow Up Care

(Pre/Post CCN)

When does care coordination follow up occur?

Care coordination follow up occurs after the Veteran has attended their appointment(s). The team member responsible for the follow up should identify the Veteran's appointment date in the care coordination tool or the consult toolbox and follow up with the Veteran by using the Veteran's preferred form of communication.

HSRM's task management system helps facility community care staff manage all aspects of care coordination for each episode of care. The Task List also streamlines communication between facility community care staff and community providers. In addition, users can utilize tasks to review Veteran and referral information, create, assign and track care coordination activities, as well as set reminders and alerts to promote efficient and timely referral processing.

HSRM Tasks Available Related to Conducting Follow Up Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
Follow Up with Provider (2-Day Follow Up with Provider to Verify Attendance at the Appointment)	When two days have passed since the date of the Veteran's first appointment.	<ol style="list-style-type: none"> 1. Contact the community provider staff to confirm that the appointment was attended 2. Contact the Veteran and see if there are any additional appointments or services required 3. Document the contacts with the Veteran and the community 	Facility community care staff

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
		provider staff within the CC-CCP Note 4. Mark the task as complete	
Follow up with Provider (25-Day Follow Up for Medical Documentation - Subsequent Request)	When medical documentation has not been received from community provider staff, within 25 days of status change to Initial Care Given or within 25 days of the earliest appointment.	1. Contact community provider staff for medical documentation 2. Document the request 3. Mark the task as complete	Facility community care staff
Review Medical Documents from Community	When documents are uploaded to HSRM with the Medical Documentation type tag.	1. Locate the medical documents received for the Veteran 2. Conduct a review of the documents 3. If indicated, send medical documents for a clinical review	Facility community care staff

Task Dispositions Available Related to ‘Review Medical Documents from Community’ Task in HSRM:

Task Disposition	Description	Recommended Guidance
1) Document needs to be uploaded to VistA/EHR (MD1)	Received medical documents from community provider but have not yet uploaded the documents to VistA/EHR system	<ul style="list-style-type: none"> Locate medical documents Follow local process for uploading medical documents to VistA/EHR system Mark task as Completed in HSRM
2) Document uploaded to VistA/EHR (MD2)	Medical documents uploaded to VistA/EHR system	<ul style="list-style-type: none"> Validate medical documents in VistA/EHR system Mark task as Completed in HSRM
3) No upload to VistA/EHR required (MD3)	Received medical documents which do not require upload to VistA/EHR system	<ul style="list-style-type: none"> Determine why medical documents do not require upload to VistA/EHR system When confirmed, mark task as Completed in HSRM
4) Document has incomplete information (MD4)	Received medical documents which has incomplete or missing information	<ul style="list-style-type: none"> Contact community provider staff to request missing medical documents or information Once received, locate medical documents Follow local process for uploading medical documents to VistA/EHR system

		<ul style="list-style-type: none"> Mark task as Completed in HSRM
5) Document loaded to incorrect Veteran (MD5)	Medical documents uploaded to incorrect referral	<ul style="list-style-type: none"> Conduct medical documentation review to upload medical documents to correct referral <ul style="list-style-type: none"> Attach medical documents to correct referral Remove medical documents from incorrect referral as needed If medical documents have not been received, contact community provider staff to upload medical documents to the correct referral <ul style="list-style-type: none"> Once received, locate medical documents Follow local process for uploading medical documents to VistA/EHR system Mark task as Completed in HSRM

PROCEDURES	
STEP	ACTIVITY
1	<p>Review Clinical Documentation: Review clinical documentation related to episode of care including the clinical response to the requested referral. The designated clinical staff from the integrated team (Registered Nurse and/or Social Worker) must assess documents for any critical values, follow up care, assessments, and recommendations for the referring VA provider.</p>
2	<p>Coordinate Follow up Care: Coordinate between the VA ordering provider and the interdisciplinary team regarding treatment, planning, and follow up referral for the Veteran's continuity of care.</p> <ul style="list-style-type: none"> Any critical results must to be reported immediately to the ordering VA provider for action. <p>Significant Findings: This function allows a sender or a receiver to flag a consult as containing vital or specific information for special attention. This triggers an alert to the sending or receiving provider (<u>per VHA Directive 1232 Consult Processes and Procedures</u>, amended Jun 28, 2019).</p>
3	<p>Create a Community Care-Coordination Plan Note: If a Community Care-Coordination Plan Note does not exist, create a Community Care-Coordination Plan Note in CPRS/HSRM to document the facilitation and coordination of services required for the Veteran.</p>

	<p>To generate a Community Care-Coordination Plan Note, select the note title in CPRS and complete the template, filling out all required fields. Add all pertinent VA staff (e.g., Patient).</p> <p>Note: The Community Care Coordination Plan Note is not required for the Direct Scheduling Consults, GEC, and Emergency Treatment.</p> <p>Aligned Care Team, specialty provider, social worker, etc.) should be identified as additional signers to the Community Care Coordination Note to notify and/or assist in coordinating services for the Veteran.</p> <p>To create a Community Care-Coordination Plan Note in HSRM:</p> <ul style="list-style-type: none"> • After accessing the referral details screen, click the three vertical dots found on the right of the screen. • Click on the menu item of Letters. • Choose the Community Care-Coordination Plan (CCP) Note template from the dropdown, then click “New”. The CC-CCP note will then populate for you to begin filling out. • Once the user is finished, select “Apply/Update” to save changes. • Copy/paste the Note in CPRS as it’s the official medical record. <p>You will then be able to print the note to upload to CPRS or copy/paste the note.</p> <p>NOTE: User must copy & paste CC-CCP Note from HSRM back to CPRS until full functionality within HSRM is implemented. This has been approved by HIMS. As a shortcut, place your cursor inside of the letter, click CTRL+A (for all), then CTRL+C (for copy). This will copy everything in the note. Go to Step 4</p> <p>For additional information, see:</p> <p><u>Community Care-Coordination Plan Note SOP</u></p> <p><u>HealthShare Referral Manager VA SharePoint Page</u></p> <ul style="list-style-type: none"> • for additional information on the: <ul style="list-style-type: none"> ○ HSRM User Guide ○ HSRM Tasking Functionality for Care Coordination ○ HealthShare Referral Manager Task List Quick Reference Guide for VA Facility Community Care Staff
4	<p>Continue Documenting Care Coordination Efforts: Use the MAKE ADDENDUM feature of the Community Care-Coordination Plan Note to document additional information throughout the episode of care.</p> <p>Once the note is signed, the progress note cannot be edited. Therefore, to add information to a completed CC-CCP note, users must create an addendum to document any additional information related to the Veteran’s care coordination needs.</p> <p>Place cursor over “Action” command on the toolbar and select “Reload Boilerplate Text.”</p>

Reminder Dialog Template: COMMUNITY CARE-COORDINATION PLAN NOTE

VA-CC Coord Plan Emer Care Version 1.4

Select documentation for entry:

☒ Community Care Coordination Plan

Select documentation to be entered:

☐ Initial Note

☐ Addendum Templates

☐ Veteran self-presented to community emergency facility

Visit Info Finish Cancel

Community Care Coordination Plan

<No encounter information entered:

* Indicates a Required Field

- Go to the “Addendum” templates

Reminder Dialog Template: COMMUNITY CARE-COORDINATION PLAN NOTE

VA-CC Coord Plan Emer Care Version 1.4

Select documentation for entry:

☒ Community Care Coordination Plan

Select documentation to be entered:

☐ Initial Note

☒ Addendum Templates

☐ Care Coordination Follow Up

☐ Appointment Management

☐ Case Management

☐ Continued Stay Review

☐ Disease Management

☐ Discharge Planning

☐ Patient Contact

☐ Provider Contact

☐ Transfer

☐ Veteran self-presented to community emergency facility

Visit Info Finish Cancel

Community Care Coordination Plan

<No encounter information entered:

* Indicates a Required Field

The CCP progress note template will reload for user to select the addendum required. Nine addendum templates will display:

- Appointment Management

- Care Coordination Follow Up
- Case Management
- Continued Stay Review
- Disease Management
- Discharge Planning
- Patient Contact
- Provider Contact
- Transfer

Select the appropriate addendum, identify any additional staff as needed.

How does the integrated team member know follow up is complete?

The integrated team member will know follow up is complete when services have been provided and there are no additional consults indicated that need to be addressed. All clinical documents related to the Veteran's episode of care should be requested, received and evaluated before community care (CC) follow up is considered complete.

A consult summary note should be submitted, documentation should be received and attached to the consult, and the consult should be closed using the consult toolbox.

When can a consult be closed?

After the episode of care is complete for the referral and the community provider has submitted all medical documentation to VA, the facility community care staff member reviews the medical documentation and determines if the referral can be closed. The facility community care staff member receives a task on his or her task list when medical documentation is uploaded to a referral in HSRM. Once the facility community care staff member has reviewed the documentation and confirms that the EOC is complete, he or she updates the referral status to EOC Complete on the Referral Details screen [HealthShare Referral Management VA SharePoint page](#) for additional information in the [HSRM User Guide](#).

Note: A distinction between "consult" and "referral" is required. The consult is closed in CTB once the referral is sent, accepted by the community provider, and medical documentation has been provided. The Referral remains open in CPRS/HSRM until the EOC is complete.

HSRM Tasks Associated with EOC Complete Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
Submit Medical Documents to VA	When seven days have passed since the referral status was changed to Initial Care Given .	Submit medical documents to the VA	Community provider staff using HSRM
Episode of Care (EOC) Complete – Follow Up for Medical Documentation	When a referral status is changed to EOC Complete but does not have medical documentation attached	<ol style="list-style-type: none"> 1. Send a request for medical documents to community provider staff 2. Set a manual task to follow up within 10 days 3. Mark the task as complete (once all completed medical documents have been received) 	Facility community care staff

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
Review GEC Documents	1) When GEC Homemaker/Home Health Aide Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Homemaker/Home Health Aide Treatment Plan/Timesheet.	GEC clinical staff/Facility community care clinical staff	Treatment Plan <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	Treatment Plan <ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Timesheet***</p> <ol style="list-style-type: none"> 1. Administrative staff receives timesheet and reviews to ensure hours worked match

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>authorization and hours invoiced</p> <ol style="list-style-type: none"> Discrepancies noted are reported to GEC Program Coordinator Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	<p>2) When GEC In Home Respite Care Treatment Plan* document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Respite Treatment Plan/Timesheet.</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> GEC Program Coordinator reviews treatment plan Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> If treatment plan is received by administrative staff, send for clinical review GEC Program Coordinator reviews treatment plan and returns to administrative staff Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			Timesheet*** <ol style="list-style-type: none"> Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced Discrepancies noted are reported to GEC Program Coordinator Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	3) When GEC Community Adult Day Health Care Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Adult Day Care Treatment Plan.	GEC clinical staff/Facility community care clinical staff	<ol style="list-style-type: none"> GEC Program Coordinator reviews treatment plan Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<ol style="list-style-type: none"> If treatment plan is received by administrative staff, send for clinical review GEC Program Coordinator reviews treatment plan and returns to administrative staff Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>4) When GEC Veteran Directed Care Spending Plan document is uploaded.</p>	GEC clinical staff/Facility community care clinical staff	<ol style="list-style-type: none"> 1. GEC Program Coordinator reviews and approves spending plan 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i>** <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If spending plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews spending plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i>** <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>5) When GEC PACE Treatment Plan* document is uploaded.</p> <p>*Document name will be coming in HSRM in the future.</p>	GEC clinical staff/Facility community care clinical staff	<ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan and confirms level of care 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i>**

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>6) When GEC Bowel/Bladder Care Treatment Plan* document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Bowel/Bladder Care Treatment Plan/Timesheet.</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan (may be Spinal Cord Injury coordinator who reviews) 2. Send to ordering provider for signature, if needed 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HRSM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>3. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>4. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff or PACT team, administrative staff completes these steps.</p> <p>Timesheet***</p> <p>1. Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced</p> <p>2. Discrepancies noted are reported to GEC Program Coordinator</p> <p>3. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>4. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record</p>
	<p>7) When GEC Skilled Home Health OASIS/485 document is uploaded.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<p>OASIS</p> <p>1. GEC Program Coordinator reviews OASIS document</p> <p>2. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>3. Mark HSRM task as <i>Completed**</i></p> <p>485</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<ol style="list-style-type: none"> 1. GEC Program Coordinator reviews 485 document 2. Send to ordering provider for signature, if separate process for signing orders is not established** 3. When signed order is returned, send to vendor, if separate process for returning orders is not established** 4. Mark record as received, upload document to EHR and attach to consult for closure** 5. Mark HSRM task as <i>Completed</i>** <p>**These steps may be completed by administrative staff.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
		GEC administrative staff/Facility community care administrative staff	<p>OASIS</p> <ol style="list-style-type: none"> 1. If OASIS document is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews OASIS document and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i>** <p>485</p> <ol style="list-style-type: none"> 1. If 485 document is received by administrative staff, simultaneously send for clinical review and ordering provider, if separate process for signing orders is not established**

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<ol style="list-style-type: none"> When signed order is returned, send to vendor, if separate process for returning orders is not established** Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
	<p>8) When GEC Inpatient Hospice Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Hospice Outpatient/Inpatient Treatment Plan or Discharge Summary.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<p>Treatment Plan</p> <ol style="list-style-type: none"> GEC Program Coordinator reviews treatment plan Send to ordering provider for signature/orders, as needed** Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>Discharge Summary</p> <ol style="list-style-type: none"> Send to ordering provider to review discharge summary and write orders, as needed Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>**These steps may be done by administrative staff.</p>
		GEC administrative	Treatment Plan

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
		staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Send signed treatment plan to agency** 5. Mark HSRM task as <i>Completed**</i> <p>Discharge Summary</p> <ol style="list-style-type: none"> 1. If discharge summary is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews discharge summary and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>9) When GEC Home Infusion Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Home Infusion Treatment Plan/Pharmacy Delivery Notice.</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan 2. Send to ordering provider for signature/orders, as needed** 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Pharmacy Delivery</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews documentation

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i> ** **These steps may be done by administrative staff.
		GEC administrative staff/Facility community care administrative staff	Treatment Plan 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i> ** Pharmacy Delivery 1. Administrative staff receives pharmacy delivery slip 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i> ** **If not managed by clinical staff, administrative staff completes these steps.
	10) When GEC Community Nursing Home document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Community Nursing Home	GEC clinical staff/Facility community care clinical staff	MDS 1. GEC Program Coordinator reviews initial MDS 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Upload subsequent MDS, as needed** 4. Mark HSRM task as <i>Completed</i> ** Care Plan/Notes

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	MDS/Care Plan/Notes.		<ol style="list-style-type: none"> 1. GEC Program Coordinator reviews documentation 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>MDS</p> <ol style="list-style-type: none"> 1. If MDS is received by administrative staff, send for clinical review to evaluate MDS 2. GEC Program Coordinator reviews MDS (if document is initial MDS, or MDS is a change in level of care, update authorization) and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Care Plan/Notes</p> <ol style="list-style-type: none"> 1. If documentation is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews documentation and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	11) When GEC TBI Residential Rehabilitation Treatment Plan document is uploaded. *Document name will be coming in HSRM in the future.	GEC clinical staff/Facility community care clinical staff	1. GEC Program Coordinator reviews treatment plan and confirms level of care 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i> ** **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i> ** **If not managed by clinical staff, administrative staff completes these steps.

3.21 How to Manage Clinical Documentation from Community Providers



Clinical documentation retrieval by TPA in the initial TriWest VAMCs (prior to December 2018) will stop April 30, 2019. Effective May 1, 2019 all VAMCs, to include the original TriWest VAMCs will start collecting their own medical documentation PC3 contracted care regardless of date of service.

Once service has been provided, clinical documentation should be sent to the VA from the community provider within the designated timeframe (see Clinical Documentation Return Timeframes by Program below). Facility Community Care Office staff will then:

In cases where clinical documents were not returned, Facility Community Care Office staff should contact community providers to request the clinical documents. If after attempt(s) to contact and retrieve the medical documentation from the provider fail, staff should confirm care

was delivered and administratively close the consult using the Consult Toolbox Consult Completion tab. Per consult policy, staff should notify their supporting clinical staff to track for follow-up and continue to pursue the documents even after closure. Staff and leadership can track the administratively closed consults with the [Community Care Closed without Records](#) report. Refer to the [10N Memo](#) for Clarification.

CLINICAL DOCUMENTATION RETURN TIMEFRAMES		
COMMUNITY CARE PROGRAM	STATUS	CLINICAL DOCUMENTATION RETURN TIMEFRAMES
PC3 National Contract	Inpatient	30 days after discharge
	Outpatient	14 days after initial appointment
Individual Authorizations	Inpatient	90 days after discharge (initiate request at 30 days)
	Outpatient	90 days after initial appointment (initiate request at 30 days)
Veteran's Care Agreements (VCA)	Inpatient	30 days after discharge
	Outpatient	30 days after the initial appointment
CCN Optional Tasks	Inpatient	30 days after discharge
	Outpatient	30 days after initial appointment
DOD	Inpatient	Reference contract terms for return of medical documentation
	Outpatient	Reference contract terms for return of medical documentation

For additional information, see: [Appointment and Clinical Documentation Management Process Guide](#) and [Community Care - HIM SOPs for Community Care Responsibility](#).

3.22 How to Verify the Veteran Attended the Appointment

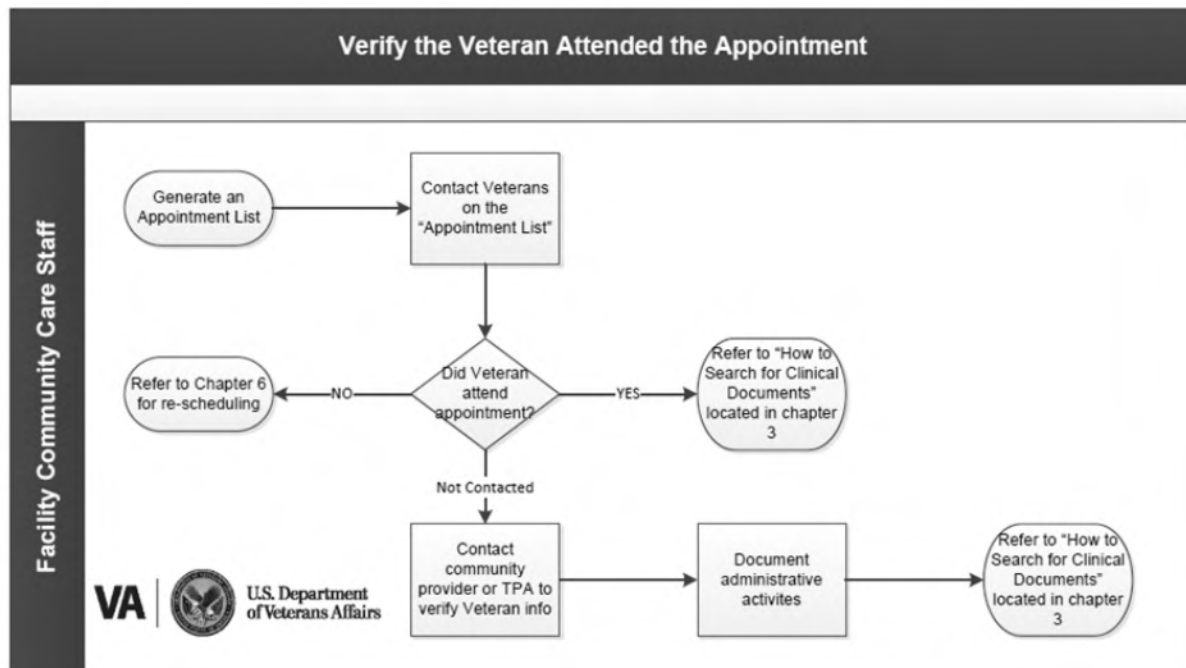
(Pre/Post CCN) 

Before searching for various communication routes such as TPA portal, local fax machine, electronic fax folders, or Azure RMS for clinical documentation, Facility Community Care Office staff should verify that the Veteran attended the appointment, and if follow up tests were ordered, confirm that the Veteran also attended those associated appointments.

To confirm if the Veteran attended the appointment, Facility Community Care Office staff should generate a list of all appointments scheduled for the prior two business days (T-2 report) daily for non-count clinics after an appointment was supposed to occur. All scheduled community care appointments will be assumed to give a scheduled status in respective non-count community care clinic in VistA Appointment Manager as directed in the policy. Specific steps required to undertake appointment verification are listed in the table below.

The HSRM Task List has several tasks associated with appointment follow up. Facility Community Care Office staff can verify that the Veteran attended the appointment using the following Follow-up tasks including:

- Follow Up with Provider – When 2 days have passed since the date of the Veteran's first appointment
- Follow Up with Provider – Medical documentation has not been received from the community provider within 25 days of status change to *Initial Care Given*, or within 25 days of the earliest appointment
- Review Medical Documents from Community - Documents are uploaded to HSRM with the *Medical Documentation* type tag



PROCEDURES

STEP	ACTIVITY
1	<p>Generate an Appointment List: Generate a list of all appointments scheduled T-2 (business) days utilizing the Appointment List option in VistA. Select the Appointment List (AL) option</p> <p>Select Division</p> <p>At the next prompt select: Non-Count</p> <p>Select the appropriate Non-Count clinics i.e., COMMUNITY CARE ORTHOPEDICS</p> <p>Select Date of scheduled appointments, i.e., T-2</p> <p>Default "NO" for Primary Care Assignment Information</p> <p>Print Report</p>

PROCEDURES	
STEP	ACTIVITY
2	Contact Veterans on the “Appointment List”: Facility Community Care Office administrative staff will contact the Veteran by phone to verify appointment was attended.
3	If Unable to Contact Veteran: Contact the community provider or TPA to verify if the Veteran attended appointment and/or to request clinical documentation. Document administrative activities (i.e. attempts to contact the Veteran), in CPRS ‘Patient Notes’ section. Go to “ <i>How to Perform Clinical Review of the Documentation and Coordinate Follow Up Care</i> ” located in this Chapter for guidance on the search order for clinical documentation.

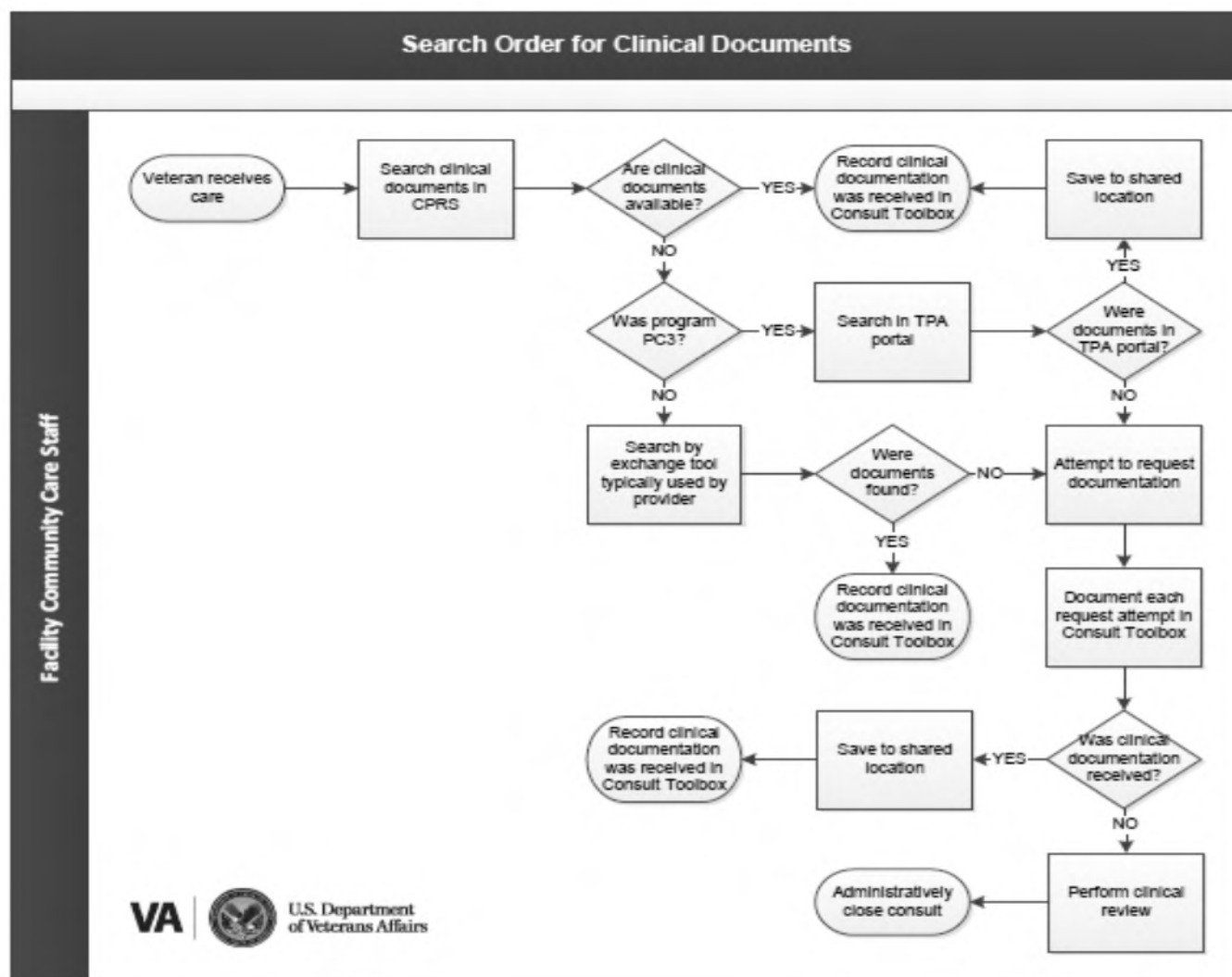
3.23 How to Search for Clinical Documents



There are two processes that staff should follow to search for clinical documents:

Daily Review and Upload: Facility Community Care Office staff should review the primary clinical document exchange tools, and when new documents are found, those documents should be saved to the shared location. This daily process ensures that there is no backlog of medical records, and that CPRS via VistA Imaging Capture is populated without significant delays for all Veterans at that facility.

Veteran Specific Search and Upload: Once VA staff have confirmed the Veteran attended the appointment and documentation was not found in the daily review, then staff should start the process of searching for clinical documentation for the Veteran’s EOC. Since there are multiple clinical document exchange tools, the search should begin in those tools most frequently used for clinical documentation exchange. The process below lists the key tasks related to this process of searching, reviewing, and uploading a specific Veteran’s record is to see which route the provider is using in CTB.



PROCEDURES

STEP	ACTIVITY
1	<p>Wait before searching. After a Veteran has received care, providers and TPAs need time to prepare and then send documents to the VA. Time lags associated with clinical documentation varies, but general guidelines are:</p> <ul style="list-style-type: none"> Urgent Care: documents should be sent to the VA after 1 to 2 days Routine-Urgent Care: there is greater variability in non-urgent care, but they should not exceed contractual guidelines as noted in Clinical Documentation Return Timelines.
2	<p>Verify Clinical Documents Were Received and Uploaded Into CPRS. Facility Community Care Office staff should ensure that documents have been received if the consult was closed.</p>

	<p>Where CPRS:</p> <ul style="list-style-type: none"> • Contains the documents > go to Step 6 • Does not contain > go to Step 3
3	<p>Determine the Veteran's Program to Narrow the Search.</p> <p>If the Veteran's program is:</p> <ul style="list-style-type: none"> • PC3 contract Provider – search the TPA portals, if the document is: <ul style="list-style-type: none"> ◦ Viewable in the TPA portal > go to Step 6 ◦ Incomplete or not in the TPA portal > go to Step 5.1 • CCN, IA/PA, DoD Provider > go to Step 4
4	<p>Check for Clinical Documentation: Check all applicable methods for documentation exchange to confirm whether clinical documentation has been received. Search the documentation exchange tools in the order they are received by a local facility.</p> <p>The search order is based on these criteria:</p> <ul style="list-style-type: none"> • The exchange tool typically used by a specific provider • The outbound communication means used by the VA, as this can be used by the provider for return communication (i.e. Azure RMS) <p>If Clinical Documentation was:</p> <ul style="list-style-type: none"> • Received > go to Step 6 • Received, but incomplete > go to Step 5.1 • Not received > go to Step 5.2
5	<p>Request Additional Documentation: If clinical documentation has been received within the timeframes outlined above, but after review, the clinical documentation is incomplete, the community provider should be contacted noting which documents appear to be missing.</p> <ul style="list-style-type: none"> • If documentation complete > go to Step 6 • If documentation incomplete > go to Section 3.25 for guidance on requesting clinical documentation from community providers and/or TPAs. <p>Request Clinical Documentation: If clinical documentation has not been received within the timeframes outlined above, Facility Community Care Office staff should contact the community provider to request the appropriate clinical documentation related to the specific episode of care. Go to Step 6 or 3.25</p> <p>For additional information, see:</p>

	<p><u>Community Care - VistA Imaging Capture Best Practice And Minimum Documentation Requirements</u></p> <p><u>Community Care - HIM SOPs for VA Community Care Responsibilities</u></p>
6	<div data-bbox="345 415 444 516"></div> <p><u>CTB Version 1.9.0078</u></p> <p>Document Attempts to Obtain Clinical Documentation: Attempts to obtain clinical documentation from the community provider must be documented on a consult using the Consult Toolbox under the Care Coordination Consult Completion tab.</p> <div data-bbox="345 716 444 816"></div> <p><u>CTB Version 2.0</u></p> <p>Document Attempts to Obtain Clinical Documentation: Attempts to obtain clinical documentation from the community provider must be documented on a consult using the Consult Toolbox under the "Consult Completion" tab.</p> <p><u>CTB V1.9.0078 AND CTB Version 2.0</u></p> <p>If documentation has:</p> <ul style="list-style-type: none"> • Been received and quality checked per Section 3.39 > go to Chapter 4, Section 4.1 for guidance on uploading and indexing medication documentation into VistA Imaging Capture • Not been received after the community provider has been contacted to request the documentation > go to Chapter 4, Section 4.3 for guidance on closing the Consult without clinical documentation. <p>For additional information, see: <u>Consult Toolbox SharePoint Site</u></p>

3.24 How to Save Document to the Shared Folder Location

Once clinical documents have been sent by the community provider AND have passed Quality Check as outlined in Section 3.38, Facility Community Care Office will save those to the shared folder location.

Each site has a different shared location for the temporary storage of clinical documents after they are downloaded or scanned, and before they are loaded into VistA Imaging. Regardless of the exchange tool by which clinical documentation is received, once the documents have been quality checked and clinically reviewed, the process for importing and indexing documents into VistA Imaging Capture is the same, see Chapter 4, Section 4.1 for additional detail.

3.25 Roles and Responsibilities for Importing Clinical Documentation



(Pre/Post CCN)

While the overarching business process for clinical documentation remains the same in certain locations there is a defined division of labor between the Facility Community Care Office and the Health Information Management (HIM) staff. The table below shows the responsibility at the summary level for business processes related to receiving and storing clinical documentation. Staff should speak with their supervisor to confirm which process is in use at their site.

PROCEDURES			
STEP	REFERENCE SECTION	OPTION 1 Facility Community Care Staff and HIMs	OPTION 2 Facility Community Care Staff Only
1 Receive Clinical Documentation	3.27	Community Care	Community Care
2 Review, identify the appropriate consult	3.3 – 3.35 – depends on the tools by which documentation is received	Community Care	Community Care
3 Check Quality of clinical documentation file	3.39	Community Care	Community Care
4 Undertake Care Coordination		Community Care	Community Care
5	3.40	Community Care	Community Care

Save Clinical Documentation to Shared Location			
6 Import and Index to Clinical Documentation to VistA Imaging Capture	4.1	Community Care and HIMs	Community Care
7 Complete Consult Closure Note	4.2	Community Care and HIMs	Community Care

3.26 Release of Information (ROI) and Accounting of Disclosure

(Pre/Post CCN)

The focus of this chapter is receiving and acting upon clinical documentation, however, during communication with providers staff may need to send clinical documentation to community providers. To protect Veteran privacy, sending and releasing clinical documentation to community providers should follow VHA Office of Community Care Release of Information Requirements Fact Sheet. The new REFDOC release incorporates accounting of disclosure.

VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans. Authorized care is community care or treatment approved in advance by VA, whereas, unauthorized care is emergency care or treatment not approved by VA prior to the care or treatment being provided to the Veteran. For the purposes of this Fact Sheet, Community Care is treatment by community health care providers authorized or unauthorized at the time of treatment and paid for by VA. Community Care information regarding Veterans is located at: <https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp>.

Emergency Care

VHA may disclose individually identifiable health information, including Title 38 U.S.C. 7332 protected health information, to a community health care provider treating a Veteran under emergent conditions.

VHA facilities and facility programs are required to keep an accurate accounting of disclosures for each Emergency Care disclosure.

Accounting of Disclosures

VHA health care facilities and programs are required to keep an accurate accounting for each disclosure of a record to any person or to another agency that is outside of VA,

including State reporting and research. Release of Information staff are normally responsible for releasing and accounting for the disclosure of patient health information. However, some facilities have chosen to share this responsibility with other departments. Access to the DSS ROI Plus software is not restricted for use by HIM staff and may be given to staff outside of HIM at the discretion of the Chief HIM, so long as the users have been trained.

Whether using the DSS ROI Plus software or REFDOC, Community Care staff that disclose individually identifiable information must maintain an accounting of disclosure in accordance with local facility policy. With the latest deployment of REFDOC Version 2.2, accounting of disclosure information is now captured electronically when creating a packet of patient information for the community provider. It also includes Accounting of Disclosure reporting capability. Prior to the release of REFDOC V2.2, the tool did not capture the accounting of disclosure and did not contain historical accounting of disclosure information.

Individuals responsible for releasing health records must work with their local Privacy Officer (PO) and Health Information Management (HIM) staff to select the best possible means of tracking the disclosures. Tracking of the accounting of disclosures may include use of the DSS ROI Plus software, REFDOC, or a manual accounting of disclosure via a spreadsheet. The spreadsheet must include the name of the individual to whom the information pertains, the date of disclosure, description of what was disclosed (i.e. progress note dated xx/xx/xx; discharge summary), the purpose of the disclosure, a copy of the written request, the name of the person or organization requesting the information, and the address of the person or organization. See [Appendix A](#).

VHA facilities and facility programs such as Social Work and Community Care, which are responsible for disclosing protected health information, are required to keep an accurate accounting of disclosure for each disclosure that is made to a community provider. NOTE: VHIE Exchange and Direct Secure Messaging maintain an accounting of all disclosures electronically, which is available upon request.

3.27 How to Use Available Clinical Document Exchange Tools



In this section, the tools are listed together with their recommended use, benefits, and access instructions. The tools to send/receive clinical documents will vary by site based on referral volume, and community provider capability. As highlighted in the table under “recommended use,” the key is to select the ‘right tool’ for the situation at hand.

TOOLS AVAILABLE FOR DOCUMENT EXCHANGE			
TOOL	RECOMMENDED USE	BENEFITS	HOW TO GAIN ACCESS
TriWest Portal See Section 3.3 <i>**Additional information regarding VA Portal Functional and Appearance Changes occurring in June 2020 is located in the "Tools" section of the Office of Community Care Field Guidebook*</i>	For Veterans associated with TriWest Portal	<ul style="list-style-type: none"> Allows users to view images of paper-based documentation sent to VA by providers. Identifies clinical documentation associated with claims and authorizations. Custom search and scan of clinical documents 	Email: (b)(6)@triwest.com
Azure RMS See Section 3.30	Low-high referral volume	<ul style="list-style-type: none"> Is configured on all Microsoft office VA computers. Large file sharing enabled 	Email: (b)(6)@va.gov
VHIE Direct Secure Messaging (DSM) See Section 3.31	Medium-high referral volume	<ul style="list-style-type: none"> Incoming/outgoing, end-to-end documentation and notification sharing of Consolidated Clinical Document Architecture (CCDA) and PDF files. Automated accounting of disclosure. Can be integrated into other VA Systems: JLV, FBCS, eHMP. Supports directory of non-VA partner emails. Veterans need to approve access to their files. 	Email: (b)(6)@va.gov
VHIE Joint Legacy Viewer (JLV) See Section 3.32	Medium-high referral volume	<ul style="list-style-type: none"> Searchable/query access to real-time data. Available to all VA Employees with CPRS access. 	Email: (b)(6)@va.gov
VHIE eHealth Exchange – JLV See Section	Medium-high referral volume	<ul style="list-style-type: none"> Standards based transport (CCDA). Real-time data access for immediate information need (e.g. ER visit). Incoming/outgoing documentation sharing. 	Email: (b)(6)@va.gov

		<ul style="list-style-type: none"> • Veteran approval needed for access to their files. • Automated Accounting of Disclosure. • Retrieved using a viewer such as JLV 	
Secure e-Fax (StreamFax, RightFax) See Section 3.33	Low-medium referral volume	<ul style="list-style-type: none"> • Easy facility/user adoption. • Prevents the need to print. 	Contact local staff and email: (b)(6)@cleo.com
Traditional Fax See Section 3.34	Low-medium referral volume	<ul style="list-style-type: none"> • Easy facility/user adoption. • Prevents the need to print and scan. • Insecure and may not be accepted by some provider/ TPA. 	Local use
US Mail See Section 3.35	Referral volume can vary	<ul style="list-style-type: none"> • US mail is scanned and indexed locally. • In the future – the P2E (Print to Electronic Data Interchange) project will centrally scan and send images. 	Local use
HSRM See Section 3.37	For Facility Community Care Staff and Community Providers to streamline community care referral and authorization management	<ul style="list-style-type: none"> • Easy to upload and share documents between VA and the treating facility. • Standardized process through one easy to use secure portal. • VA Facility Community Care staff & Community Providers can share clinical documentation and images. 	To gain access to HSRM or if a current VA HSRM user needs technical assistance, please create a VA Enterprise Help Desk ticket by calling: (b)(6) TTY (b)(6) or visiting https://yourit.va.gov

3.28 Requesting Clinical Documentation from the Community Providers

(Pre/Post CCN)



If clinical documentation has not been received within thirty (30) days, Facility Community Care Office staff should contact the community provider to request the appropriate clinical documentation related to the specific EOC

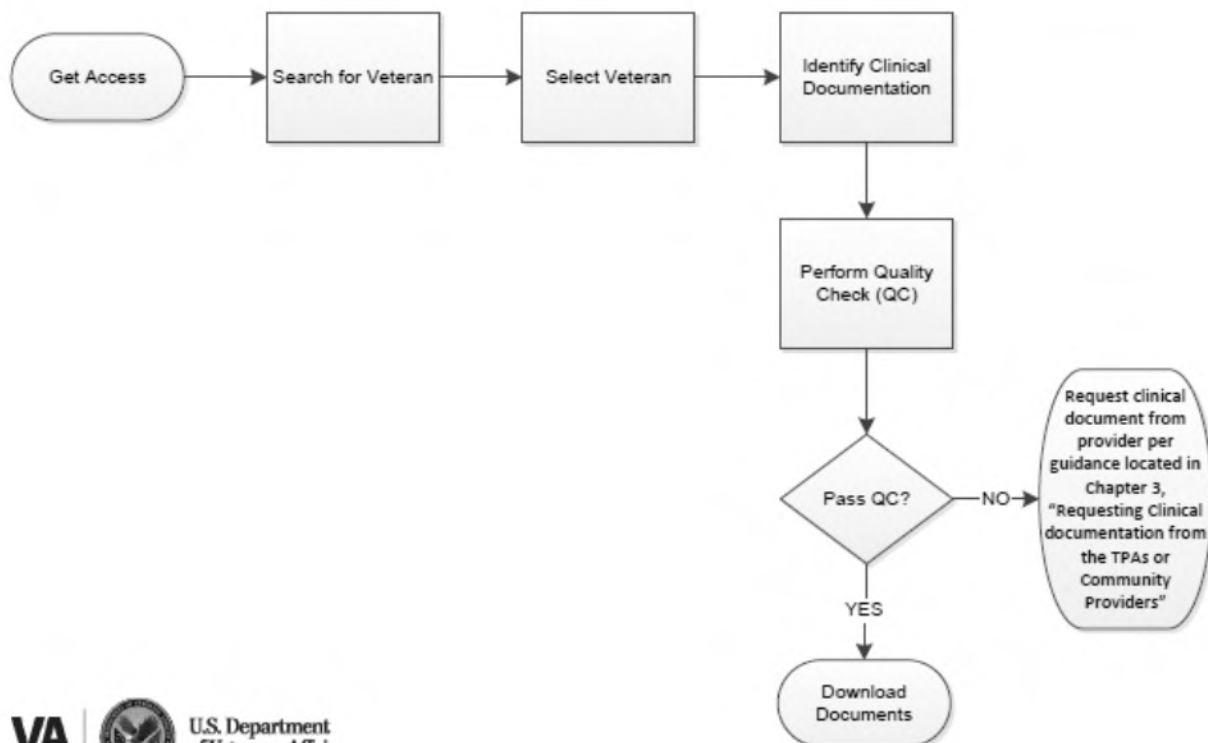
3.29 Receiving Documents via TriWest Portal (TPA)

(Pre CCN)



Receiving Documents via TriWest Portal (TPA)

Facility Community Care Staff



VA



U.S. Department
of Veterans Affairs

PROCEDURES

STEP	ACTIVITY
1	Access TW VA Staff Portal: Select Med Doc Download Tab.
2	Find Veteran: Select Search Tab. Enter VA Auth #, or TW Auth #, or SSN, or Last Name's Initial & 4 digits of SSN.
3	<p>Select Document(s): Filter the download by selecting "Created Date" range and "Program"</p> <ul style="list-style-type: none"> Select Download All Documents to initiate batch download. Select Confirm All to confirm and remove downloaded documents from the work list.

PROCEDURES	
STEP	ACTIVITY
4	<p>Perform QC review in line with Section 3.39 If QC:</p> <ul style="list-style-type: none"> • Passes > go to Step 5 • Fails > request clinical documentation from provider/TPA, per Section 3.28
5	<p>Download Document(s):</p> <ul style="list-style-type: none"> • Click on the Calendar Icon to select the “Created Date” range. • Click on the All Programs dropdown menu to view a list of programs/contracts available in the work list (i.e. PC3, etc.) • Click Download All Documents • Click Confirm All after the download
6	<p>Document Extract: Locate the “Downloads” folder and right click on the downloaded folder</p> <ul style="list-style-type: none"> • Select Extract All. Once the folders have been extracted, verify the downloaded files have been saved and subcategorized by Category of Care, and save to the Shared Location. • Use the Facility Community Care Office site file-naming convention. <p>Go to Section 3.40 for guidance on saving clinical documentation to a Shared Location.</p>

For additional information, see: [TriWest User Guide](#)

3.30 Receiving Documents via Azure Rights Management Service (RMS)

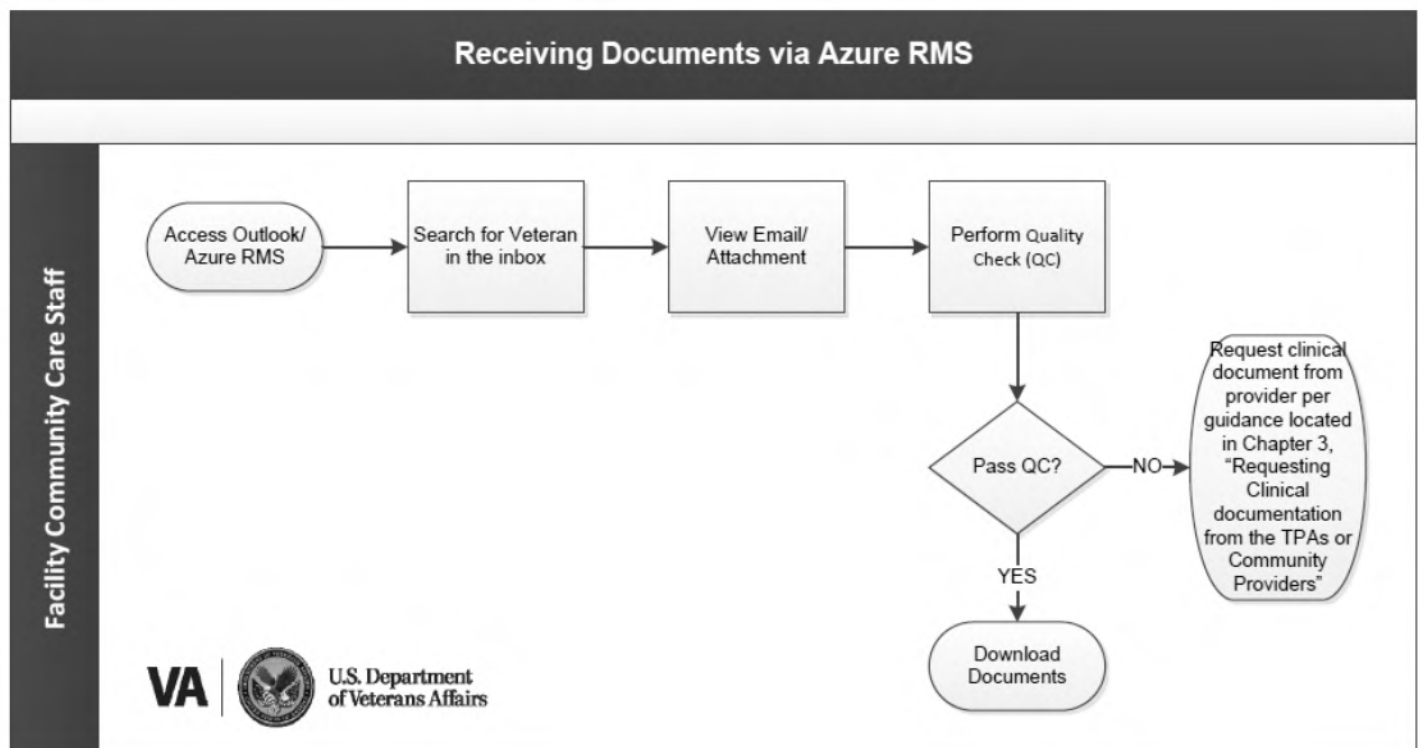


Azure RMS allows VA to securely exchange information with community providers using encrypted email that is already installed on all Microsoft VA computers. Community Providers can seamlessly read and respond to email through their existing email provider or open the email in a web browser to read and respond securely. Community care providers can utilize Azure RMS directly in their existing email account without installing software, using portals, or creating new accounts.

Facility Community Care staff must send and receive encrypted emails with community providers. VA must first send an encrypted email using Azure RMS. This will deliver community providers a means to respond with encryption.

Community providers do not need to install additional information to decrypt Azure RMS protected data. The individual End User License will automatically be issued after authentication process establishes the recipient's identity and appropriate permission level to view the protected information.

VA staff should not communicate Protected Health Information (PHI) or Personal Identifiable Information (PII) unless using a VA approved means of exchange.



PROCEDURES	
STEP	ACTIVITY
1	Access Azure RMS: Click the “Azure RMS” tab at the top of Outlook to open Azure RMS.
2	Search for Veteran in the inbox: To find a specific Veteran, staff must search for the provider and view specific emails.
3	View Email/Attachment: Once staff identify the email pertaining to a Veteran; they open the email and view any attachments.

4	Perform QC review in line with Section 3.39 If QC: <ul style="list-style-type: none"> • Passes > go to Step 5 • Fails > request clinical documentation from provider/TPA, per Section 3.28
5	Document Extract: Locate the “Downloads” folder and right click on the downloaded folder. <ul style="list-style-type: none"> • Select Extract All. Once the folders have been extracted, verify the downloaded files have been saved and subcategorized by Category of Care, and save to the Shared Location. • Use the local site file-naming convention Go to Section 3.40 for guidance on saving clinical documentation to a Shared Location.

For additional information, see: [Azure RMS Fact Sheet](#)

3.31 Receiving Documents via VHIE Direct Secure Messaging (DSM)



DSM is a secure web inbox with a portal located at (<https://direct.va.gov>) enabled by the Veterans Health Information Exchange (VHIE) that provides users the ability to exchange information as an individual or through a group mailbox (distribution list) with community providers.

There is no installation required.

A simple registration question allows users to gain functionality within minutes.

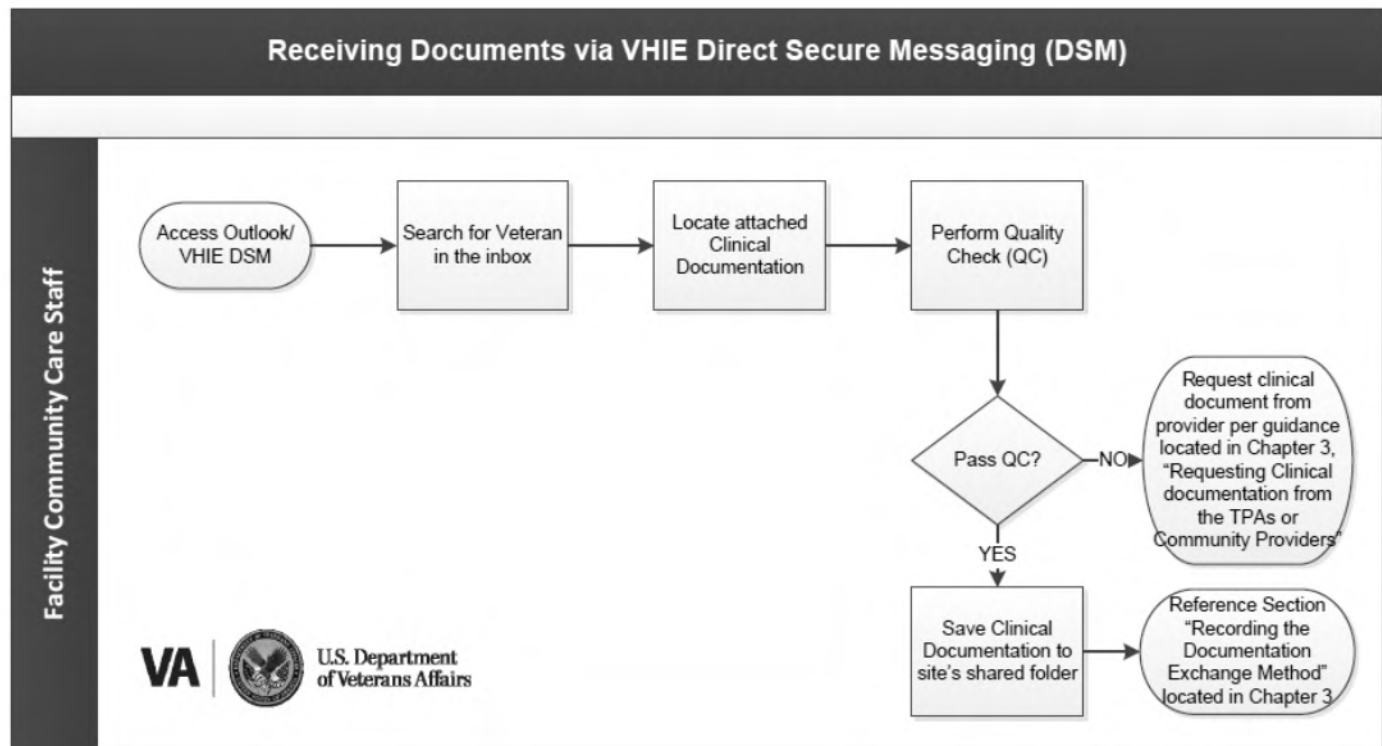
DSM allows VA users to exchange clinical information with Community Care providers via secure messaging under a trusted network (point to point). It can transmit a Consolidated Clinical Document Architecture (CCDA) (structured/standardized health record) file in addition to referral documentation.

DSM is available for communication between select community partners that have been approved for VHIE.

The Validated CCPs and Connected HIEs-HISPs list contains community care providers with which VA Direct is currently connected. This file also contains a list of the Direct Technical Partners and HIEs connected with VA Direct Messaging.

For more information on how to enable DSM in the Facility Community Care Office please contact: (b)(6)@va.gov, your facility's local Virtual Lifetime Electronic Record (VLER) Coordinator, or visit the [Myees VA](#) website for more information.

Note: We recommend VAMC's reach out to their local hospitals and emergency departments where veterans are typically admitted and encourage them to sign up for DSM. This will allow VAMCs to automatically receive any notes created in these facilities or inpatient units. The VAMC's should set up appropriate DSM mailboxes that include PACT teams, staff that support community care, and perhaps transfer coordinators.



PROCEDURES	
STEP	ACTIVITY
1	<p>Enable DSM and Determine Community Partner</p> <p>The Facility Community Care Office staff should be aware if their facility exchanges information with community partners through VHIE. Questions regarding VHIE status can be answered by your local VHIE Coordinator, HIM Chief or email the VHIE Coordinator group at: (b)(6)@va.gov</p>
2	<p>Receive notification via Outlook</p> <p>If a user is a DSM user, they will receive a notification anytime a payload is received from a community partner via a notification in Outlook indicating that they have received documentation for a specific Veteran.</p>
3	<p>Log into Direct</p>

	The user should log into DSM at https://direct.va.gov using their Personal Identify Verification (PIV) Card
4	Open group or individual DSM mailbox Because DSM supports distribution lists, messages can be received in a group/common inbox. If a user has an individual inbox and belongs to a group inbox (facility inbox) they should ensure they select and are checking the correct inbox.
5	Search the inbox to find the Veteran. Identify the provider that was/is providing service to the Veteran, review Direct Secure Message messages to find messages related to a specific Veteran.
6	Locate attached clinical documentation. Open the attachment(s) associated with the message received from provider in the Direct Secure Message inbox by clicking on the link provided.
7	Perform QC review in line with Section 3.40 If QC: If clinical documentation passes QC - go to Step 3 If clinical documentation fails QC - request clinical documentation from provider/TPA per Section 3.29
8	Save clinical documentation to your site's shared folder. Click "Save as" in the pop-up window, locate the shared folder location, name the document in line with local naming conventions, and save the document. Review the local site file-naming convention, as noted in Section 3.41 noting that local guidance may vary
9	Closing the consult Vista Imaging Capture should be used to complete the consult via a progress note and attachment of clinical documentation from the community partner. See Chapter 4, Section 4 for guidance on attaching documentation and closing a consult using Vista Imaging Capture.
10	Once completed, staff should record the method by which records were received in the Consult Completion tab of the Consult Toolbox. Go to Section 3.42 for guidance on recording the documentation exchange method.

For additional information, see:

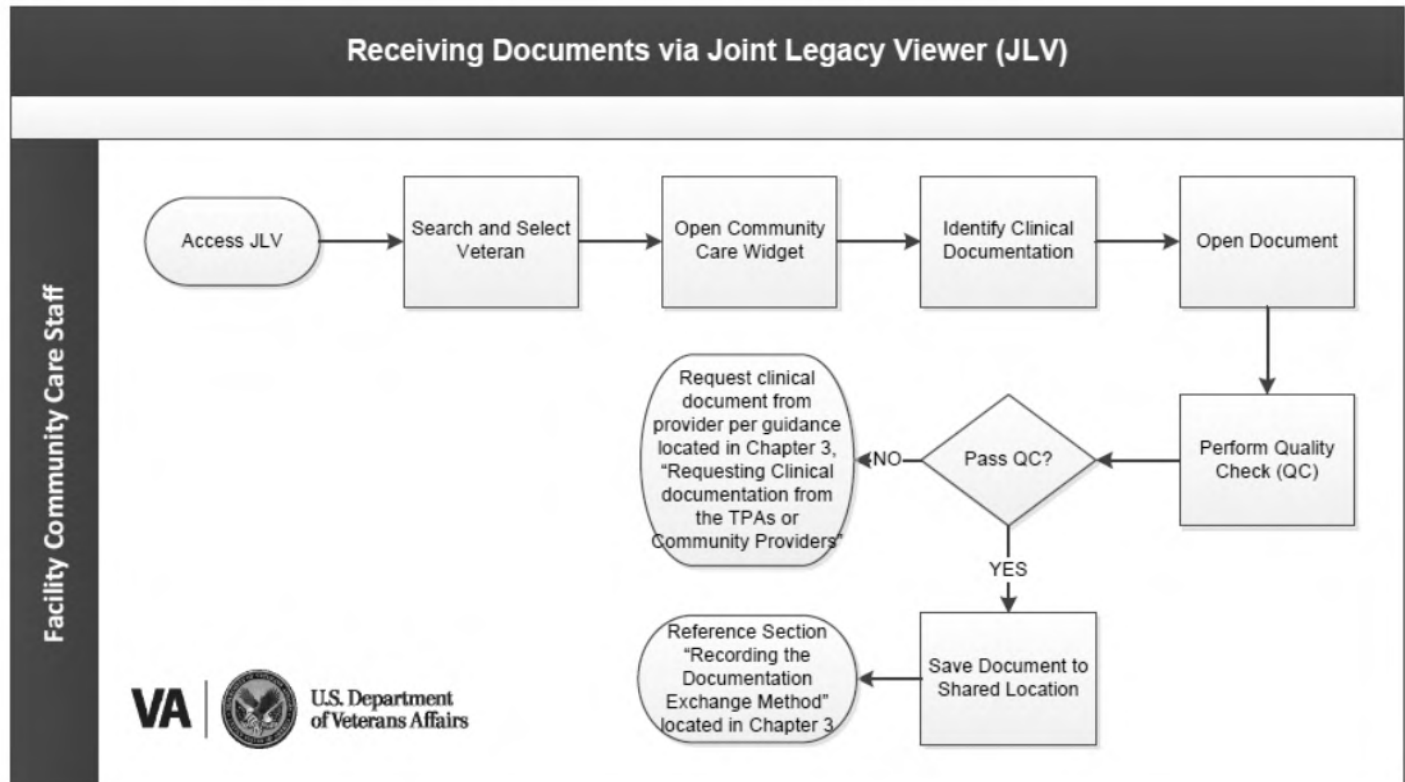
Community Care - HIM SOPs for Community Care Responsibility

3.32 Receiving Documents via Joint Legacy Viewer (JLV)

(Pre/Post CCN)



JLV provides an integrated read-only view of health data from all VA, DoD, and VA community care partners where a Veteran or Service member has received care. VA providers can view Veteran health data provided outside of the VA by utilizing the Community Health Summary widget, eliminating the need to access two separate applications. eHealth Exchange Records may be retrieved using JLV if the Veterans have been properly correlated.



PROCEDURES

STEP	ACTIVITY
1	Start Application Launch JLV from an Internet Explorer web browser or from the tool's menu in CPRS. JLV is located at https://jlv.med.va.gov . JLV should automatically sync the Veteran selected in CPRS.
2	Enable Accessibility to Data Prior to searching for community data, a Veteran will need to be "announced" or correlated via the Veteran Access and Preferences (VAP) at http://nvppapp-prd.va.gov/nvap-web/Login.do

	<p>So, if any available data is visible:</p> <ul style="list-style-type: none"> • Enable the View Non-VA Community Data checkbox option in CPRS by selecting the "Remote Data" prompt (top right of display). • If there is "Non-VA Data Available", it will now be viewable by JLV. <p>See the JLV user guide for additional information: JLV User Guide</p>
3	<p>Find Veteran</p> <p>Use patient search to locate the Veteran's information in JLV. Note that JLV does not notify users of new documentation automatically.</p>
4	<p>Select Program</p> <ul style="list-style-type: none"> • Click on the Open Widget Tray option that is located on the bottom right corner of the JLV window. • Drag the Community Health Summary widget onto your workspace and enter the appropriate date range of a Veteran's appointment to identify the appropriate documentation you are trying to locate. <p>Note It is common for Non-VA appointments to be rescheduled to a date that does not match the consult. In other words, you may have to look at records for a date different than the one shown in the CPRS consult.</p>
5	<p>Select Document Program</p> <p>Using the Community Health Summary Widget.</p> <ul style="list-style-type: none"> • Click and drag the widget to the middle of the screen so that it appears. You will now see the Community Health Summary window appear with content listed.
6	<p>View the appropriate dates and community partner</p> <ul style="list-style-type: none"> • Select the appropriate community health summary from the widget and add it to the report builder. • If there are multiple health/encounter summaries and notes, they should be selected and added to the report builder. The report builder bundles summaries and notes into one PDF file.
7	<p>Open Vista Imaging Capture</p> <ul style="list-style-type: none"> • Create a new Consult Result Note by selecting the "create progress note" button. • From the community provider's note visible in the community health summary within JLV, copy and paste the appropriate documentation into the newly created progress note notating the date of service and from whom the clinical information is from. • Do not copy the Community Care providers electronic signature.

	<p>Note: MSA/HIM staff that do not have Copy/Paste functionality – please see guidance below:</p> <p>In the instances where administrative staff (i.e. Office of Community Care Medical Support Assistants (MSA), HIM staff, etc.) import clinical information from Joint Legacy Viewer (JLV), Virtual Lifetime Electronic Record (VLER) eHealth Exchange, Direct Secure Messaging, or other remote data sources, the documentation must be downloaded as a PDF file, imported and attached to the Community Care Consult Result Note. HIM/Facility Community Care Office staff should leave the note open and change it to the relevant clinician's name for completion.</p>
8	<p>Link consult to Progress Note in Vista Imaging Capture</p> <p>A list of open consults for the Veteran will appear in the progress note prompt. The Consult Result note should be linked to the appropriate consult.</p>
9	<p>Open Attachment from Report Builder</p> <p>The content of the Community Health Summary will appear.</p> <ul style="list-style-type: none"> • Click on the "Convert" option. • Click on the drop-down arrow next to "Convert", • Select the "Convert Web Page to PDF" option.
10	<p>Perform QC review in line with Section 3.40</p> <p>If QC:</p> <ul style="list-style-type: none"> • Passes go to Step 7 • Fails, request clinical documentation from provider/TPA, per Section 3.29
11	<p>Save Attachment</p> <ul style="list-style-type: none"> • Use the local site file-naming convention, as noted in Section 7.41 • Go to Section 3.42 for guidance on recording the documentation exchange method.
12	<p>Select attachment using Vista Imaging Capture</p> <ul style="list-style-type: none"> • To attach documentation, the saved PDF should be attached to the appropriate consult linked (see Step 8 above). • This will now result in the PDF being visible in the record and the note (see Step 7) referring to what occurred, without having to relaunch Vista Imaging Display

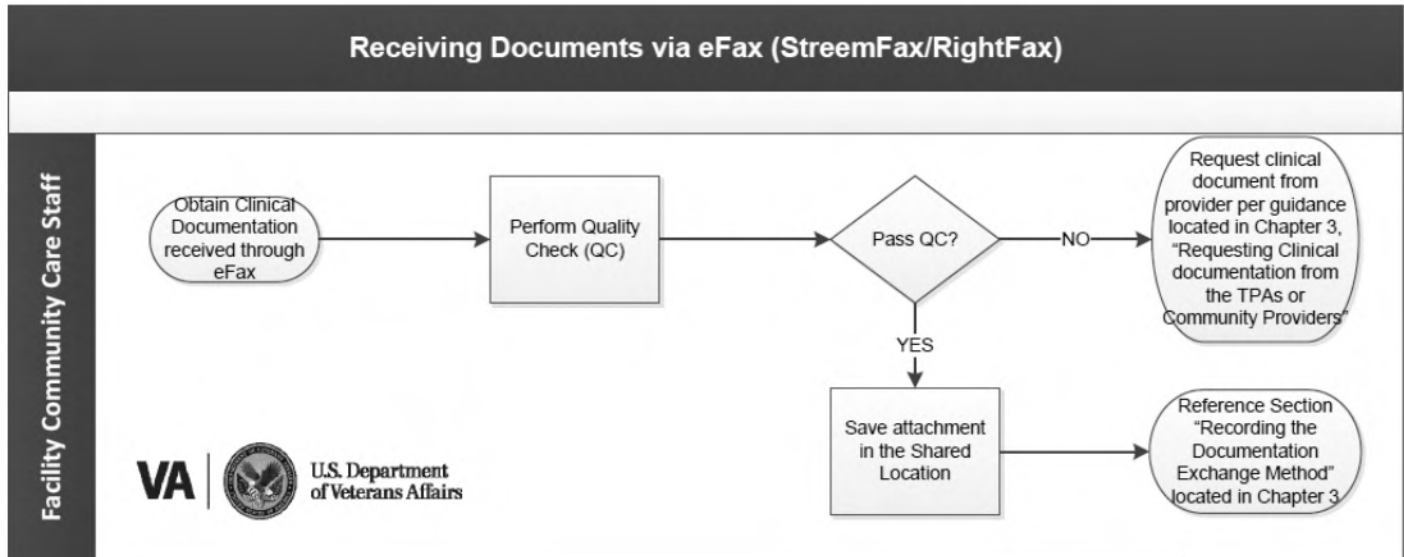
For additional information, see: [Community Care - HIM SOPs for Community Care Responsibility](#)

3.33 Receiving Documents via eFax (StreamFax/RightFax)

(Pre/Post CCN)



Electronic fax systems allow VA staff to receive incoming documentation electronically from providers' traditional or eFax services. eFax has some advantages over traditional fax as there is no requirement to scan paper faxes into image files to be saved at the Shared Location.



PROCEDURES

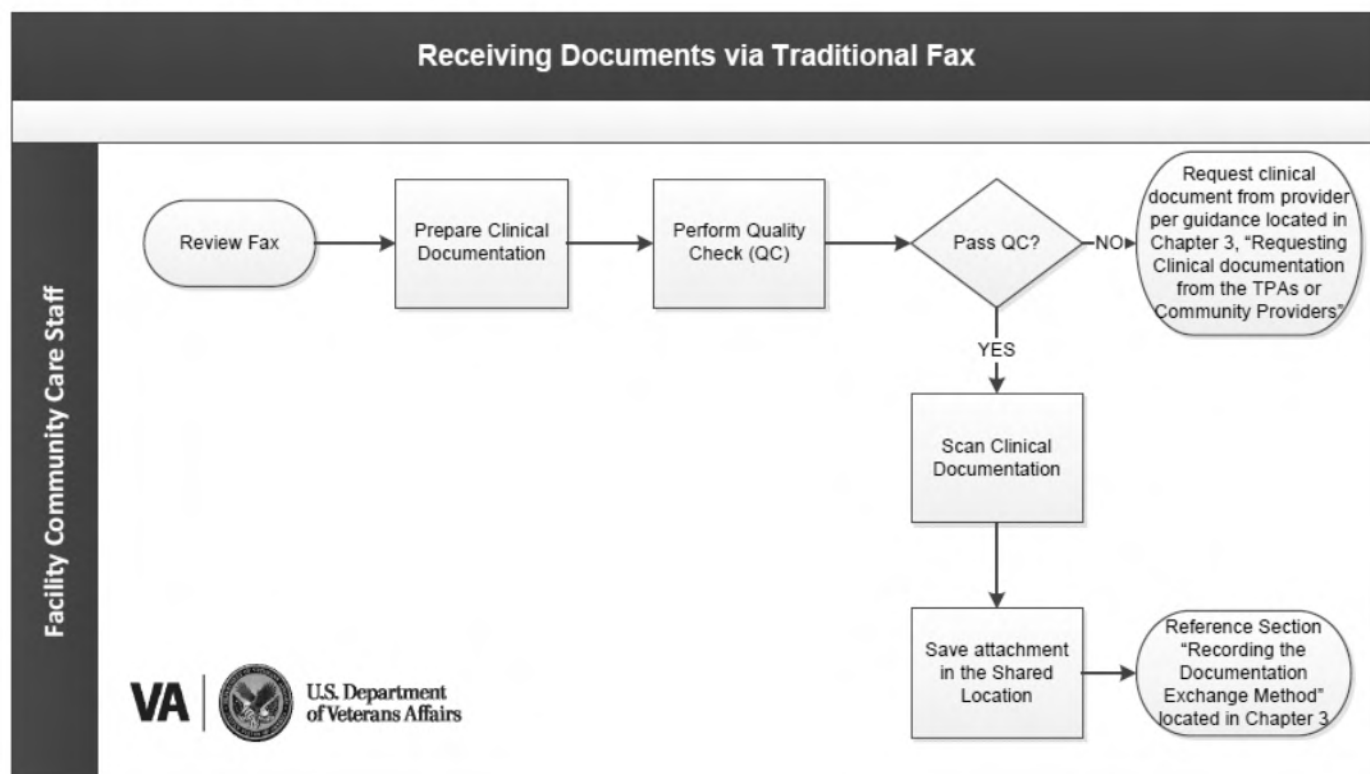
STEP	ACTIVITY
1	Obtain clinical document received through eFax. <ul style="list-style-type: none"> There are two eFax options, StreamCenter and RightFax, available across sites. For both options, the clinical documentation sent by the provider can be accessed via the link embedded in the email received. If you are unfamiliar with which eFax option your site uses, please ask your supervisor.
2	Click on the attachment, identify the Veteran, then review the files that need to be saved and perform QC review in line with Section 3.39 If QC: <ul style="list-style-type: none"> Passes > go to Step 4 Fails > request clinical documentation from provider/TPA, per Section 3.28

3	<p>Save Attachment in the Shared Location</p> <ul style="list-style-type: none"> • Use the local site file-naming convention, and save the file(s), as noted in Section 3.40. • Go to Section 3.41 for guidance on recording the documentation exchange method.
---	--

3.34 Documents via Traditional Fax

(Pre/Post CCN)

Some providers will fax records to VA; however, the use of electronic documentation exchange methods is highly encouraged. Scan medical records to the appropriate shared folder or scan and import/ index directly to VistA Imaging.



PROCEDURES

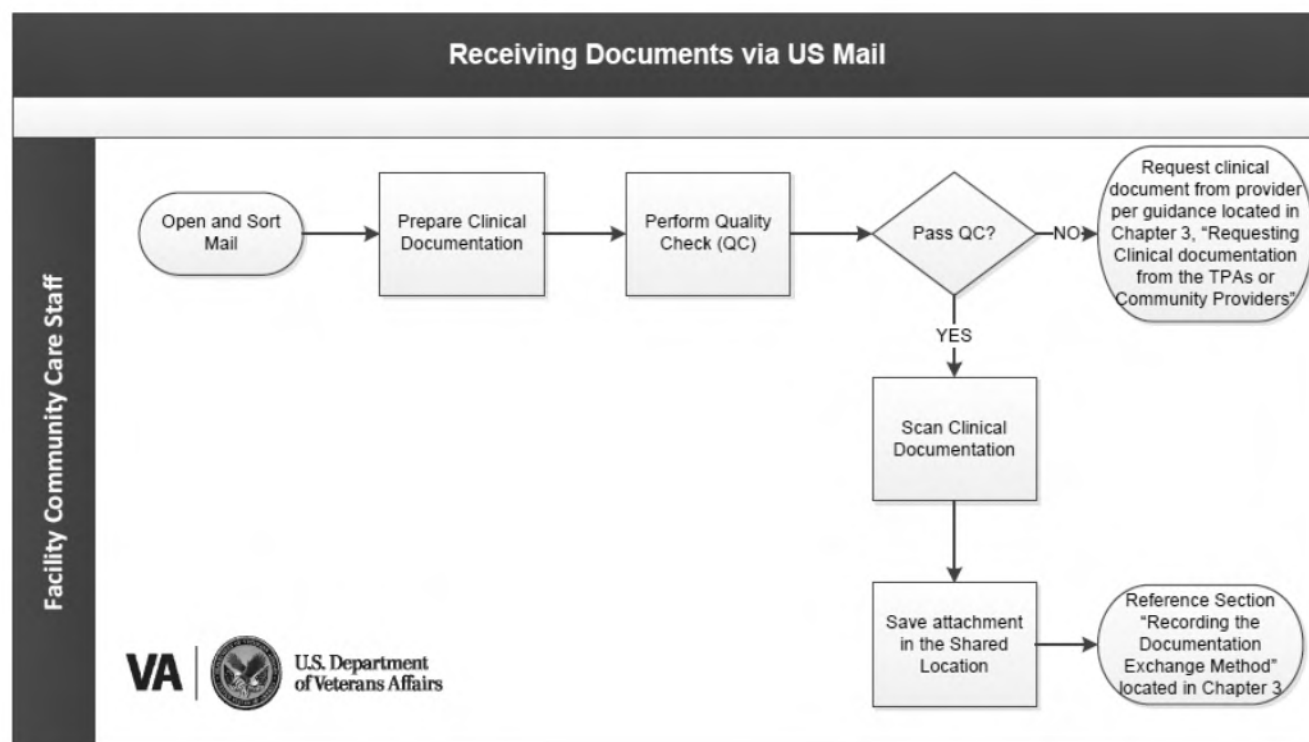
STEP	ACTIVITY
1	<p>Review Fax</p> <p>Identify Veteran and verify that all documents related to that Veteran are assembled.</p>
2	<p>Prepare Clinical Documentation</p> <p>Prepare the received fax document for scanning (e.g., remove staples, paper clips, etc.).</p> <p>Select the fax documents that you want to scan and save and perform QC review in line with Section 3.39</p> <p>If QC:</p>

	Passes > go to Step 4 Fails > request clinical documentation from provider/TPA, per Section 3.28
3	Scan Clinical Documentation Scan documentation to shared folder as designated by the facility.
4	Save Document Use the local site file-naming convention, as noted in Section 3.40 Go to Section 3.41 for guidance on recording the documentation exchange method.

3.35 Receiving Documents via US Mail

(Pre/Post CCN)

Some providers will mail records to the VA; however, the use of electronic documentation exchange methods is highly encouraged.



PROCEDURES

STEP	ACTIVITY
1	Open and Sort Mail Open mail and sort to identify medical records for scanning
2	Prepare Clinical Documentation Prepare document for scanning (e.g., remove staples, paper clips, etc.)

	Click on the attachment that you want to save and perform QC review in line with Section 3.39 If QC: Passes > go to Step 4 Fails > request clinical documentation from provider/TPA, per Section 3.28
3	Scan Clinical Documentation Scan documentation to shared folder
4	Save Document Use the local site file-naming convention

Summary of the Paper to Electronic Data Interchange (P2E) Initiative:

In order to improve its claims submission and processing capabilities, the VHA Office of Community Care is implementing the Paper to Electronic Data Interchange (P2E) initiative, which is currently in its testing phase. P2E will transition most community provider paper claims to an electronic format known as Electronic Data Interchange (EDI) transactions using a centralized paper claims intake process.

Note The national launch of P2E, which is currently scheduled for mid-2019, is also being released in conjunction with the EDI 275 Attachments capability, which will allow providers to send electronic unsolicited attachments (275 Attachments) with electronic claims.

Inter-Operable Capability (IOC) Testing Phase

PROCEDURES	
STEP	ACTIVITY
1	Currently, during P2E's testing/IOC phase, community providers should continue mail the claims to their local medical VA Medical Centers (VAMC). VAMC/Claims Adjudication Reimbursement (CAR) staff separate the received paper claims from attachments and mail claims overnight to a new, consolidated location.
2	At the consolidated location, ImageNet contractors scan the paper claims for compliance to national standards and convert them to an electronic format.
3	Once converted to an EDI transaction, claims will be submitted using the normal EDI process through VA's clearinghouse, Change Healthcare.
4	VA staff in a customer services support role can assist providers with P2E claims, particularly those that have questions related to rejected claims, by looking up the details of the claim.

	To identify a P2E claim, staff should first open the Fee Basis Claims System (FBCS) and open the “Distribution and Processing” module.
5	The Fee Payment Processing System (FPPS) number indicates whether the claim came to VA through EDI. All P2E claims will be sent to VA via EDI.
6	Note: The “Special Provider Category” field, listed as “Special Prov Cat,” should show as “P2E.”
7	If a claim is a P2E claim, VA staff can view the basic claim details in Datanet, including the reason for rejection if the claim has been rejected.

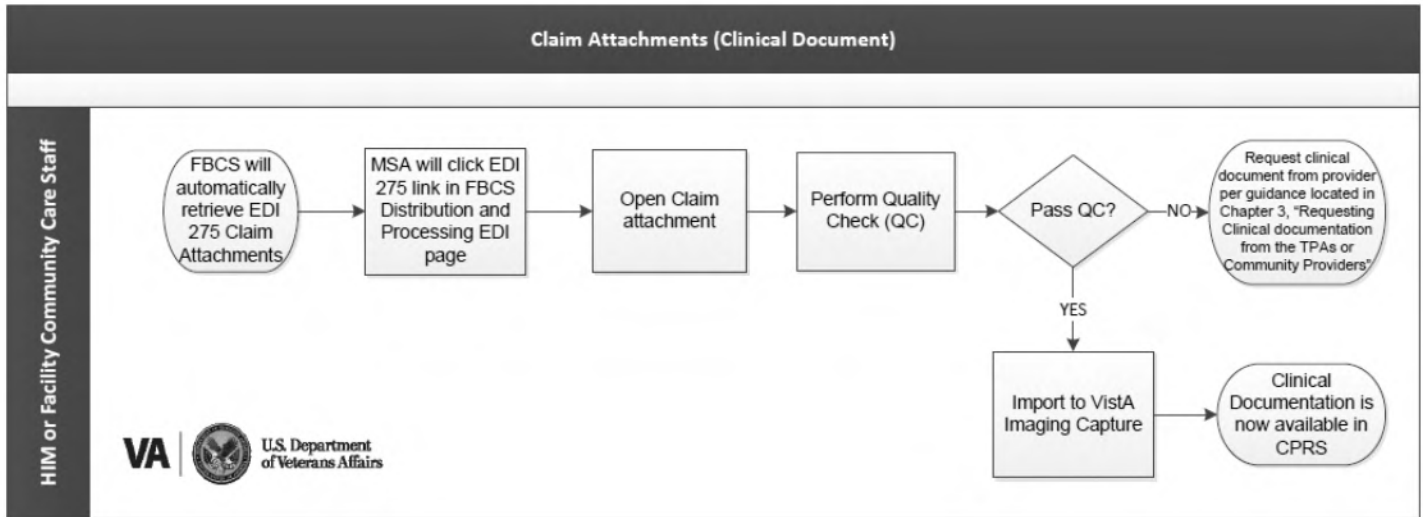
The [P2E SharePoint page](#) contains more information on how to use Datanet to view claim details, as well as reference guides and other resources to help support providers through the new process.

Shipping claims process for staff during IOC:

PROCEDURES	
STEP	ACTIVITY
1	When shipping claims from all site managers, we also recommend that VAMC and CAR staff create a general email to include the shipment and site details from which the shipment will be mailed, and send this email to Availity (b)(6) at (b)(6) and (b)(6) at (b)(6) ImageNet at (va-upsmail@imagenetllc.com), and CAR (b)(6) at (b)(6) @va.gov.
2	<p>Example email</p> <ul style="list-style-type: none"> To: (b)(6) (b)(6)@imagenetllc.com; (b)(6)@va.gov Subject: VA Shipment – [Location name(s)]: VAMC's P2E Claims on [day of week], [MM DD, YYYY] Body of Email: <ul style="list-style-type: none"> [Greeting], [Site location, name, and affiliation] is shipping one package with 69 claims today (UPS Tracking Number: [tracking number]). 837I – UB Claims X 837P – HCFA Claims XX Total claims XX

3.36 How to Use FBCS to Receive and Upload Clinical Documentation

(Pre/Post CCN)



PROCEDURES

STEP	ACTIVITY
1	Login into FBCS and run the FBCS Distribution & Processing (D&P) Queue to identify EDI claims with electronic attachments.
2	Click an Attachment ID within D&P to review attached documentation.
3	<p>Verify that the attachment is legible and a clinical document. If the document is:</p> <ul style="list-style-type: none"> Not legible – staff should contact the provider and request a legible version of the document. Legible – proceed to reconcile attachment with CPRS (Step 5)
4	<p>Determine for the associated Veteran:</p> <ul style="list-style-type: none"> If the attachment is NOT loaded into CPRS, proceed to 3.21 to perform clinical review of the documentation. If the selected attachment is loaded in the CPRS, no further action is required. Go to Section 3.41 for guidance on recording the documentation exchange method.
5	Upload to Vista Imaging Capture – Documents retrieved via FBCS D&P Queue need to be exported and uploaded to VistA Imaging, see 4.1 for instructions

3.37 Receiving Documents via HSRM

HealthShare Referral Manager provides the capability to upload and share documents between the VA and the treating facility. There are two different links to upload documents in HealthShare Referral Manager. Access to each link is based on the user role. VA Community Care staff can access a link to add documents to a referral in the Referral Details section of the Referral Details screen. Community Provider staff can access a link to add documents to a referral in the Treatment Information section of the Referral Details screen. To upload and share documents:

PROCEDURES	
STEP	ACTIVITY
1	Locate the referral
2	Click the Add Documents to Referral link to open the Documents screen. VA Community Care staff can locate the link in the Referral Details section; community provider staff can locate the link in the Treatment Information section on the Referral Details screen.
3	Click the New button at the bottom of the Documents screen. The New Scan screen appears.
4	Enter data in the corresponding fields on the New Scan screen. Note: The Date Created and Time Created fields are filled in automatically and are read-only.
5	Click the Upload button to locate and attach the file. Note: It is possible to upload multiple documents by repeating this process
6	Select the file from the computer's hard drive. Note: HealthShare Referral Manager accepts multiple file types, including JPG, BMP, PNG, Microsoft Office, and PDF. JPG and PDF files display in the preview section.
7	Click the Update button at the bottom right of the screen to save and go back to the Documents screen.
8	Select Referral Details from the <u>Breadcrumb Trail</u> drop-down list in the top left of the screen to go back to the Referral Details screen or continue to add documents in the same manner.

HSRM Tasks Available related to Medical Documents Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
Submit Medical Documents to VA	When seven days have passed since the referral status was changed to Initial Care Given .	Submit medical documents to the VA	Community provider staff using HSRM
Episode of Care (EOC) Complete – Follow Up for Medical Documentation	When a referral status is changed to EOC Complete but does not have medical documentation attached	<ol style="list-style-type: none"> 1. Send a request for medical documents to community provider staff 2. Set a manual task to follow up within 10 days 3. Mark the task as complete (once all completed medical documents have been received) 	Facility community care staff

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
Review GEC Documents	1) When GEC Homemaker/Home Health Aide Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Homemaker/Home Health Aide Treatment Plan/Timesheet .	GEC clinical staff/Facility community care clinical staff	Treatment Plan <ol style="list-style-type: none"> 4. GEC Program Coordinator reviews treatment plan 5. Mark record as received, upload document to EHR and attach to consult for closure** 6. Mark HSRM task as <i>Completed**</i> **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	Treatment Plan <ol style="list-style-type: none"> 5. If treatment plan is received by administrative staff, send for clinical review

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>6. GEC Program Coordinator reviews treatment plan and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>Timesheet***</p> <p>5. Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced</p> <p>6. Discrepancies noted are reported to GEC Program Coordinator</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	2) When GEC In Home Respite Care	GEC clinical staff/Facility	Treatment Plan

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Respite Treatment Plan/Timesheet.	community care clinical staff	4. GEC Program Coordinator reviews treatment plan 5. Mark record as received, upload document to EHR and attach to consult for closure** 6. Mark HSRM task as <i>Completed**</i> **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	Treatment Plan 5. If treatment plan is received by administrative staff, send for clinical review 6. GEC Program Coordinator reviews treatment plan and returns to administrative staff 7. Mark record as received, upload document to EHR and attach to consult for closure** 8. Mark HSRM task as <i>Completed**</i> Timesheet*** 5. Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced 6. Discrepancies noted are reported to GEC Program Coordinator

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	<p>3) When GEC Community Adult Day Health Care Treatment Plan* document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Adult Day Care Treatment Plan.</p>	GEC clinical staff/Facility community care clinical staff	<p>4. GEC Program Coordinator reviews treatment plan</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed**</i></p> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>5. If treatment plan is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews treatment plan and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	4) When GEC Veteran Directed Care Spending Plan document is uploaded.	GEC clinical staff/Facility community care clinical staff	<p>4. GEC Program Coordinator reviews and approves spending plan</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed**</i></p> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>5. If spending plan is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews spending plan and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	5) When GEC PACE Treatment Plan* document is uploaded. *Document name will be coming in HSRM in the future.	GEC clinical staff/Facility community care clinical staff	4. GEC Program Coordinator reviews treatment plan and confirms level of care 5. Mark record as received, upload document to EHR and attach to consult for closure** 6. Mark HSRM task as <i>Completed**</i> **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	5. If treatment plan is received by administrative staff, send for clinical review 6. GEC Program Coordinator reviews treatment plan and returns to administrative staff 7. Mark record as received, upload document to EHR and attach to consult for closure** 8. Mark HSRM task as <i>Completed**</i> **If not managed by clinical staff, administrative staff completes these steps.
	6) When GEC Bowel/Bladder Care Treatment Plan* document is uploaded. *Change in document name will be updated	GEC clinical staff/Facility community care clinical staff	Treatment Plan 5. GEC Program Coordinator reviews treatment plan (may be Spinal Cord Injury coordinator who reviews)

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	in HSRM in the future to: GEC Bowel/Bladder Care Treatment Plan/Timesheet.		6. Send to ordering provider for signature, if needed 7. Mark record as received, upload document to EHR and attach to consult for closure** 8. Mark HSRM task as <i>Completed**</i> **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	Treatment Plan 5. If treatment plan is received by administrative staff, send for clinical review 6. GEC Program Coordinator reviews treatment plan and returns to administrative staff 7. Mark record as received, upload document to EHR and attach to consult for closure** 8. Mark HSRM task as <i>Completed**</i> **If not managed by clinical staff or PACT team, administrative staff completes these steps. Timesheet*** 5. Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>6. Discrepancies noted are reported to GEC Program Coordinator</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record</p>
	7) When GEC Skilled Home Health OASIS/485 document is uploaded.	GEC clinical staff/Facility community care clinical staff	<p>OASIS</p> <p>4. GEC Program Coordinator reviews OASIS document</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed**</i></p> <p>485</p> <p>6. GEC Program Coordinator reviews 485 document</p> <p>7. Send to ordering provider for signature, if separate process for signing orders is not established**</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>8. When signed order is returned, send to vendor, if separate process for returning orders is not established**</p> <p>9. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>10. Mark HSRM task as <i>Completed**</i></p> <p>**These steps may be completed by administrative staff.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
		GEC administrative staff/Facility community care administrative staff	<p>OASIS</p> <p>5. If OASIS document is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews OASIS document and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>485</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>5. If 485 document is received by administrative staff, simultaneously send for clinical review and ordering provider, if separate process for signing orders is not established**</p> <p>6. When signed order is returned, send to vendor, if separate process for returning orders is not established**</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
	<p>8) When GEC Inpatient Hospice Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Hospice Outpatient/Inpatient</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <p>5. GEC Program Coordinator reviews treatment plan</p> <p>6. Send to ordering provider for signature/orders, as needed**</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	Treatment Plan or Discharge Summary.		<p>8. Mark HSRM task as <i>Completed**</i></p> <p>Discharge Summary</p> <p>4. Send to ordering provider to review discharge summary and write orders, as needed</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed**</i></p> <p>**These steps may be done by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <p>6. If treatment plan is received by administrative staff, send for clinical review</p> <p>7. GEC Program Coordinator reviews treatment plan and returns to administrative staff</p> <p>8. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>9. Send signed treatment plan to agency**</p> <p>10. Mark HSRM task as <i>Completed**</i></p> <p>Discharge Summary</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>5. If discharge summary is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews discharge summary and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>9) When GEC Home Infusion Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Home Infusion Treatment Plan/Pharmacy Delivery Notice.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<p>Treatment Plan</p> <p>5. GEC Program Coordinator reviews treatment plan</p> <p>6. Send to ordering provider for signature/orders, as needed**</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>Pharmacy Delivery</p> <p>4. GEC Program Coordinator reviews documentation</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>6. Mark HSRM task as <i>Completed**</i></p> <p>**These steps may be done by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <p>5. If treatment plan is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews treatment plan and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>Pharmacy Delivery</p> <p>4. Administrative staff receives pharmacy delivery slip</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	10) When GEC Community Nursing Home document is uploaded.	GEC clinical staff/Facility community care clinical staff	<p>MDS</p> <p>5. GEC Program Coordinator reviews initial MDS</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	*Change in document name will be updated in HSRM in the future to: GEC Community Nursing Home MDS/Care Plan/Notes.		6. Mark record as received, upload document to EHR and attach to consult for closure** 7. Upload subsequent MDS, as needed** 8. Mark HSRM task as <i>Completed</i> ** Care Plan/Notes 4. GEC Program Coordinator reviews documentation 5. Mark record as received, upload document to EHR and attach to consult for closure** 6. Mark HSRM task as <i>Completed</i> ** **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	MDS 5. If MDS is received by administrative staff, send for clinical review to evaluate MDS 6. GEC Program Coordinator reviews MDS (if document is initial MDS, or MDS is a change in level of care, update authorization) and returns to administrative staff 7. Mark record as received, upload document to EHR and attach to consult for closure**

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>8. Mark HSRM task as <i>Completed</i>**</p> <p>Care Plan/Notes</p> <p>5. If documentation is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews documentation and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed</i>**</p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>11) When GEC TBI Residential Rehabilitation Treatment Plan document is uploaded.</p> <p>*Document name will be coming in HSRM in the future.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<p>4. GEC Program Coordinator reviews treatment plan and confirms level of care</p> <p>5. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>6. Mark HSRM task as <i>Completed</i>**</p> <p>**These steps may be completed by administrative staff.</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
		GEC administrative staff/Facility community care administrative staff	<p>5. If treatment plan is received by administrative staff, send for clinical review</p> <p>6. GEC Program Coordinator reviews treatment plan and returns to administrative staff</p> <p>7. Mark record as received, upload document to EHR and attach to consult for closure**</p> <p>8. Mark HSRM task as <i>Completed**</i></p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>

Reviewing Medical Documentation for Community Providers in HSRM

The screenshot displays the 'Task List' interface in the HSRM system. At the top, there's a search bar with 'Task Item' and 'Review Medical Documents from Commun'. Below this are filters for 'Referral Number', 'Last Name Start', 'Last Name End', and 'Task Status' (set to 'Pending'). To the right, there are date filters ('Date From: 02/17/2020', 'Date To'), a 'Priority' dropdown, and 'Assigned Group' and 'Assigned User' dropdowns. A 'Preferences' section with a 'Lock' checkbox is also visible. The main table lists tasks with columns: Start Date, Due Date, Referral Number, Task, Task Status, Priority, Assigned User, Assigned Group, Assigned Facility, Category of Care, Last Name, First Name, Gender, Date of Birth, Completed, and Comments. The first row shows a task for '(b)(3):38 U.S.C. 5701' with a redacted first name and gender.

- 1) Click on the row for the task, you will be brought to the screen that you need to be on to complete that task type. In this case, selecting Review Medical Documents from Community will take you to the Documents screen.

Note: If you click on any of the teal hyperlinks, you will be brought to another part of HSRM. If you click on *Review Medical Documents from Community* under *Task* you will be brought to the *Task Edit* screen to modify task details. If you click on *Last Name*, you will be brought to the *Patient Details*.

- 2) Select the *Medical Documents* option to review the document.

- 3) Selecting *Medical Documents* will direct you to the *Document Details* screen. You can select the link to download this document in order to save it to your desktop for review.

* Status	Description	Code
Pending	Document has incomplete information	MD5
Pending	Document loaded to incorrect Veteran	MD4
Pending	Document needs to be uploaded to VistA	MD1
Pending	Document uploaded to VistA	MD2
Pending	FR - Closed Non-billable	FR1
Pending	FR - Closed OHI termed	FR2
Pending	FR - Closed Precent Not Req'd	FR3
Pending	FR - Closed ROI not obtained	FR4
Pending	FR - Closed ROI Obtained	FR17
Pending	FR - Closed ROI refused	FR5
Pending	FR - Pending Additional Information	FR6
Pending	FR - Pending Information - Date Entry Issue	FR7
Pending	FR - Pending Information - Med Rec / Documentation Needed	FR8
Pending	FR - Pending Information - Provider	FR9
Pending	FR - Pending IV Review Needed	FR10

- 4) In addition to *Medical Documents*, you may also download images and upload them to VistA Imaging. Integration between HSRM and VistA Imaging may come in a future release.

3.38 How to Perform Quality Assurance and Upload Clinical Documentation

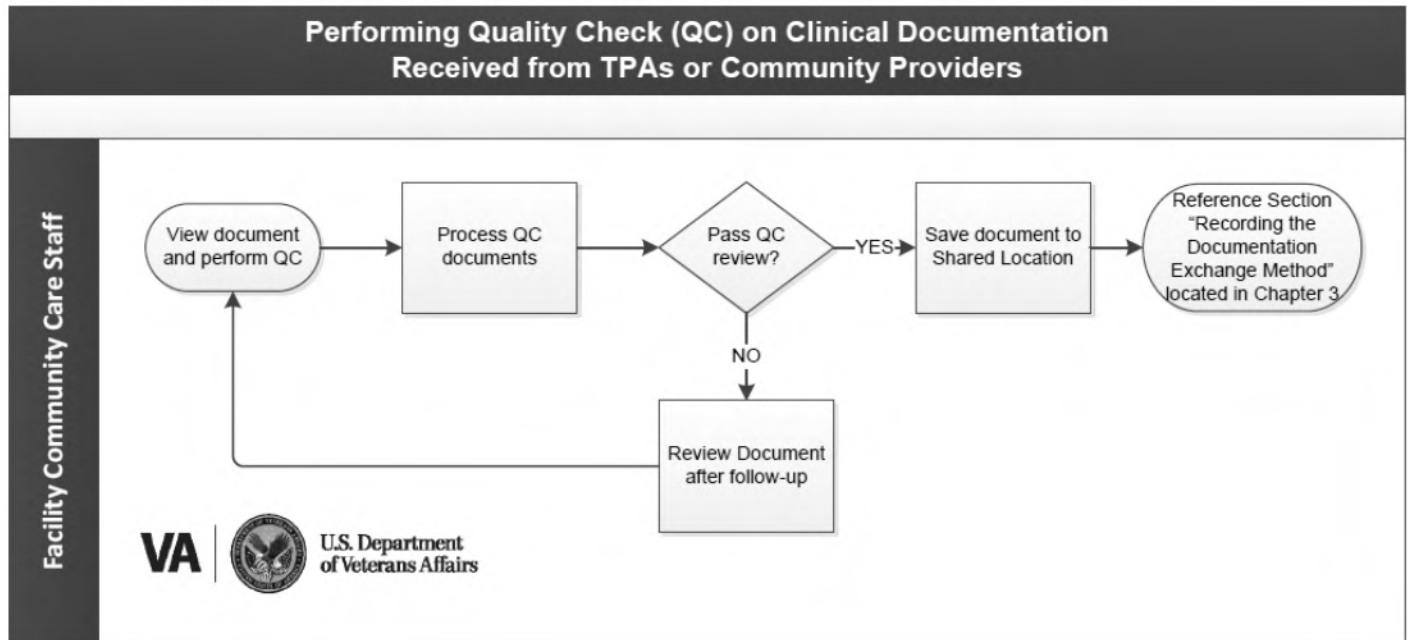


3.39 Performing Quality Assurance on Clinical Documentation Received from Community Providers

(Pre/Post CCN)



Quality checks of the clinical documentation must be performed prior to inserting it to a shared location. Each document must be reviewed to ensure that it can be used for follow-up and care coordination based on the criteria listed in the process below.



PROCEDURES

STEP	ACTIVITY
1	View Document and Perform QC <ul style="list-style-type: none"> • All pages are for the same Veteran • Documents are authenticated (written or electronic signature) by the external provider • Documents are readable & legible • Duplicate document or image. Caution must be taken to ensure that duplicate documentation is not being imported into VistA Imaging and appropriate titles are selected. • Pages are not blank or misaligned
2	Process QC Documents If clinical document:

	<ul style="list-style-type: none"> • Passes QC -the document should be saved to the Shared Location and then loaded to VistA Imaging (Chapter 4, section 4.1) go to Step 4 • Fails QC – the staff member should contact the provider, noting the deficiency and then request a new/edited document go to Step 3
3	Review Document After Follow Up Review message exchange methods, and when the document is returned go to Step 1
4	Save Document to Shared Location <ul style="list-style-type: none"> • Use the local site file-naming convention, as noted in Section 3.40. • Go to Section 3.41 for guidance on recording the documentation exchange method.

3.40 Saving Clinical Documentation to a Shared Location



Once clinical documentation has passed QC and have been downloaded or scanned from the applicable documentation exchange tool, the documents should be saved to a shared folder in preparation for importing and indexing into VistA Imaging Capture.

Shared folders are designated by VA facility (e.g. secure local drive, SharePoint, etc.). Documents should be named according to a standard naming convention established by local policy (e.g., Last name, first initial of first name, last 4 of SSN-date of service, Specialty). Documents should not be left in the shared location permanently and should be deleted once HIM has performed the quality assurance review.

PROCEDURES	
STEP	ACTIVITY
1	Naming Convention of QC Passed Documentation The naming convention for the document should follow the order of Last name, first initial of first name, last 4 of SSN-date of service, specialty (e.g., Doe, J0000-05192014.) <ul style="list-style-type: none"> • If more than one message for the same Veteran, same date, append alpha to the end of the document name (e.g., Doe, J0000-05192014OrthoA, Doe, J0000-05192014OrthoB.)

PROCEDURES	
STEP	ACTIVITY
2	Download the file/s into the appropriate designated folder, per the file name and the naming convention.

3.41 Recording the Documentation Exchange Method

(Pre/Post CCN) 

Staff should record the method by which records were received in the Consult Completion tab of the Consult Toolbox

3.42 Request for Service (RFS)

Background

Currently, when a community provider requests care for Veterans, they complete a Secondary Authorization Request (SAR). The SAR form will be replaced by the Request for Service (RFS) Form 10-10172. RFS Form 10-10172 should be used to request additional or continued care requests from community providers to include all Prosthetic and DME requests. This new form includes a dedicated section for Durable Medical Equipment (DME), Prosthetics, and Sensory Aids Services (PSAS).

RFS Form 10-10172 should be used to accept additional or continued care requests. For additional information and procedure guides for Durable Medical Equipment (DME), Prosthetics, and Sensory Aids Services (PSAS), please visit the Community Provider Order SharePoint site.

Procedure

Use of the RFS Form 10-10172 is mandatory for all community provider-requested services to include DME, Prosthetics and Sensory Aid Services. Additionally, utilization of this standardized form will ensure that community providers submit appropriate information and documents which prevents delays in care. Community Providers may use the 'other' section of the RFS Form 10-10172 to request services not specifically indicated in other sections of the form, including radiology requests. The facility must process all RFS(s) within three business days of receipt; the end result being RFS reviewed, approved, or denied, consult or order created (if approved) and notification sent to the community provider. This procedure guide will describe these processes.

Please see the **RFS and CPO Frequently Asked Questions (FAQ)** for additional information.

PROCEDURES
General Considerations:

The steps outlined below will provide guidance on accessing and utilizing Request for Service Form 10-10172 to receive requests from community providers for clinical services for Veterans.

STEP	ACTIVITY
1	<p>Send Blank RFS Form 10-10172 to Community Providers</p> <p>1.1 Attach a blank form 10-10172 as a PDF to all outgoing REFDOC packets.</p>
2	<p>Receive RFS Form 10-10172 from a Community Provider</p> <p>2.1. Receive Request for Service (RFS) Form 10-10172 from Community Provider via approved method (HSRM, Electronic fax, VirtuPro, or mail)</p> <p>2.2. Validate that the request was not included in previous authorization/SEOC; if authorized on a prior referral, notification to the provider completes the process.</p> <p>2.3. If requested service was not previously authorized, ensure completed RFS Form 10-10172 contains:</p> <ul style="list-style-type: none"> •Provider signature AND •Supporting medical documentation <p>2.3.1. If the RFS does not contain the provider signature or supporting medical documentation, contact the community provider to obtain missing information.</p> <p>2.3.2. If the updated RFS is not received within three business days, deny the RFS -see step 5.</p> <p>2.4. Scan/import the RFS Form 10-10172 into VistA Imaging Capture by creating a new note titled "Community Care-Request for Service Note" and view alert the appropriate DOA for clinical review.</p> <p>2.5. Follow local Delegation of Authority (DOA) review process. Refer to Chapter 3.6 of the FGB for additional information</p>
3	<p>Approval Processes based on the review of the RFS Form 10-10172</p> <p>3.1. Document approval on the SAR/RFS tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable).</p> <p>3.2. Create the Community Care-RFS Response Letter in CPRS to notify the community provider.</p> <p>3.3. Send the Community Care-RFS Response Letter to the requesting community provider notifying them the RFS is approved.</p>
4	<p>Coordinating and Authorizing the Care</p> <p>4.1. Care may be provided within VA or in the community as appropriate based on service or appointment availability, as well as Veteran community care eligibility. Refer to Chapter 3.2.3 of The Field Guidebook for additional information</p> <p>4.2. Follow Chief of Staff (or designee) guidance for creation of the order or consult with applicable SEOC in CPRS.</p> <p>4.3. If the care is to be provided in the community, creation of the REFDOC package and scheduling will follow standard processes. Refer to Chapter 3 of The Field Guidebook for additional information.</p>
5	Denial of the request

- 5.1. If the RFS is a new request, document denial on the Community Care-RFS Response Letter in CPRS OR if the RFS was related to a previously authorized referral, document the denial on the ORIGINAL consult using SAR/RFS in Consult Toolbox.
- 5.2. Create the Community Care-RFS Response Letter in CPRS to notify the community provider. Send the Community Care-RFS Response Letter to the requesting community provider notifying them the RFS is denied. Include the reason the request was denied. It is the responsibility of the community provider to notify the Veteran and discuss alternate plans for care.

HSRM Tasks Available related to Request for Services Include:

Automated Task	Trigger	Actions to Complete Task	Receiver of Task
Review RFS Document	When a Request for Service (RFS) document has been uploaded to a referral. Note: RFS was formerly known as Secondary Authorization Request (SAR)	<ol style="list-style-type: none"> 1. Review the RFS form 2. Send the RFS form for clinical review, if required 3. Enter a new consult if services are approved 4. Mark the task as complete 	Facility community care staff based on level of care coordination assigned

3.43 Management of Community Provider Request for Services

(Pre/Post CCN) 

Background

Currently, when a community provider requests care for Veterans, they complete a Secondary Authorization Request (SAR). The SAR form will be replaced by the Request for Service (RFS) Form 10-10172. RFS Form 10-10172 should be used to accept additional or continued care requests from community providers to include all Prosthetic and DME requests.

This new form includes a dedicated section for Durable Medical Equipment (DME), Prosthetics, and Sensory Aids Services (PSAS). For additional information and procedure guides for Durable Medical Equipment (DME), Prosthetics, and Sensory Aids Services (PSAS), please visit the [Community Provider Order SharePoint](#) site.

Procedure

Use of the RFS Form 10-10172 is mandated for all community provider-requested services to include DME, Prosthetics and Sensory Aid Services. Additionally, utilization of this standardized form will ensure that community providers submit appropriate information and documents which prevents delays in care.

Community Providers may use the 'other' section of the RFS Form 10-10172 to request services not specifically indicated in other sections of the form, including radiology requests.

The facility must process all RFS(s) within three business days of receipt; the result being RFS reviewed, approved or denied, consult or order created (if approved) and notification sent to the community provider. This procedure guide will describe these processes.

Please see the [RFS and CPO Frequently Asked Questions \(FAQ\)](#) for additional information.

Note: Community Care-Request for Service Note not yet available. (Coming Soon)

PROCEDURES



General Considerations:

If an RFS is received for services included in the original consult and is a continuation of that care (i.e., request for additional visits or duration), a new opt-in to community care is not required from the Veteran.

If the RFS is for care not included in the original consult (i.e., Veteran has approval for primary care in the community and the community provider submits an RFS for physical therapy) then the facility community care office must alert the designated Delegation of Authority appointed by the facility Chief of Staff (COS) to review the care for approval/disapproval. If approved, the facility community care staff will work with the internal service to determine if the care can be provided within the VA within the access standards and determine if the Veteran chooses to return to the VA. If not, confirm community care eligibility using appropriate tools (Decision Support (DST)/CTB 2.0 CC Eligibility tab, CPRS, Enrollment System (ES)). Once these steps have been completed, a new consult with its accompanying SEOC must be created and the referral sent to HSRM. All referrals must include 1 consult and 1 SEOC that outlines an approved set of services related to the plan of care.

The steps outlined below will provide guidance on accessing and utilizing Request for Service Form 10-10172 to receive requests from community providers for clinical services for Veterans.

STEP	ACTIVITY
1	Send Blank RFS Form 10-10172 to Community Providers 1.1 Attach a blank form 10-10172 as a PDF to all outgoing REFDOC packets.

2	<p>Receive RFS Form 10-10172 from a Community Provider</p> <p>2.1. Receive Request for Service (RFS) Form 10-10172 from Community Provider via approved method (HSRM, Electronic fax, Azure (RMS), or mail)</p> <p>2.2. Validate that the request was not included in previous authorization/SEOC; if authorized on a prior referral, notification to the provider completes the process. The facility community care office should notify the provider that the request is approved as part of the initial SEOC.</p> <p>2.3. If requested service was not previously authorized, ensure completed RFS Form 10-10172 contains provider signature and supporting medical documentation</p> <p>2.3.1. If the RFS does not contain the provider signature or supporting medical documentation, contact the community provider to obtain missing information.</p> <p>2.3.2. If the updated RFS is not received within three business days, deny the RFS -see Step 5.</p> <p>2.4. Scan/import the RFS Form 10-10172 into VistA Imaging Capture by creating a new note titled "Community Care-Request for Service Note" and view alert the appropriate DOA for clinical review.</p> <p>Follow local Delegation of Authority (DOA) review process</p>
3	<p>Approval Processes based on the review of the RFS Form 10-10172</p> <div data-bbox="280 831 378 926">  </div> <p><u>CTB Version 1.9.0078</u></p> <p>3.1. Document approval on the SAR/RFS tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable)</p> <div data-bbox="297 1045 394 1140">  </div> <p>3.1. <u>CTB Version 2.0</u></p> <p>Document approval on the "Request for Service (RFS)" tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable)</p> <p>3.2. Create the Community Care-RFS Response Letter in CPRS to notify the community provider.</p> <p>3.3. Send the Community Care-RFS Response Letter to the requesting community provider notifying them the RFS is approved.</p>
4	<p>Coordinating and Authorizing the Care</p> <p>4.1. Care may be provided within VA or in the community as appropriate based on service or appointment availability, as well as Veteran community care eligibility.</p> <p>4.2. Follow Chief of Staff (or designee) guidance for creation of the order or consult with applicable SEOC in CPRS</p> <p>4.3. If the care is to be provided in the community, creation of the REFDOC package and scheduling will follow standard processes.</p>
5	<p>Denial of the request</p> <p>5.1 If the RFS is a new request, document denial on the Community Care-RFS Response Letter in CPRS OR if the RFS was related to a previously authorized referral, document the denial on the ORIGINAL consult using SAR/RFS in Consult Toolbox.</p> <p>5.2. Create the Community Care-RFS Response Letter in CPRS to notify the community provider. Send the Community Care-RFS Response Letter to the requesting community provider notifying them the RFS is denied. Include the reason the request was denied. It is the responsibility of the community provider to notify the Veteran and discuss alternate plans for care.</p>

3.44 Community Provider Orders (for facilities that have Opted-In Only)

Currently, when a community provider requests care for Veterans that receive most of their care in the community, the challenge is creating a consult or order for the requested service. VA providers are concerned with being associated with an order for a service or procedure that a community provider has requested when VA is not familiar with the patient or their medical history. This has led to delays in care and increased responsibility on the local VAMC Chief of Staff to manage requests of this nature.

Community Provider Orders allows for consults or orders to be created in the name of the requesting provider specifically if the requesting provider is a community provider. The process decreases the time for a Veteran to receive care, improves care coordination between VA and its affiliated network providers, drives care into the VA, and ultimately improves access to care for Veterans.

Please see the [RFS and CPO Frequently Asked Questions \(FAQ\)](#) for additional information.

PROCEDURES





General Considerations:



This procedure guide will describe steps required to process requests using the CPO process. Community Providers may use the 'other' section of the RFS Form 10-10172 to request services not specifically indicated in other sections of the form, including radiology requests

Any request from a community provider that is not received on a signed RFS Form 10-10172 may not be processed using CPO.


Note: The local Delegate of Authority (DOA) may determine that specific services are not applicable for the CPO process and must be ordered by a VA provider. Please follow local guidance.

STEP	ACTIVITY
1	New Request for Service (RFS) from a community provider <ul style="list-style-type: none"> • Receive Request for Service (RFS) from Community Provider that contains provider signature supporting medical documentation • If the RFS does not contain the provider signature or supporting medical documentation, contact the community provider to obtain missing information. • If the updated RFS is not received within three business days, deny the RFS, following steps for denial below. • Confirm Veteran eligibility in CPRS.

	<ul style="list-style-type: none"> • Scan/import the RFS form into VistA Imaging Capture by creating a new note titled "Community Care-Request for Service Note" and view alert the appropriate DOA for review. • DOA performs clinical review and approves or denies the community provider to proceed with the requested clinical services.
2	<p>Denied after clinical review (if appropriate)</p> <ul style="list-style-type: none"> • DO NOT create a new consult or order  <p><u>CTB Version 1.9.0078</u></p> <ul style="list-style-type: none"> • Document denial on the SAR/RFS tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable).  <p><u>CTB Version 2.0</u></p> <ul style="list-style-type: none"> • Document denial on the "Request for Service (RFS)" tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable). • Populate and send the "Community Care-RFS Response Letter" to the requesting provider. Include the reason the request was denied. It is the responsibility of the community provider to notify the Veteran and discuss alternate plans for care.
C	<p>Approved after clinical review (if appropriate) and care being provided in the community</p> <ul style="list-style-type: none"> • Appropriate facility community care staff create a new consult or order under the requesting community provider name. (A new consult or order must be created before the request is formally accepted to allow for consult or order tracking.) • Select "Alert when Results" to ensure that the person entering the consult or order receives the alert -the community provider will NOT receive alerts from CPRS.  <p><u>CTB Version 1.9.0078</u></p> <ul style="list-style-type: none"> • Document approval on the SAR/RFS tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable).  <p><u>CTB Version 2.0</u></p> <ul style="list-style-type: none"> • Document approval on the "Request for Services (RFS)" tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable). • Notify Veteran's VA primary care provider (if assigned) by adding the primary care provider as an additional signer on the consult or order.

	<ul style="list-style-type: none"> • Populate and send the "Community Care-RFS Response Letter" to the requesting provider and Third-Party Administrator (TPA) (if appropriate). • Since care will be provided in the community, update the ORIGINAL consult with the approval language and release as signed on chart. • Create REFDOC packet and attach a blank copy of the Request for Service RFS 10-10172 to send to the community provider. • Upload the REFDOC packet into HSRM or community provider's preferred method.
4	<p>Approved after clinical review (if appropriate) and care being provided in the VA</p> <ul style="list-style-type: none"> • Appropriate facility community care staff create a new consult or order under the requesting community provider's name. (A new consult must be created before the request is formally accepted to allow for consult or order tracking.) • Select "Alert when Results" to ensure that the person entering the consult or order receives the alert -the community provider will NOT receive alerts from CPRS. <p> <u>CTB Version 1.9.0078</u></p> <ul style="list-style-type: none"> • Document approval on the SAR/RFS tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable). <p> <u>CTB Version 2.0</u></p> <ul style="list-style-type: none"> • Document approval on the "Request for Services (RFS)" tab in the Consult Toolbox (CTB) on ORIGINAL consult (if applicable). • Notify Veteran's VA primary care provider (if assigned) by adding the primary care provider as an additional signer on the consult or order. • Populate and send the "Community Care-Request for Service (RFS) Response Letter" to the requesting community provider and Third-Party Administrator (TPA) (if appropriate). • Since care should be provided in a VA facility, follow the local VA process for scheduling within the VA. • Update the ORIGINAL consult with the approval language and release as "Signed on Chart."

Section 2: The following information is only applicable if FBCS remains in use at the local facility. (When both HSRM and ECAMS are not deployed at a facility)

PROCEDURES	
STEP	ACTIVITY
1	<p>Extension of a SEOC (Note: only applicable if using FBCS; HSRM does not have a process for extending existing SEOCs)</p> <p>Receive RFS Form 10-10172 form from Community Provider that contains provider signature and supporting medical documentation</p> <p>If the RFS does not contain the provider signature or supporting medical documentation, contact the community provider to obtain missing information. If the updated RFS is not received within three business days, deny the RFS, following steps for denial below.</p> <p>Scan/import the RFS form into VistA Imaging Capture by creating a new note titled "Community Care-Request for Service Note" and view alert the appropriate DOA for review.</p> <p>DOA performs clinical review and disapproves the request</p> <p>DO NOT create a new consult/authorization</p>
2	<p>Denied after clinical review (if appropriate): (Note: only applicable if using FBCS; HSRM does not have a process for extending existing SEOCs)</p> <p>Document denial on the SAR/RFS tab in the Consult Toolbox (CTB).</p> <p>Populate and send the "Community Care-Request for Service (RFS) Response Letter" to the community provider. Include the reason the request was denied. It is the responsibility of the community provider to notify the Veteran and discuss alternate plans for care.</p>
3	<p>Approved after clinical review (if appropriate) and care being provided in the community: (Note: only applicable if using FBCS; HSRM does not have a process for extending existing SEOCs)</p> <p>Document approval on the SAR/RFS tab in the Consult Toolbox (CTB) including the number of additional visits or duration.</p> <p>Populate and send the "Community Care-Request for Service (RFS) Response Letter" to the community provider, primary care or original ordering VA physician, and Third-Party Administrator (TPA) (if appropriate).</p> <p>Tri-West Site, VA schedules: update the authorization in FBCS for additional visits or duration and populate and upload 10-0836SCH form to Tri-West Portal.</p> <p>Tri-West site, Tri-West schedules: populate and upload 10-0386 form to Tri-West Portal.</p>
4	<p>Approved after clinical review (if appropriate) and care being provided in the VA: (Note: only applicable if using FBCS; HSRM does not have a process for extending existing SEOCs)</p> <p> <u>CTB Version 1.9.0078</u></p> <p>Document approval on the SAR/RFS tab in the Consult Toolbox (CTB).</p>

Populate and send the "Community Care-Request for Service (RFS) Response Letter" to the requesting provider and Third-Party Administrator (TPA) (if appropriate).



CTB Version 2.0

Document approval on the "Request for Service (RFS)" tab in the Consult Toolbox (CTB).

Populate and send the "Community Care-Request for Service (RFS) Response Letter" to the requesting provider and Third-Party Administrator (TPA) (if appropriate).

Since care should be provided in a VA facility, follow the local VA process for scheduling within the VA.

Community Provider Orders Non-VA Provider Technical Reference

The Community Provider Order (CPO) process enables facility community care offices to accept a Request for Services (RFS) from community providers as orders and input them in the Computerized Patient Record System (CPRS) as consults, or orders, under the name of the community provider. Per the 10N Memorandum released on September 16, 2019, the Chief of Staff (COS) and Associate Director for Patient Care Services (ADPCS) must opt-in for a VA medical facility to use the CPO process. Please note, for those VA medical facilities who have opted-out of CPO, RFSs will be processed utilizing the designated Delegation of Authority (DOA) at the local facility.

This guide is a supplement to the Office of Community Care Communications: Community Provider Orders—Field Update. It provides instructions to perform suggested actions as well as descriptions and timelines for planned VistA/CPRS Enhancements. The resource documents associated with this information is listed below:

- [Office of Community Care Community Provider Orders Non-VA Provider Technical Reference](#)
- [10N Memo-091619 Community Provider Orders and Requests for Services Processes](#)

Additional Training



TMS

TMS- VA 38938

VA Mission Act- Veteran Community Care Program Eligibility (Recording)

TMS VA 4527029

Request for Services from Community Providers (RFS Form 10-10172)

TMS VA 4527921

Request for DME and Prosthetics from Community Providers

TMS VA 4532036

Community Provider Orders

TMS VA 4540183

Scheduling Using HealthShare Referral Manager (HSRM)

TMS VA 39280

Care Coordination Model (CCM) Overview

TMS VA 4558351

Authorized Emergency Treatment Under 38 CFR 17.4020(c)

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 4561464

Webinar: RBW VA DoD Sharing Agreements and Care Coordination

TMS VA 4563031

Webinar: Community Care VA Online Scheduling (VAOS) and Scheduling Manager (SM)

TMS VA 4541952

Optimizing Veteran Care-The VA Online Scheduling (VAOS) and Scheduling Manager Systems

TMS VA 4567147

HealthShare Referral Manager (HSRM): Additional Tools Microlearning

Community Care Hub

Hub Only

- Organizational Change Management Role-Based Webinar on Care Coordination
- Community Care Emergency Care Treatment Process
- Managing Consults and Referrals
- Webinar: Emergency Care Reporting Portal Demo

TMS & Hub

- HealthShare Referral Manager (HSRM): Additional Tools Microlearning
- HealthShare Referral Manager (HSRM): Appointments Microlearning

TMS VA 4567145

HealthShare Referral Manager (HSRM):
Appointments Microlearning

TMS VA 4552035 Admin Screening and Clinical
Triage in CTB 2.0

Additional HSRM Training Information

- [HSRM Education Resources Information Sheet](#)

CCN Scheduling End-To-End Simulation (5 Module) Series is live in TMS. The TMS link has been updated on both the [CCN Core Courses](#) and [Referrals and Authorizations](#) pages.

TMS ID	Course Name	Course Description
VA 4557037	<p><u>CCN End-to-End Scheduling Simulation:</u></p> <p>The following modules must be completed for credit:</p> <ul style="list-style-type: none"> • 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. <p>Live Session Recording: <u>E2E Live Session</u> (recorded 5/5/2020)</p>	<p>An interactive, simulation-based course, taking users through the process of initiating a consult to schedule an appointment for a Veteran. This course will simulate how we use our software, which includes, CPRS, HSRM, PPMS and Consult Toolbox, to provide a step-by-step process from the beginning of when a Veteran is seeking to schedule an appointment until the end where the consult is closed in HSRM.</p> <p><i>You may take this course by selecting each module sequentially or skip around and visit the modules in the order preferred.</i></p>



- [Article: Finding a community provider, making appointments, and getting care](#)
- [Fact Sheet: Appointments and Getting Care](#)
- [Video: Veteran Community Care: Making Appointments](#)
- [Webpage \(Public – Providers\)](#)
- [Article: VA's new urgent care benefit for Veterans](#)
- [Top Questions Answered Article/Blog](#)
- [Fact Sheet: Urgent Care](#)
- [Video: Veteran Community Care: Urgent Care](#)
- [Article: Answers to the top five questions](#)

Last Updated on: Tuesday, August 3, 2021

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 4: Consult Completion and Medical Records Management

How to Close Community Care Consults	4.0	<u>How to Close Community Care Consults</u>
	4.1	<u>Uploading and Indexing Clinical Documentation into VistA Imaging Capture</u>
	4.2	<u>Update to Current Procedure: Administratively Closing the Community Care Consult</u>
	4.3	<u>How to run the Administrative Closure Report</u>
	4.4	<u>Network Adequacy Discussions with the TPA</u>
	4.5	<u>Veterans Health Information</u>
Metrics	4.6	<u>Metrics</u>
	4.7	<u>Impact and Performance Benchmarks</u>
	4.8	<u>How to Evaluate Referral Management Timeliness</u>
	4.9	<u>Review of Community Provider Opioids Prescribing Practices</u>
	4.10	<u>Community Administration of Vaccine Encounters (CAVE)</u>

4.0 How to Close Community Care Consults

Although clinical documentation is not required for claims adjudication of authorized care; retrieval of medical records is necessary for continuity of Veteran care. Every effort must be made to work with the community provider to ensure that the facility receives authenticated information and it is scanned and/or uploaded into the Veteran's health record.

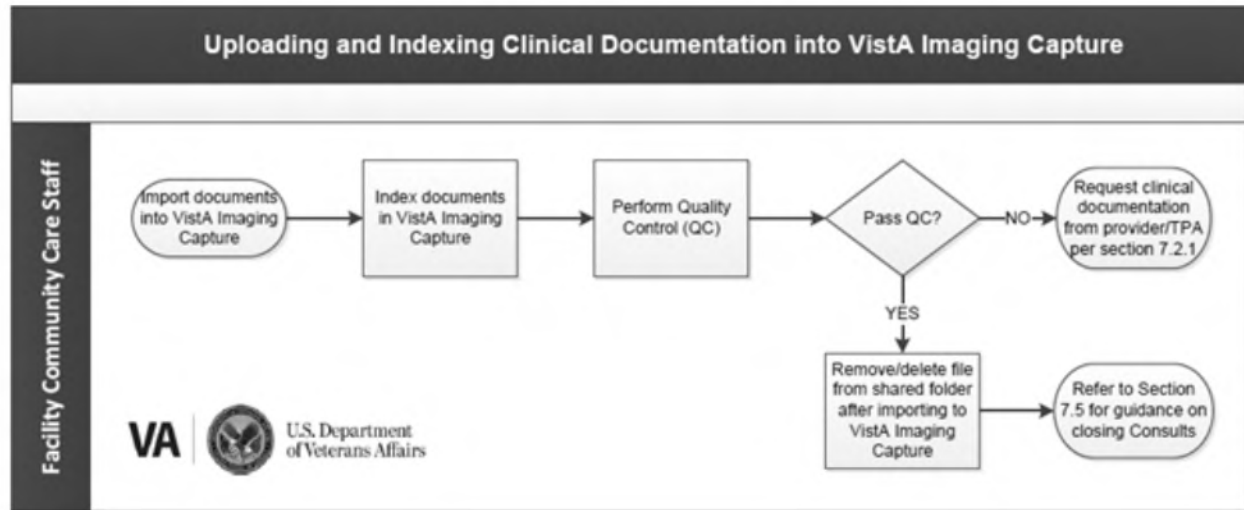
4.1 Uploading and Indexing Clinical Documentation into VistA Imaging Capture

While the overarching business process for clinical documentation remains the same, in certain locations there is a defined division of labor between Facility Community Care Office and HIM Staff.

It is the responsibility of HIM to ensure that those responsible for scanning, importing, and indexing into VistA Imaging are trained appropriately. HIM is the custodian of the

Last Updated on: Tuesday, August 3, 2021

health record and it is essential that the integrity of the health record is maintained. Please contact your local HIM chief for additional training on VistA Imaging.



PROCEDURE

STEP	ACTIVITY
1	<p>Import documents into VistA Imaging Capture from the Shared Location</p> <ul style="list-style-type: none"> • Open VistA CPRS and select File and “Select New Patient” • Locate the Veteran from the patient list and click OK • Access VistA Imaging Capture by clicking on Tools and selecting “Imaging Capture” • In Vista Imaging Capture, select the Import option • Right click the gray box and select “Import Directory Options”. This allows the user to set the new path as the default directory • Select and import the desired Veteran files <p>For additional information, see: HIM References Health Record Resources VistA Imaging SharePoint</p>
2	<p>Index documents in VistA Imaging Capture.</p> <ul style="list-style-type: none"> • Once the document/s are imported, a list of index fields will appear • Fill out all index fields and click the Capture button • Click OK to save the document <p>VistA Imaging Capture Indexing Reference Guide for Internal & External Documents Fact Sheet (Link to be added when available)</p>

Last Updated on: Tuesday, August 3, 2021

PROCEDURE	
STEP	ACTIVITY
	HIM References Health Record Resources VistA Imaging SharePoint
3	Process QC Documents: If clinical document: <ul style="list-style-type: none"> • Passes QC-the document should be saved to the Shared Location and then loaded to Vista Imaging>go to Step 4. • Fails QC– the staff member should contact the provider, noting the deficiency and then request a new/edited document
4	Remove/delete file from shared folder (if applicable) after importing into VistA Imaging Capture.

For additional information, see [HIM References Health Record Resources VistA Imaging SharePoint](#)

Best Practices

Within two (2) business days of receipt, the Facility Community Care staff will review the clinical documentation and designate the appropriate consult. If HIM is responsible for indexing, after writing the summary note and identifying the correct consult, Community Care will move the documents from the Community Care Inbox to the HIM Inbox within two (2) business days of receiving the documentation. Depending on the best practice selected below by the facility either Community Care or HIM will then import and index the documentation into VistA Imaging.

One of the following two best practices must be implemented. Approval by all parties is recommended (VACC, VISN/Facility Director, Facility OCC, and HIM) with such approval documented in a local policy.

HIM or Facility Community Care Scanning/Importing and Indexing Options

Option 1 - The Facility Community Care (clinical staff) will receive the incoming documentation, review the documentation for clinical appropriateness and care coordination, designate the appropriate consult or Community Care Emergency Treatment note that it should be attached, or create a new Consult request for the referring VA provider's notification and review of the completed consult. Facility Community Care will then move the document/image to the HIM Inbox, whether through FBSCS, HSRM, Third Party Administrator (TPA) portal, StreamFax, other electronic means, or paper. Once received, HIM will scan or import and index the

Last Updated on: Tuesday, August 3, 2021

document/image to the appropriate consult or Community Care Emergency Treatment note. If it's attached to a Consult, using the COMMUNITY CARE CONSULT RESULT note, the consult will close/complete so that the alert goes to the appropriate VA provider. Facility Community Care MSA staff are responsible for performing a review of the incoming documentation designated as Low Risk Clinics.

Option 2 - The Facility Community Care (clinical staff) will receive the incoming documentation, review the documentation for clinical appropriateness and care coordination, designate the appropriate consult or Community Care Emergency Treatment note that it should be attached with, or create a new Consult request and then write a summary note for the referring VA provider's notification and review of the completed consult. Whether through FBCS, HSRM, TPA portal, StreamFax, other electronic means, or paper, the document/image will be scanned or imported and indexed to the appropriate consult or Community Care Emergency Treatment note by Facility Community Care staff. If Facility Community Care attaches the documentation to a Consult, using the COMMUNITY CARE CONSULT RESULT note, the consult will close/complete so that the alert goes to the appropriate VA provider. Facility Community Care MSA staff are responsible for performing a review of the incoming documentation designated as Low Risk Clinics. Option 2 has no HIM involvement.

Note: A summary note may only be written by a clinical staff member. If an MSA receives and imports incoming clinical documentation, they must import and index the documentation to the COMMUNITY CARE CONSULT RESULT note.

4.2 Update to Current Procedure: Administratively Closing the Community Care Consult

As an update to the 10N Memorandum titled Clarification of Administrative Closure of Community Care Consults (dated 03/06/2018), open community care consults shall be administratively closed when the following criteria is met:

- Confirmation is made that the Veteran attended the requested community care appointment
- One documented attempt to retrieve medical documentation is recorded in the Consult Toolbox in the Consult Completion Tab
- Administrative closure MUST occur within ninety (90) days of the initial scheduled appointment.
- Two additional attempts to retrieve medical documentation must be recorded in the consult toolbox within 90 days of the scheduled appointment, except for low risk consults (see low risk listing below, as outlined in VHA Directive 1232).

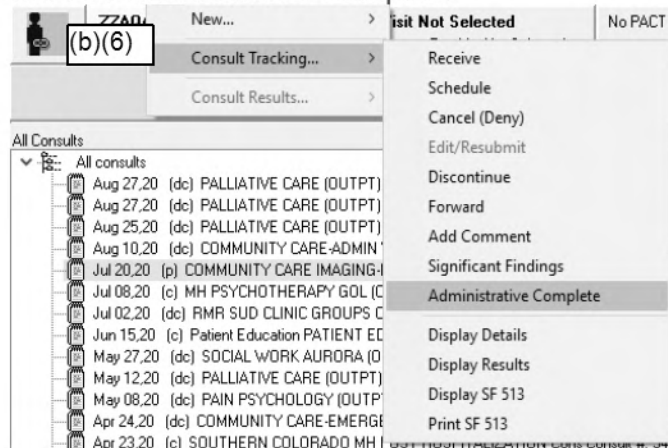
Note: Administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care

Last Updated on: Tuesday, August 3, 2021

Consults that are administratively closed without documentation, and that require two additional attempts to obtain the medical documentation shall be monitored for ninety (90) days from the scheduled appointment utilizing the "Administratively Closed without Documentation Report."

If after the required number of attempts, no records are received from the community care provider, the following process should be followed:

- In CPRS select the appropriate consult and in the menu bar select Consult Tracking
- Select Administrative Complete



(CTB Version 1.9.0078)



- Choose if Significant Findings were identified or if unknown

Administratively Complete

Significant Findings - Current status: Not yet entered

☐ Yes ☐ No ☒ Unknown

Comments

Date/time of this action: Now

Responsible Person: (b)(6) ASSISTANT CHIEF

OK Cancel

Last Updated on: Tuesday, August 3, 2021

- Right click on order to select Administrative Complete within the CTB

Administratively Complete

Significant Findings - Current status: Not yet entered

☐ Yes ☐ No ☒ Unknown

Comments

Copy
Paste
Cut
Undo
Administratively Complete
Settings

- Select the check mark, based on the appropriate process being followed in order to allow for the consult to be administratively completed.

Administratively Close

☒ Administratively Close without records after at least one attempt.

Facility Community Care staff have received confirmation that the Veteran has attended the initial visit. One attempt has been made to obtain medical records, without timely response from the community provider. This consult is being administratively closed. Two additional documented attempts must be made to obtain the medical records, if the consult is not considered low risk, per the guidance in VHA directive 1232.

OK

The following message will populate in the comments section

Administratively Complete

Significant Findings - Current status: Not yet entered

☐ Yes ☐ No ☒ Unknown

Comments

ACN-Administratively closed without records.

Facility Community Care staff have received confirmation that the Veteran has attended the initial visit. One attempt has been made to obtain medical records, without timely response from the community provider. This consult is being administratively closed. Two additional documented attempts must be made to obtain the medical records, if the consult is not considered low risk, per the guidance in VHA directive 1232.

Last Updated on: Tuesday, August 3, 2021

(CTB Version 2.0)



- Choose if Significant Findings were identified or if unknown, then select Open Consult Toolbox

Administratively Complete

Significant Findings - Current status: Not yet entered

☐ Yes
☐ No
☒ Unknown

Comments

Date/time of this action
Responsible Person

Now
...

...

Open Consult Toolbox
OK
Cancel

- Select the option based on the appropriate process being followed in order to allow for the consult to be administratively completed and save changes.

Last Updated on: Tuesday, August 3, 2021

Consult Toolbox v2.0.0 What's New TBD Help Logout

Veteran Name: PATIENT, TEST
 Date of Birth: Jan 1, 1900 [121]
 Residential Address: (b)(3):38 U.S.C. 5701; (b)(6)
 Consult to Service/Specialty: cardiology
 Urgency: Routine
 CID: 04/18/2021
 Seen As: Outpatient
 Community Care Eligibility: ? Not Established

ADMIN COMPLETE

Administratively Complete

View Consult History
 User Settings
 SAVE CHANGES

Administrative Complete

Administratively Complete Consult *(required)*

☒ Administratively complete with records follow-up

Facility community care staff have received confirmation that the Veteran has attended the initial visit. One attempt has been made to obtain medical records without timely response from the community provider. This consult is being administratively completed. Two additional documented attempts must be made to obtain the medical records per the guidance in the Office of Community Care Field Guidebook.

☐ Administratively complete without records follow-up (low-risk consult)

Low Risk Consult - Facility community care staff have received confirmation that the Veteran has attended the initial visit. One attempt has been made to obtain medical records without timely response from the community provider. This consult is being administratively completed per the guidance in the Office of Community Care Field Guidebook.

Additional Comments

Select the **Administratively complete with records follow-up** radio button to administratively complete the consult with records follow-up OR select the **Administratively complete without records follow-up** radio button to administratively complete the low-risk consult without records follow-up.

The corresponding message will populate in the comments section.

Note: The ability to run the Administratively Closed without Documentation Report will require access to the Corporate Data Warehouse (CDW). For further instructions for CDW access, follow the link to the [CDW Support Site](#), then click "[CDW Guide: Introduction and Policies](#)" under Guides in the left-hand navigation pane.

Exception: Low Risk Clinics (Step 2 in Procedure Table below). Following the first initial documented attempt, consults including a primary service identified as a Low Risk do not require documentation of additional attempts to retrieve medical records. Low Risk Clinics/Consults are designated and outlined in [VHA Directive 1232 Consult Processes and Procedures](#). A full list of low risk clinics can be found in the [VHA Consult SOP](#).

Last Updated on: Tuesday, August 3, 2021

PROCEDURE**General Considerations:**

In general, the process for closing a community care consult if documentation is not received includes the following steps. For detailed guidance on the processes for administratively closing a consult, review the following:

[Office of Community Care/HIM Consult Closure Fact Sheet](#)

[Consult Toolbox and One Consult Model User Information Site](#)

[Office of Community Care Consult Result Note Fact Sheet](#)

[Administrative Consult Closure Fact Sheet](#)

[Clarification of Admin Closure of Community Care Consults 10N Memo](#)

STEP	ACTIVITY
1	<p>Request clinical documentation/records from community provider</p> <ul style="list-style-type: none"> Document all attempts to obtain the clinical documentation for authorized care from the community provider on the consult using the Consult Toolbox. Documentation must state the dates of the attempts and the name and phone number of the Community Provider. For further information, see: Office of Community Care/HIM Consult Closure Fact Sheet
2	<p>Refer consult to a clinical staff member for review and administrative completion if no records are provided:</p> <ul style="list-style-type: none"> If documentation is not received within fourteen (14) days of the initial scheduled appointment; upon receipt and confirmation the Veteran attended their first appointment, document one (1) attempt to retrieve medical records in the Consult Toolbox. Once the above criteria are met, consults should be administratively closed. Administratively closed consults without receipt of medical documentation shall be followed for ninety (90) days after the initial scheduled appointment via the "Administratively Closed without Documentation Report." Following administrative closure of a consult, two additional attempts to retrieve medical documentation must be recorded in the consult toolbox within ninety (90) days of the scheduled appointment. With the exception of Low Risk Clinics which only require one (1) documented attempt and no additional follow up post administrative closure.

Last Updated on: Tuesday, August 3, 2021

PROCEDURE	
	<ul style="list-style-type: none"> • See low risk exception rules above this table. <p>For further guidance see: Consult Toolbox and One Consult Model User Information Site</p>
3	<p>Notify Community Care Supervisor of the lack of response from the community provider</p> <ul style="list-style-type: none"> • Notify the community care supervisor of the lack of response from the community provider: <ul style="list-style-type: none"> ○ Supervisor will respond accordingly to work with community care contract staff if they notice a trend with a provider. ○ Supervisor will directly contact the Office Manager or designee of the community provider to obtain medical documentation.
4	<p>Document why the consult is being administratively completed/closed</p> <ul style="list-style-type: none"> • If the consult is administratively completed utilizing the consult toolbox, the comment will automatically populate on the consult <p>See: Office of Community Care/HIM Consult Closure Fact Sheet</p> <ul style="list-style-type: none"> • Administrative closure and two additional attempts to receive medical records (when applicable) must take place, using the above criteria, NLT ninety (90) days after the appointment was scheduled if medical records were not received. • Administratively closed without Documentation Report. This report must be generated at least monthly up to ninety (90) days from the initial scheduled appointment. Efforts to retrieve medical documentation must be made and documented informing medical records have been requested from the community provider. <p>Note 1: Managers should make sure to convey to their staff that administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care</p> <p>Note 2: In the case of family caregivers providing Bowel and Bladder care to the Veteran, Community Care Bowel and Bladder consults are closed administratively utilizing the Community Care Consult Result Note or Community Care Consult Result – Bowel and Bladder Note. A statement</p>

Last Updated on: Tuesday, August 3, 2021

PROCEDURE	
	<p>must be notated that the family caregiver is providing the care and the monthly invoices are scanned as an administrative document.</p> <p>Note 3: If the Veteran was NOT seen by the Provider, a recommendation to follow up with the Veteran should be documented as part of the consult closure.</p> <p>Note 4: If the Veteran was seen by the provider, and the Facility Community Care Office is confident that the provider is aware of the Veteran's status, further recommendations do not need to be added to the consult.</p>

For additional information, see:

[Consult Toolbox and One Consult Model User Information Site](#)

4.3 How to run the Administrative Closure Report

Note: Managers should make sure to convey to their staff that administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care. Below are instructions on how to run the Administrative Closure Report to view consults that were administratively closed without obtaining clinical documents.

This report must be run at least monthly up to the ninety (90) day period from the scheduled appointment and efforts must be made and documented in the consult toolbox that the missing records were once again requested from the community provider.

Managers: After ensuring backlog has been reviewed, the Administrative Closure Report should be utilized in the monthly TPA/VA meetings in order to escalate med doc issues

The ability to run the report will require access to the Corporate Data Warehouse (CDW). For further instructions for CDW access, follow the link to the [CDW Support Site](#), then click "[CDW Guide: Introduction and Policies](#)", under Guides in the left-hand navigation pane.

Link to Report:

Last Updated on: Tuesday, August 3, 2021

https://vaww.cc.cdw.va.gov/sites/CC_ConsumTB/Dashboards/CommCareClosedWoRecords.rdl?Web=1

Guidance on running reports in the Corporate Data Warehouse (CDW) from data in the Consult Toolbox- Consults Closed/Open/Scheduled Administratively Without Medical Records/Automatically Discontinued is Below:

CC Consults Closed without records after 3 attempts to get records

Station/StopCode/Service/Patient	Consult Request Date	Admin Close Date	Closed By	First Attempt Date	Second Attempt Date
(648) Portland, OR (CACHE 5.0)	Count: 276				
(304) DERMATOLOGY	Count: 1				
Dermatology - General Outpt	Count: 1				
(413) THORACIC SURGERY	Count: 1				
Thoracic Surgery - E-Consult IFC	Count: 1				
(669) COMMUNITY CARE CONSULT	Count: 274				
CHOICE-FIRST ALLERGY	Count: 4				
CHOICE-FIRST BEHAVIORAL HEALTH	Count: 3				
CHOICE-FIRST CHIROPRACTIC	Count: 50				
CHOICE-FIRST DENTAL	Count: 1				
CHOICE-FIRST GENERIC	Count: 1				
CHOICE-FIRST PELVIC FLOOR PT	Count: 2				
COMMUNITY CARE-ACUPUNCTURE	Count: 1				
COMMUNITY CARE-ADMIN CARDIOLOGY	Count: 1				
COMMUNITY CARE-ADMIN DENTAL	Count: 87				
COMMUNITY CARE-ADMIN DERMATOLOGY	Count: 5				
COMMUNITY CARE-ADMIN PADY	Count: 1				

Parameters include information in regard to Consults Open, Closed, Scheduled, VISN, Facilities within that VISN, Stop Code, Yes or no (whether records have subsequently been uploaded), and Consult Service Name. Demo mode uses test data.

Parameters

Select VISN: VISN 20

Station(s): (648) Portland, OR (CACHE 5.0)

Include Stop Code: (000) Missing Stop Code, (1) EH

Demo Mode: No

Records Received: No

Service Name: CHOICE-FIRST ALLERGY, CHOICE-FIRST BEHAVIORAL HEALTH, CHOICE-FIRST CHIROPRACTIC, CHOICE-FIRST DENTAL, CHOICE-FIRST GENERIC, CHOICE-FIRST PELVIC FLOOR PT, COMMUNITY CARE-ACUPUNCTURE, COMMUNITY CARE-ADMIN CARDIOLOGY, COMMUNITY CARE-ADMIN DENTAL, COMMUNITY CARE-ADMIN DERMATOLOGY, COMMUNITY CARE-ADMIN PADY

Last Updated on: Tuesday, August 3, 2021

4.4 Network Adequacy Discussions with the TPA

The purpose of the Network Adequacy SharePoint is to document recurring CCN network access issues; SharePoint reporting should be utilized after network accessing concerns have been brought up to the TPAs during monthly Network Adequacy meetings. OCC's Network Support team will review submissions and follow up with the facility and TPAs accordingly. Facility Community Care Departments can utilize the Network Adequacy SharePoint and Network Adequacy Checklist to prepare for monthly Network Adequacy meetings with their TPA.

<p>The <u>Network Adequacy SharePoint</u> is the one-stop-shop for all network adequacy resources to include:</p>	<ul style="list-style-type: none"> ▪ Network Adequacy Overview ▪ Network Adequacy Guidebook ▪ Monthly Meeting Checklist ▪ Monthly Reporting Form ▪ VA Market Assessment Documents ▪ CCN Require for Proposal (RFP/contract) ▪ Network Adequacy Deviation Template ▪ Regional and OCC Points of Contact
<p>The <u>Network Adequacy Checklist</u> should be used to facilitate the monthly meetings between the VAMC and the contractor.</p>	<ul style="list-style-type: none"> ▪ Suggested Attendees ▪ Quantitative Data to be reviewed during the monthly meeting ▪ Topics for consideration during the monthly meeting ▪ Reporting ▪ Appendices

To assist with tracking network issues, sites can utilize the processes found in Field Guidebook Chapter 6.A Coronavirus (COVID 19) Guidance for Community Care Consult Referral Management.

Administrative Closure Report

Community Care offices should run the Administrative Closure Report located in FBG Chapter 4.3 to capture community providers that are not timely returning progress notes, which can be discussed during Monthly network adequacy calls.

Last Updated on: Tuesday, August 3, 2021

Scheduling Challenges Report

The Office of Community Care has created [the Scheduling Challenges Report in VSSC](#). This report is available to identify the specific Community Care consults that have a documented scheduling challenge in the CTB. This report will be shared by OCC to the TPA for review and follow up.

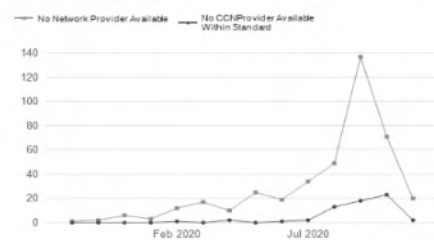
Facility: (1V01) (402) Togus, ME, (1V01) (405) W... Referral Returned (RFV) Start Date: 6/6/2020 Referral Returned (RFV) End Date: 11/27/2020
 Stop Code: (669) COMMUNITY CARE CONSULT CPRS Status: ACTIVE,CANCELLED,COMPLETE,DISCO...
 1 of 13 100% Find | Next



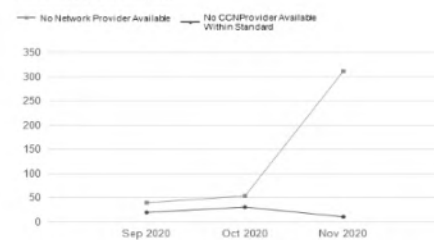
Consult ToolBox - Scheduling Challenges

Data Definitions VSSC Help Desk Rate Report

Total Consults by File Entry Date



Total Consults by RFV Activity Date



Facility	Total Consults Referral Returned	No Network Provider Available	No CCN Provider Available Within Timeliness Standard
Total	458	406	62
(1V01)	131	118	13
(1V02)	135	135	0
(1V04)	2	1	1
(1V06)	46	15	31
(2V07)	38	37	1
(2V08)	8	8	0
(2V09)	9	2	7
(3V10)	2	2	0
(3V12)	12	10	2
(3V23)	3	2	1
(4V16)	2	1	1
(4V17)	19	18	1
(4V19)	3	1	2
(5V20)	12	12	0
(5V21)	5	5	0
(5V22)	41	39	2

This report enables local, regional, and national monitoring ability to work with the Community Care Network (CCN) Third Party Administrators (TPA) to enhance the community care network through a better understanding of local scheduling challenges. Community Care staff will follow the process for searching for providers & capturing scheduling issues located in FGB Chapter 6.0

More information can be found in the [Capturing Community Care Scheduling Challenges and Addressing Network Adequacy Reference Sheet](#) and in the Office of Community Care Field Guidebook Chapter 6, Section 6A Coronavirus (COVID 19) Guidance for Community Care Consult Referral Management.

[Capturing Community Care Scheduling Challenges and Addressing Network Adequacy Live Demo](#)

Last Updated on: Tuesday, August 3, 2021

4.5 Veterans Health Information

MISSION Act Changes

Under Section 132 of the VA MISSION Act, Congress has now removed some of the existing restrictions for health information sharing, **allowing VA to move to an “informed opt out” model**. Beginning in April 17, 2020, following necessary technical upgrades to the VHIE systems, VA will begin seamlessly and securely sharing a Veteran’s health information when they have an appointment with their community provider. This move will give community providers a more complete view of Veterans’ medical histories so they can make more informed treatment decisions that drive better health outcomes. However, Veterans may opt out of electronic sharing via VHIE if they choose by submitting VA Form 10-10164 or using the new online system in My HealtheVet Vet (see key messaging below for more details).

VA believes this rule change will also dramatically improve continuity of care when Veterans move between VA and non-VA community providers. However, some Veterans may have privacy concerns regarding this change, particularly those whose records may contain highly sensitive health information (e.g. HIV or sickle cell status, mental health issues, etc.).

The implementation timeline for changes to VHIE opt out is as follows:

Available Now: Online option for managing electronic sharing preferences released in My HealtheVet.

April 17, 2020: Automatic sharing via VHIE begins.

03 APPROVED KEY MESSAGES

The key messages below are included in prepared collateral including an outreach partner toolkit, factsheet, flyer, and the new VHIE website (see section 05). Please leverage these messages and materials as appropriate.

These messages are intended to:

- Clearly explain what VHIE is and the limited circumstances when information is seamlessly and securely shared with community providers.
- Highlight both the benefits of VHIE sharing and the risks of opting out.
- Inform Veterans about how to opt out if they choose.

These messages are representative and may be adapted to suit specific communications tactics.

Last Updated on: Tuesday, August 3, 2021

Topic	Key Messaging
Context for change	<ul style="list-style-type: none"> • With the launch of the VA MISSION Act, VA has expanded Veterans' access to community care – and our network of community providers. Because these providers do not have direct access to VA's electronic health record, we use the <u>Veterans Health Information Exchange (VHIE)</u> program to securely share vital health information they need to treat Veterans. • The VA MISSION Act of 2018 removes certain restrictions on electronic health information sharing, which enables VA to seamlessly and securely share Veteran's health information with community providers who are a part of their care team. • This change will take effect April 17, 2020. Previously, Veterans had to complete a form to opt in or elect to share your personal health information via VHIE.
What is VHIE? How does it work?	<ul style="list-style-type: none"> • VHIE gives health care providers a more complete view of Veterans' health to help them make more informed treatment decisions. Through VHIE, community providers who are a part of a Veteran's care team can safely and securely receive VA health information electronically. • Health Information Exchanges (HIEs) like VHIE are a common tool used across the health care industry to improve continuity of care, reduce duplicative tests, and avoid clinical error when patients see health care providers from different practices or health care networks. For more general information about HIEs, visit www.HealthIT.gov. • VA only shares a Veteran's health information with community providers via VHIE when they are treating the Veteran.
Benefits of VHIE	<ul style="list-style-type: none"> • The more information health care providers have about a Veteran's medical history, the better. In fact, the instant exchange of information made possible by VHIE can dramatically improve patient safety, especially during emergency situations. • Giving providers a more complete view of Veterans' medical history can lead to better health outcomes. • VHIE provides secure, seamless access to a Veteran's medical record, helps health care providers make more informed treatment decisions, provide safer, higher quality care. • This secure system eliminates the need to send paper medical records by mail or for a Veteran to carry their records with them to appointments with community providers. • Secure, seamless sharing via VHIE means Veterans care teams will be able to: <ul style="list-style-type: none"> ○ Better understand your health history so they can focus more time on what's important to you. ○ Develop safe, more effective treatment plans. ○ Work together to keep you safe and improve your overall health.
Opting out	<ul style="list-style-type: none"> • If Veterans do not want their care teams to receive their information via VHIE, <u>they may opt out</u> of electronic sharing.

Last Updated on: Tuesday, August 3, 2021

	<ul style="list-style-type: none"> • If a Veteran opts out, his or her community providers may not be able to receive their medical records before they receive treatment. This could put them at risk. • To opt out, Veterans must complete and submit VA Form <u>10-10164</u> to their facility's Release of Information Office (ROI). They may also submit this form online via <u>My HealtheVet</u>. • There is no deadline to opt out, and Veterans may do so at any time before or after automatic sharing begins. If they previously opted out but want to resume secure, seamless sharing, they may also opt back in at any time by completing VA Form <u>10-10163</u>.
Privacy	<ul style="list-style-type: none"> • VA is committed to protecting the privacy of all Veterans' personal health information. VHIE, like all other VA health IT systems, complies with all federal patient privacy laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Use the following link to access <u>Notice of Privacy Practices</u>. • Only community health care providers and organizations that are a part of VA's approved, trusted network may receive a Veteran's health information. Additionally, all VA and community care providers work to protect Veteran health information and only share the appropriate information when it is needed.

04 Public Affairs Posture

Public Affairs posture is passive. OPIA's Office of Media Relations will lead responses to queries from news media. Please follow the process through your regional office.

05 COMMUNICATIONS PRODUCTS

Please use the products listed below to promote awareness about VHIE. Most of these resources can be found on the new VHIE website or on the VA Insider MISSION Act page. Links provided below.

Product	Purpose & Audience	Source	Notes
Communications Products Available Now			
NEW VHIE Website	Purpose: Replaces the previous VA.gov/VLER site. Audience: All audiences (geared toward Veterans)	<u>VA.gov/VHIE</u>	Serves as the primary resource for updated VHIE information.

Last Updated on: Tuesday, August 3, 2021

Outreach Partner Toolkit	<p>Purpose: Provide VA outreach partners and stakeholders with materials to share with Veterans via their communications channels.</p> <p>Audience: Can be shared with local Veteran Service Organizations and other partners.</p>	<u>Available Here</u> (VA Insider)	<p>Toolkit includes the following products:</p> <ul style="list-style-type: none"> • Introduction and basic VHIE facts for stakeholders • Veteran Factsheet • Veteran Flyer • Sample blog post • Sample social media posts
Veteran Factsheet	<p>Purpose: Provide clear, summary information about VHIE changes and direct readers to website for more information.</p> <p>Audience: All audiences (geared toward Veterans)</p>	<u>Available Here</u> (External site)	This factsheet is included in the outreach partners toolkit and available on the new VHIE website.
Veteran Flyer	<p>Purpose: Promote awareness about VHIE changes and direct readers to new website for more information.</p> <p>Audience: All audiences (geared toward Veterans)</p>	<u>Available Here</u> (External site)	This flyer is included in the outreach partners toolkit and may be used as either a flyer or poster in VA facilities.
Sample Social Media Content	<p>Purpose: Promote awareness about VHIE changes and direct readers to new website for more information.</p> <p>Audience: All audiences (geared toward Veterans)</p>	<u>Available Here</u> in Outreach Partners Toolkit (VA Insider)	Sample content can be found in the outreach partners toolkit and includes images sized appropriately for Facebook, Twitter, and Instagram platforms.
Provider/Front Line Staff Factsheet	<p>Purpose: Provide information that providers and front-line staff may use to answer questions about VHIE.</p> <p>Audience: VA and non-VA providers and front-line staff</p>	<u>Available Here</u> (VA Insider)	This factsheet also includes information about how non-VA providers can become VHIE Participating Partners so they can securely receive VA health information.
VAntage Point Blog	<p>Purpose: Release initial updated messaging to</p>	<u>Available here</u>	This post was highlighted in that week's edition of VEO's

Last Updated on: Tuesday, August 3, 2021

By Dr. Richard Stone November 20, 2019	respond to concerns and highlight benefits to Veterans/ Audience: All audiences (geared toward Veterans)	(<i>External website</i>) (<i>External website</i>)	#VetResources email (distribution: 9.5 million). Also shared via the VHA Executive in Charge weekly message.
VHIE Outreach Partners Toolkit (PDF)	Purpose: Clarification on how VHIE provides health care <i>Safety</i> and <i>Quality</i> for our Veterans Audience: VA and non-VA providers and front-line staff	<u>Available Here</u>	
Communications Products Coming Soon			
Press Release	Purpose: Promote public awareness that automatic opt in is beginning and that electronic form is available. Audience: All audiences	On or about 3/16/2020	
Vantage Point Blog	Purpose: Publish information about managing sharing options online via My HealtheVet within the context of encouraging Veterans to remain opted in. Audience: All audiences (geared toward Veterans)	On or about 3/16/2020	This post will be published under Dr. Jen MacDonald's name. It will also be highlighted in VEO's #VetResources email (distribution: 9.5 million).
MyHealtheVet "In the Spotlight" Feature	Purpose: Publish the link to the electronic opt out form, update on timing of automatic sharing, and encourage Veterans to remain opted in. Audience: My HealtheVet users	On or about 3/16/2020	This article will also be highlighted in the My HealtheVet newsletter at the time of publishing.

Last Updated on: Tuesday, August 3, 2021

4.6 Metrics

To ensure that key processes are being undertaken in a timely manner, that backlog or bottlenecks are not developing, and to ensure consults are being closed in the correct timeframe - performance metrics will be developed for clinical documentation. The table below lists the initial set of metrics, and the likely source for the data.

CLINICAL DOCUMENTATION PERFORMANCE METRICS		
KEY METRIC	DESCRIPTION	SOURCE
Attempts to Get Records	<p>Documented attempts to get records from the community provider:</p> <ul style="list-style-type: none"> • First attempt to get records • Second attempt to get records • Third attempt to get records • Records received, forwarded to medical records • No records after 1 attempt • See 4.2 on Administratively Closing a Consult 	Consult Toolbox
Percent and Volume of Consults Administratively Closed	Consults administratively closed without receiving clinical documentation from the community provider	Consult Toolbox
Open Consults – Volume	The number of open consults by location	Consult Toolbox
Open Consults – Age	The number of open consults by age (latency)	Consult Toolbox
Medical Documentation Report	The number of referrals and appointments that received Medical Documents in the past two days.	HSRM

4.7 Impact and Performance Benchmarks

Monitoring referral management for Community Care Consults is essential because delays in consult management lead to extended wait times for Veterans to receive an appointment. See below for the steps to access and view referral management data.

Once consult data is available in the necessary reporting formats, the consult metric timeline and guidance to the field will be modified to capture not only initial care request date, but also timeline from when care was forwarded to the Facility Community Care

Last Updated on: Tuesday, August 3, 2021

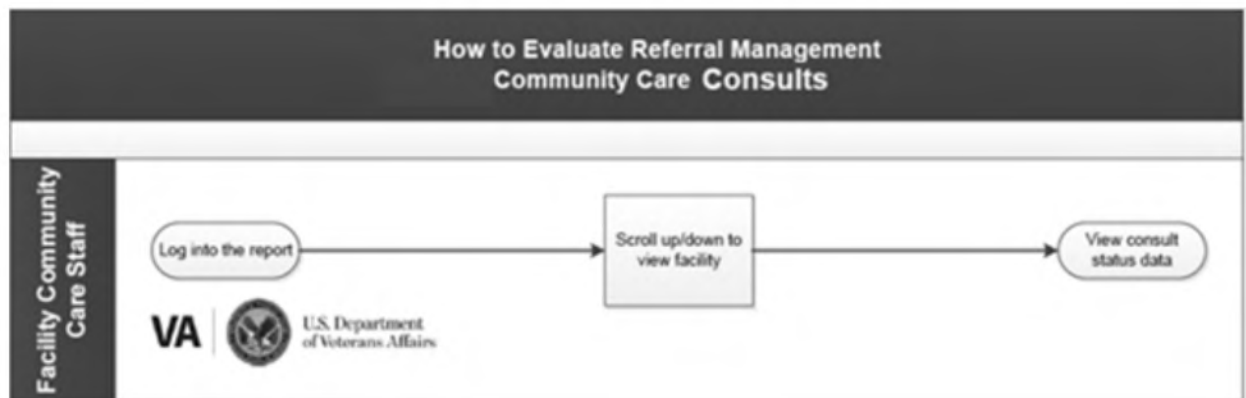
Office for action. This will be a subset of the current metric timeliness and information will be included in this section, as well as the top 8 metric definitions.

Site Target(s):

- 90% of consults should be reviewed and moved to active or scheduled within 7 days
- 90% of consults should be scheduled within 30 days
- 90% of consults should be scheduled and no greater than 90 days old

Site Performance Goals:

- Pending consults should remain in PENDING status no more than 2 business days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 2 business days (see [VHA Directive 1232\(2\)](#) for additional guidance).
- Active consults no greater than 30 days
- Scheduled consults no greater than 90 days



PROCEDURE

General Considerations:

- This report changes daily as consult status changes and consult age increases
- Each target focuses on a different element of consult management
- This report requires Pyramid access
 - Use this [Pyramid self-registration link](#) to obtain access

STEP	ACTIVITY
------	----------

Last Updated on: Tuesday, August 3, 2021

PROCEDURE

- 1 **Log into the report:** Use this [Pyramid Consult Cube link](#) to log in to the report, then click on All/Closed Consults

Right click and select Analyze Further to "create your own view" from an existing report

Home Open Consults **All/Closed Consults** Special Purpose

Overview

Cube Sync Status: Sync Complete Data is subject to immediate change if "Currently Syncing"

Cube Current Through: 12/2/2020 The max file entry date captured by the cube

Cube Sync Start Date Time: 12/3/2020 6:20:00 AM The time (eastern) from which the data is subject to change

Cube Sync End Date Time: 12/3/2020 7:03:38 AM The time (eastern) from which the data is stable until the next refresh

Toolbox (Priority) End Date: 12/3/2020 7:44:19 AM <--- still updating if blank

Toolbox Data Through Date: 12/3/2020

Consult Cube Dashboard

Product Last Updated 12/3/2020 at 6:10:00 AM CT

Open in Pyramid Analytics

Help Desk Data Definitions Notifications
Rate Report Pyramid Help

For Pyramid Analytics software to work properly, your web browser zoom level must be at 100%. No more, no less.

This cube provides information on all consults entered into VISTA after October 1, 2010, or FY11. The intent of this cube is to provide information which will assist users in completing assigned tasks, maintaining business rules and investigating consults in order that they may appropriately address these consults to bring them to the appropriate status.

Partial PHI/SSN product - Some parts of this product require PHI/SSN permissions to view.

- 2 **Select the Timeliness Report:**

Right click and select Analyze Further to "create your own view" from an existing report

Home Open Consults **All/Closed Consults** Special Purpose

By Status Timeliness Stat Trend Trend by File Entry Date Trend by Closure Date Consult Performance

Receiving Facility District - Location - Receiv... Sending Facility District - Location - Sendin... Receiving Service Classification - Receiv... File Entry Date - File Entry Date

All Facility All Sending Facility All FY19

Consults by CPRS Status and Primary Stop Clinic Type (All Facility, All, All, FY19, All Sending Facility)

Primary Stop Clinic Type	Consults	Open Consults	ACTIVE	CANCELLED	COMPLETE	DISCONTINUED	DISCONTINUED/EDIT	PARTIAL RESULTS	PENDING	SCHEDULED	NOT RECORDED
All Clinics	33,957,837	23,006	11,820	261,276	27,651,073	6,022,479		3	69	6,900	4,216
Mental Health	1,306,508	186	91	12,607	865,044	428,670		1	1	5	89
Primary Care	411,249	67	7	4,713	298,776	107,693				15	45
Specialty Care	32,240,080	22,753	11,722	243,956	26,487,253	5,486,116		2	68	6,880	4,082

- 3 **Use the Receiving Facility District drop down:** to select the facility: facilities are listed on the left-hand side of the report; be sure to deselect the All Facility

Last Updated on: Tuesday, August 3, 2021

PROCEDURE

option first, then use the drop-down arrows to select the appropriate facility

Home Open Consults **All/Closed Consults** Special Purpose

By Status **Timeliness** Stat Trend Trend by File Entry Date Trend By Closure Date Consult Performance

Receiving Facility District - Location - Receiving... Primary Stop Clinic Type - Receiving... File Entry Date - File Entry Date

Multiple Selections Multiple Selections FY19

Search

- ☐ All Facility
- ☐ District 1
 - ☐ 1V01
 - ☐ (1V01) (402) Togus, ME HCS
 - ☐ (1V01) (405) White River Junc...
 - ☐ (1V01) (518) Bedford, MA HCS
 - ☐ (1V01) (523) Boston, MA HCS
 - ☐ (1V01) (608) Manchester, NH...
 - ☐ (1V01) (631) Central Western...
 - ☐ (1V01) (650) Providence, RI H...
 - ☐ (1V01) (689) Connecticut HCS
 - ☐ 1V02
 - ☐ 1V04
 - ☐ 1V05
 - ☐ 1V06

ve, Average Days From First Active to First Scheduled, Average Days From File Entry To First

ults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	AV Fro To Ma
917,228	1.9	6.1	2.0	7.2	4.8	
933,896	2.2	5.7	4.1	7.5	6.1	
727,445	4.8	8.3	12.9	30.2	8.0	
418,495	2.5	26.2	6.1	29.6	28.3	
876,447	2.5	4.7	2.3	4.4	4.6	

4

Select the File Entry Date drop down: Select the FY for the data view.

By Status **Timeliness** Stat Trend Trend by File Entry Date Trend By Closure Date Consult Performance

Receiving Facility District - Location - Receiving... Primary Stop Clinic Type - Receiving... File Entry Date - File Entry Date

Default Member Multiple Selections FY19

Search

- ☐ All File Entry Date
 - ☐ FY12
 - ☐ FY13
 - ☐ FY14
 - ☐ FY15
 - ☐ FY16
 - ☐ FY17
 - ☐ FY18
 - ☐ FY19
 - ☐ FY20
 - ☐ FY21
 - ☐ FY21 Q1
 - ☐ Oct-FY21
 - ☐ Nov-FY21
 - ☐ Dec-FY21

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	AV Fro To Ma
Administrative	10,917,228	1.9	6.1				
ClinicalConsult	46,933,896	2.2	5.7				
ClinicalProcedure	4,727,445	4.8	8.3				
CommunityCare	14,418,495	2.5	26.2				
Prosthetics	24,876,447	2.5	4.7				

Last Updated on: Tuesday, August 3, 2021

PROCEDURE

5

Report should automatically populate:

By Status

Timeliness

Stat Trend

Trend by File Entry Date

Trend By Closure Date

Consult Performance

Receiving Facility District - Location - Receiving...

(SV21) (612A4) N. California HCS

Primary Stop Clinic Type - Receiving...

Multiple Selections

File Entry Date - File Entry Date

FY21

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From File Entry To Appointment	Average Days From First Canceled to First Edit/Resubmit	Average Days From Earliest Date to Completed Consult	Average Days From First Forwarded From to Closed
Administrative	3,651	0.7	12.7	0.9		12.0	15.0	19.3	4.8	-2.0	1.5
Clinical/Consult	36,155	1.1	5.5	2.3	5.6	6.3	8.8	34.4	3.0	6.9	10.6
ClinicalProcedure	2,016	7.4	3.2	3.7	7.0	7.7	11.3	65.4	0.0	3.4	1.0
CommunityCare	10,332	1.1	13.3	2.4	18.2	14.1	15.3	22.5	0.7	8.5	20.2
Prosthetics	15,060	2.0	NaN	1.4		1.0		0.0	0.0	3.8	2.7

6

To Extract SSN Level Data:

1. Right click in the Consults total for Community Care,
2. Hover over Cell Action list
3. Select Consult Patient SSN Report by moving the mouse to the right

Home

Open Consults

All/Closed Consults

Special Purpose

By Status

Timeliness

Stat Trend

Trend by File Entry Date

Trend By Closure Date

Consult Performance

Receiving Facility District - Location - Receiving...

(SV21) (612A4) N. California HCS

Primary Stop Clinic Type - Receiving...

Multiple Selections

File Entry Date - File Entry Date

FY21

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled

Receiving Service Classification	Consults	Interact	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From First Canceled to First Edit/Resubmit	Average Days From Earliest Date to Completed Consult
Administrative	3,651	<div>Focus Data Point</div> <div>Eliminate Data Point</div> <div>Drill Down</div> <div>Drill Up</div> <div>Drill To Level</div> <div>Dice</div> <div>Swap</div> <div>Add</div> <div>Expand Down</div> <div>Collapse</div> <div>Member Selection</div> <div>Actions</div> <div>Change Visual</div> <div>Build New Alert</div> <div>Analyze Further</div> <div>Information</div>	12.7	0.9		12.0	15.0	19.3
ClinicalConsult	36,155		5.5	2.3	5.6	6.3	8.8	34.4
ClinicalProcedure	2,016		3.2	3.7	7.0	7.7	11.3	65.4
CommunityCare	10,332		13.3	2.4	18.2	14.1	15.3	22.5
Prosthetics	15,060		NaN	1.4		1.0		0.0

Last Updated on: Tuesday, August 3, 2021

PROCEDURE

7

Review the Consult Patient SSN Report:

- From the results on the computer screen
- Export data to one of the formats available from the Save Icon drop down options

The screenshot shows a web browser window displaying the VSSC Report Viewer. The URL is [https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Access/Consults/ConsultCellAction&ApptStatus_n=0&ApptStatus_l=\(...\)](https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Access/Consults/ConsultCellAction&ApptStatus_n=0&ApptStatus_l=(...)). The page title is "ConsultCellAction". There are buttons for "Data Definitions", "VSSC Help Desk", and "Rate Report". A table displays consult data with columns: Sending Sta6a, Sending Location, From Stop Code, Ordering Provider, Consult SID, Patient SSN, and Patient Name. The first row shows: 402, TOG MED ONCO MD LEE COBI, 316, and empty cells for the others. A "Save" icon (floppy disk) is highlighted, and a dropdown menu is open showing export options: Word, Excel, PowerPoint, PDF, TIFF file, MHTML (web archive), CSV (comma delimited), XML file with report data, and Data Feed. The "Excel" option is highlighted.

Sending Sta6a	Sending Location	From Stop Code	Ordering Provider	Consult SID	Patient SSN	Patient Name
402	TOG MED ONCO MD LEE COBI	316				

Analysis

PENDING: When viewing pending consults, note that in these cases the consult has not been actioned by the Facility Community Care Office. Pending consults should remain in PENDING status no more than 2 business days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 2 business days. Analysis of these consults would include reviewing by consult specialty to determine specialty and/ or assigned community care staff workload assignment to identify possible delays in consult flow.

Note: If a consult is not received in the toolbox, it will not change into an active status

ACTIVE: Review by specialty and/or Community Care staff workload assignment to determine delays in scheduling appointments. This could include vendor and/ or network analysis as well.

Last Updated on: Tuesday, August 3, 2021

SCHEDULED: Generally, high numbers in this section indicate an issue with medical record receipt. Review possible scanning backlogs and utilize tools such as TPA Med Record Reconciliation Report (link to be added when available) close consults with medical records.

Reference Documents

- VHA Directive 1232(1): Consult Policy and Procedures (Amended 09/23/2016)

4.8 How to Evaluate Referral Management Timeliness

Monitoring referral management timeliness is essential to avoid delays in consult management resulting in extended wait times for Veterans to receive an appointment. See below for the steps to access and view referral timeliness data.

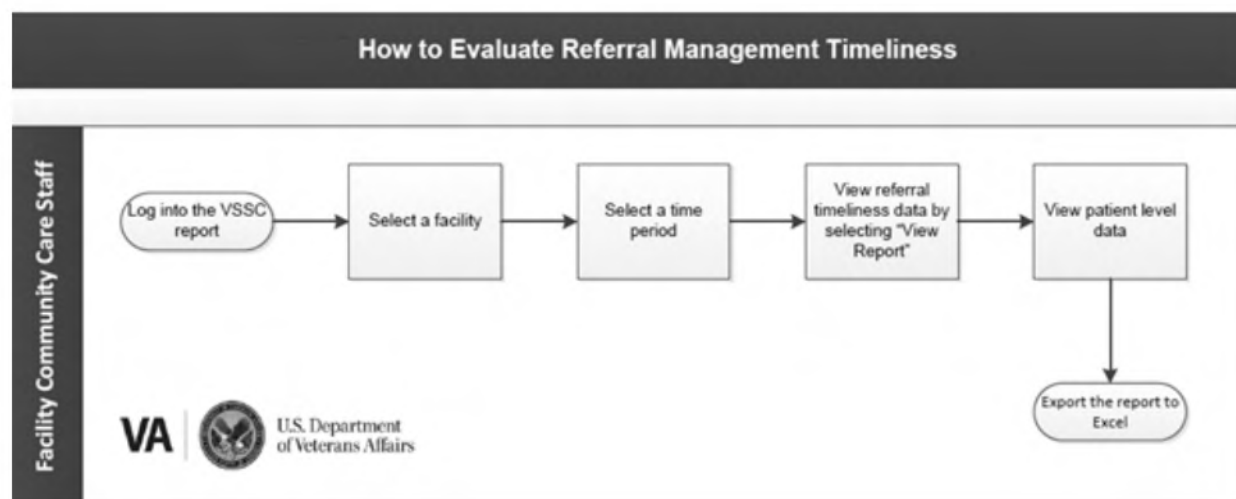
While the current report only provides timeliness metrics for Community Care consults, a multidisciplinary team from the VHA Office of Community Care is planning to deploy enhanced VSSC reports that will have more granular timelines measures and data for all Community Care consults.

Site Target(s):

- 95% of consults should be scheduled within 14 days
- 95% of Wait List referrals should be schedule within 30 days

Site Performance Goals:

- All Consults should be scheduled within 14 days
- All Wait list referrals should be scheduled within 30 days



Last Updated on: Tuesday, August 3, 2021

PROCEDURE	
General Considerations: <ul style="list-style-type: none"> • This report currently tracks Community Care referrals for services unavailable and for Wait Time Eligible Veterans. • One Consult and the Consult Toolbox have been deployed nationally and reports for additional programs are available <ul style="list-style-type: none"> ◦ The data reliability of this report is dependent on the appropriate entry of the unique ID by VA staff • To view facility level and national timeliness data, VSSC access is required • To view Veteran level data, SSN level access is required <ul style="list-style-type: none"> ◦ Please use this link to access instructions on obtaining VSSC and SSN level access 	
STEP	ACTIVITY
1	Login into the VSSC report: Use this Consult Reports link to access the Consult Timeliness report.
2	Select a facility: Select the desired facility.
3	Select a time period: Select the month(s) of data to be viewed.
4	View referral timeliness data by selecting 'View Report': View the referral timeliness data for the selected facility, all VISNs, and the nation.
5	View Veteran level data: Update in process.
6	Export the report to Excel: Click on the 'Export to Data Feed' to export the report.

Analysis

Once data has been exported it should be analyzed to determine delays in specific categories of care and/or to isolate extreme timeliness outliers affecting facility averages.

Reference Documents

- [VHA Directive 1232\(2\): Consult Policy and Procedures \(Amended 09/23/2016\)](#)
- [Interim Solution to Track Referral Timelines](#) (update in process)
- [TPA Timeliness Report Fact Sheet](#) (update in process)

Last Updated on: Tuesday, August 3, 2021

4.9 Review of Community Provider Opioids Prescribing Practices

PROCEDURE

General Considerations:

- In June 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was passed. The MISSION Act dictates numerous changes to the way the Department of Veterans Affairs partners with Community Providers. The goal of MISSION is to ease access to appropriate health care in Veteran communities where a VA Provider is unavailable or does not specialize in the Veteran's needs. Additionally, the MISSION Act outlines new requirements regarding opioid prescribing practices of community providers. This includes a requirement to review the opioid prescribing practices of non-department providers
- To meet this requirement and further support the nation's Veterans, review of community provider opioid prescribing practices will be partially incorporated into the current review process for VA Providers.
- Community providers are required to review the Opioid Safety Initiative (OSI) guidelines. VA will review community providers based on these guidelines.
- These steps outline how to review community provider opioid prescribing practices utilizing the Pharmacy Benefits Management reporting suite during the VISN Pain Committee, or equivalent committee, reviews.
- Primary Role: VISN Committee, VISN Patient Safety Officer, and VAMC Patient Safety Manager
- Secondary Roles: Chief of Staff, Facility community care office.

STEP	ACTIVITY
1	Request Pharmacy Benefits Management national opioids dashboard access Request access to National Opioid Safety Initiative Dashboard by emailing (b)(6)@va.gov
2	Open Quarterly OSI: Opioid Prescribing Trend Reports by CCN Providers http://vhacmnreport08t.vha.med.va.gov/Reports/Pages/Folder.aspx?ItemPath=%2fExternal%2fPBM%2fOpioid+Safety+Initiative+Dashboard&ViewMode=List
3	Click the VISN dropdown option
4	Select appropriate VISN for review
5	Review community provider opioid prescription data

Last Updated on: Tuesday, August 3, 2021

PROCEDURE	
6	<p>Determine if a potential deviation or concern has been identified by leveraging the <u>Guidance for Review</u> document:</p> <ul style="list-style-type: none"> • If yes, Notify VISN Patient Safety Officer on SharePoint and proceed to step 7. • If no, end review.
7	Identify VAMC Patient Safety Manager
8	Inform the OCC VAMC Oversight Council of community providers identified for review
9	Schedule recurring VISN meeting or include TPA Quality, Patient Safety Representative, and OCC in existing VISN meeting
10	Discuss identified trends, lessons learned, and/or corrective actions
11	<p>Review VA/DoD Clinical Practice Guideline Management of Opioid Therapy for chronic pain</p> <p>https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf</p>
12	Notify TPA of providers needing review through the VAMC Patient Safety Manager
13	Conduct full clinical and administrative review
14	<p>Determine if a potential deviation or concern has been identified</p> <ul style="list-style-type: none"> • If yes, submit provider to peer review committee • If no, notify VAMC PSM and VISN PSO through TPA Quality and Patient Safety Representative.
15	<p>Determine if the instance involves both TPA and VA providers.</p> <ul style="list-style-type: none"> • If yes, notify the VAMC Patient Safety Manager. • If no, notify Office of Community Care through recurring VISN review meetings
16	Initiate Provider Exclusion process and halt referrals to provider

Last Updated on: Tuesday, August 3, 2021

Training References:

- Opioid Safety--Provider Education
- ***Community Care Provider: A Perspective for Veteran Care Training***
General training encompasses TBI, PTSD, MST, and suicide prevention
 - Available VHA TRAIN MISSION ACT curriculum training site (VHA TRAIN MA) (Course ID: 1085488)
 - Highly recommended for all providers, but not required
 - Will be tracked as part of CCN High Performing Provider (HPP) algorithm (pending Optum contract modification).
- **Specialty Training Courses**
 - Traumatic Brain Injury (TBI)
 - Available on VHA TRAIN (Course ID:1088828)
 - Military Sexual Trauma (MST) Medical
 - Scheduled to release February 2020
 - Military Sexual Trauma (MST) Mental
 - Scheduled to release February 2020
 - Post-Traumatic Stress Disorder (PTSD)
 - Scheduled to release March 2020
- VHA Office of Community Care (OCC) Website
 - Provider Education and Training Resources

4.10 Community Administration of Vaccine Encounters (CAVE)

An updated and improved CAVE v1.2 version will be deployed after-hours on August 24, 2021 and will immediately become active. CAVE v1.2 will expand the process to publish community administered immunization data to VistA at the facility level. This will include all approved vaccines on the VA Formulary, including the COVID-19 vaccines administered by community providers. The goal is to improve care continuity, patient safety, prevent duplicative vaccinations, and to allow providers at the facility to view vaccination information in one place. The vaccine information will be visible on the Computerized Patient Record System (CPRS) cover sheet and resolve national clinical reminders. This process will also eliminate the need for Veterans to provide this information to their VA providers.

The vaccine information will be visible in Joint Legacy Viewer (JLV) and CPRS within the immunization summary section. The CAVE process will resolve national clinical reminders for immunizations that were administered by community providers.

Last Updated on: Tuesday, August 3, 2021

The immunization CVX code is added to the local VA medical facility Computerized Patient Record Systems (CPRS) or Veterans Health Information Systems and Technology Architecture (VistA), which results in the vaccination being recorded in the patient care episode (PCE) file as a historical immunization record. This is similar to how providers record non-VA administered immunizations using a clinical reminder.

CAVE Logic:

The Community Care Reimbursement System (CCRS) will provide Data Access Services (DAS) parsed and filtered Community Care Network (CCN) vaccine data that is ready to write to VistA including all the data elements that are necessary for the MPI patient correlation and data write to VistA. DAS will write the records to VistA.

CAVE captures the following information in the Veteran's CPRS coversheet immunization summary widget:

- Immunization name – based on the Centers for Disease Control and Prevention (CDC)
- The associated CDC CVX code
- Date the Veteran received the immunization
- Administering provider and associated NPI #
- Address of the administering provider
- Dosage information as provided by the provider (not always required by contract agreement)

Last Updated on: Tuesday, August 3, 2021

Additional Training



TMS

- **TMS- VA 34478**
Community Care Provider Opioid
Safety Initiative

Community Care Hub

LEGISLATION



- VHA DIRECTIVE 1232(2) - Consult Processes and Procedures
- VHA Handbook 1907.01, Health Information Management and Health Records

Last Updated on: Tuesday, August 3, 2021

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 5 Customer Service

Customer Service	5.0	<u>How to Receive and Document Inquiries</u>
	5.1	<u>Customer Service Escalation</u>
	5.2	<u>Veteran Complaint and Grievance Customer Service</u>
	5.3	<u>Congressional and VA Inquiry Response</u>
	5.4	<u>How to Perform Rapid Inquiry Resolution</u>
	5.5	<u>How to Communicate Resolution and Conduct Follow Up With Veterans or Community Providers</u>
	5.6	<u>Claims Pending Authorization</u>
	5.7	<u>Patient Advocate Tracking System (PATS)</u>
	5.8	<u>Community Care Eligibility Appeals</u>
	5.9	<u>Customer Relationship Management (CRM)</u>
	5.10	<u>Job Aids</u>

5.0 How to Receive and Document Inquiries

(Pre CCN)

Community care inquiries that require escalation are routed to facility community care staff at the local VA medical center (VAMC). Inquiries from a Veteran or community provider should be documented according to guidance from the facility community care office management. Documentation procedures include but are not limited to patient advocate log, local SharePoint sites, and patient safety ePIR sites. Patient Centered Community Care (PC3) contract inquiries that require escalation are routed to community care field support staff. These field support staff members have been established to bridge the communication gap between the Third-Party Administrators (TPAs) and VA by coordinating escalated concerns. Some of these concerns include provider complaints regarding timely payments by TPAs, authorization issues, medical documentation issues, potential health care quality and patient safety issues, as well as Veteran complaints about poor customer service from the TPA. Other non-PC3 contract inquiries are to be managed by the facility community care office staff based on local policy and procedures using the same principles of rapid resolution, clear and open communication, and appropriate follow up to the inquiring parties.

Last Updated on: Tuesday, August 3, 2021

Reference the Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook for guidance on how to manage potential quality and patient safety issues.

Reference the Provider Exclusion Standard Operating Procedures for guidance on the Provider Exclusionary process.

Payment Operations and Management (POM) inquiries that require escalation are mostly routed to the facility community care office at the Veteran's aligned VAMC. However, facilities located in the VISNs serviced by C4 have additional support through the Community Care Contact Center (C4). C4 provides these VISNs with inquiry resolution regarding claims for health care services provided through the Community Care Program. C4 also handles the Adverse Credit Reporting (ACR) line which provides national assistance resolving issues with collection agencies and credit bureau notifications. If C4 receives a non-core call that is an unsupported call not related to ACR or to a VISN currently supported by C4, the C4 customer service representative will inform the caller that this type of request is not currently supported and the CSR provides the caller with the appropriate point of contact information if available.

(Post CCN)

- TriWest (TW) Questions and Concerns Routing:
 - Office of Community Care (OCC) Field Assistant
 - Escalate to TW Hub Director as needed
 - Escalate to TW Regional Director as needed
 - Escalate to TW Provider Services as needed
 - FA work with COR to escalate to TW management if required to elevate

When/If the portal is down, authorization status checks can be conducted by dialing the PC3 contract Customer Service Line.

PROCEDURES	
General Considerations: <ul style="list-style-type: none"> • For PC3 contract related issues, VA Medical Centers have multiple options for addressing their questions and concerns. 	
STEP	ACTIVITY
1	For questions or concerns regarding TriWest, contact the TriWest Embedded staff and OCC Field Assistant.

Last Updated on: Tuesday, August 3, 2021

PROCEDURES	
	<u>Community Care Field Assistants Contact List</u>
2	If the issue requires escalation, reach out to the TriWest Hub Director, as needed. A list of TriWest Hub Directors for each VISN can be located on the <u>CI Solutions Page</u> .
3	In the event your issue has not been addressed, escalate the issue to the Regional Director, as needed.
4	Questions or concerns regarding the provider network can be addressed by TriWest Provider Services.
5	OCC Field Assistant will work with COR team to elevate outstanding questions/concerns to TriWest Management.

(Post CCN)

Staff from the following VA departments may reach out to the Contractor VA Support Call Center as appropriate:

- VA Community Care Contact Center (C4) Contact Service Representatives (CSRs), Leads and Supervisors.
- VA Community Care Clinical Coordinating Contact Center (C6) CSRs and Supervisors
- Facility Community Care Office (FCCO) at local VA Medical Centers (VAMCs). The call center at the FCCO/VA Medical Center (VAMC) level is sometimes referred to as C3.
- VHA Office of Community Care (OCC) Congressional Correspondence Directorate (CCD).
- VHA OCC Clinical Network Management, Provider Relations Services (PR&S).
- VHA OCC Clinical Network Management, Clinical Integration (CI).

C4 is equipped to screen and resolve Veteran calls related to either Adverse Credit Reporting (ACR), general information or claim inquiries. The C3 is the appropriate body to triage all other non-clinical Veteran inquiries. If C3 requires input from the Contractor to resolve a Veteran's inquiry, C4 will be the primary point of contact unless there is an issue with quality and safety, pharmacy inquiry, provider availability or escalation. An escalation is an urgent issue that requires immediate attention.

Contractors will not take calls from Veterans; therefore, Veterans should not contact network providers directly for questions. All network provider calls will be initially handled by Contractor staff. Contractors will transfer urgent referral calls to the VA when required. Table 2 contains the types of calls VA staff will be escalating to the Contractor.

Last Updated on: Tuesday, August 3, 2021

VA Staff Call Types and Escalation

VA Staff Caller	Subject	Optum Number
Facility Community Care Office)/ VAMC/(C3)	Pharmacy Inquires	(b)(6)
	Provider Availability	
	Receipt of Referral or Eligibility	
	Veteran Complaints and Grievances	
	Quality or Safety Issues	
Community Care Contact Center (C4)	Pharmacy Inquiries	
	Receipt of Referral or Eligibility	
	Status of a Claim	
	Veteran Complaints and Grievances	
	Escalating a Billing Inquiry	
	Escalating a Complaint	
Community Care Contact Center Clinical Coordinatization (C6)	Pharmacy Inquiries	
	Receipt of Referral or Eligibility	
	Veteran Complaint and Grievances	
	Quality or Safety Issues	
VA Congressional Staff	Status of Congressional Issues	

Call Types highlighted are for escalated calls.

Last Updated on: Tuesday, August 3, 2021

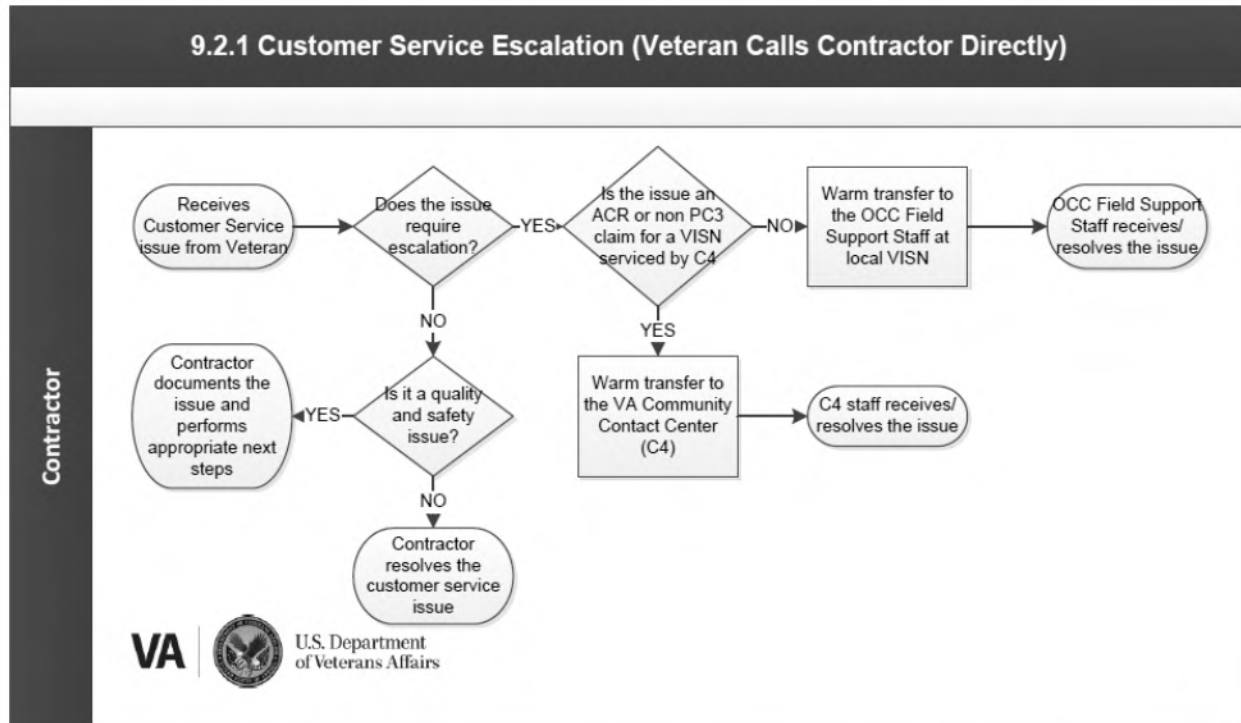
5.1 Customer Service Escalation

(Pre/Post CCN)



(Pre CCN)

The below flow chart illustrates the process for escalating customer service issues if a Veteran calls the Contractor directly.



PROCEDURES - VETERAN CALLS CONTRACTOR DIRECTLY

STEP	ACTIVITY
1	The Contractor receives a customer service issue from a Veteran or provider
2	The Contractor determines whether the issue requires escalation
3a	If the issue requires escalation, the Contractor determines if the issue is an Adverse Credit Reporting (ACR) issue or a non-PC3 contract claim related inquiry for VISNs serviced by the VA <u>Community Care Contact Center (C4)</u>
3b	If the issue does not require escalation, the Contractor determines if it is a quality and safety issue

Last Updated on: Tuesday, August 3, 2021

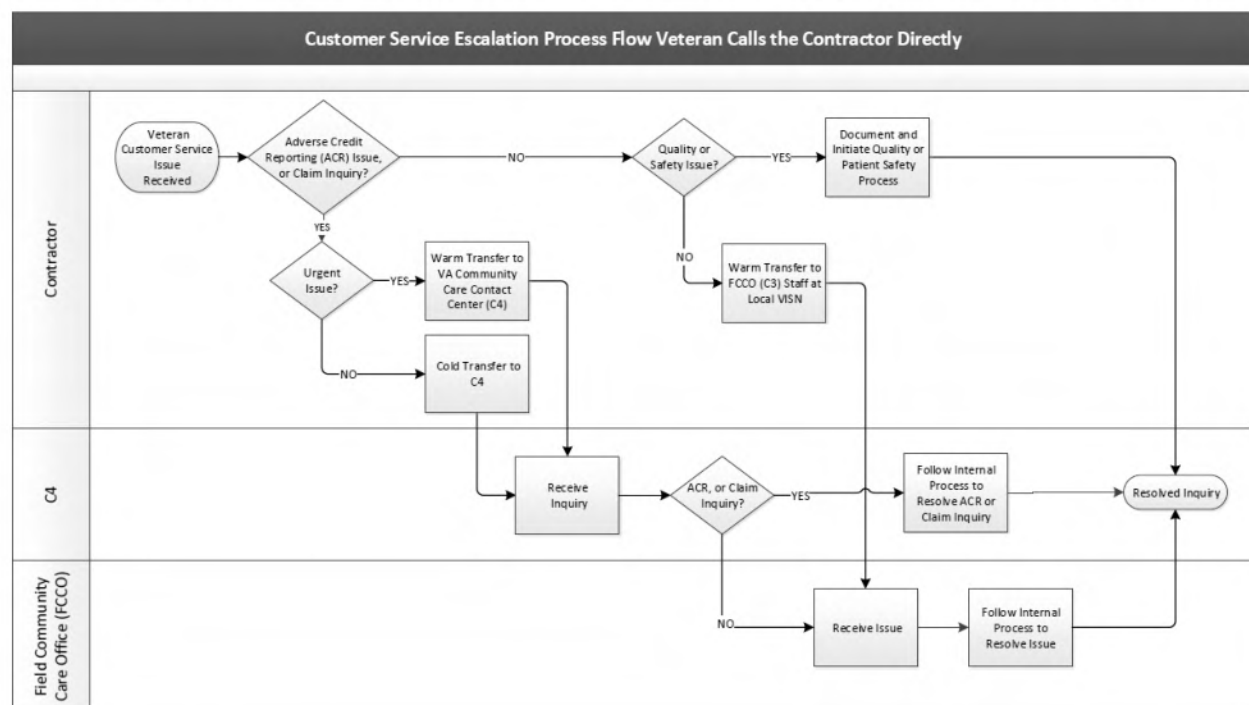
PROCEDURES - VETERAN CALLS CONTRACTOR DIRECTLY	
4a	<p>If the issue is an ACR or a non-PC3 contract claim for VISNs serviced by C4, the Contractor warm transfers to the VA Community Contact Center (C4)</p> <p>A Warm Transfer is defined as the following:</p> <ul style="list-style-type: none"> • The Contractor speaks directly to a Customer Service Representative (CSR) on the VA Call Center Escalation Line to introduce the issue • The Contractor introduces the caller directly to the CSR on the VA Call Center Escalation line before completing the transfer
4b	<p>If the issue does not require escalation and is not a quality and safety issue, the Contractor resolves the customer service issue</p> <p><process ends></p>
4c	<p>If the issue requires escalation but is not an ACR or non-PC3 contract claim for VISNs serviced by C4, the Contractor warm transfers to OCC Field Support Staff at the local VISN</p>
4d	<p>If the issue does not require escalation but is a quality and safety issue, the Contractor documents the issue and performs appropriate next steps based on contractual requirements, organizational procedures, and the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>. Next steps may include reporting the issue as a Potential Quality Issue and/or reporting the event through organizational patient safety reporting systems and including in trend reporting shared with VHA staff at identified meetings</p> <p>Note: TPA's are responsible for ensuring that safe medical care is provided to Veterans by providers in their network. Each TPA is responsible for investigating adverse events and close calls that occur to Veterans who see a provider in their network through the CCN program and to ensure that appropriate follow up actions are taken when necessary</p> <p><process ends></p>
5a	<p>If the issue is an ACR or non-PC3 contract claim for VISNs serviced by C4, C4 staff receives the issue</p>
5b	<p>If the issue requires escalation, but is not an inquiry for ACR or non-PC3 contract claim for VISNs serviced by C4, OCC Field Support Staff receives the issue</p>

Last Updated on: Tuesday, August 3, 2021

PROCEDURES - VETERAN CALLS CONTRACTOR DIRECTLY	
6a	If the issue is an ACR or non PC3 claim for VISNs serviced by C4, C4 staff follows internal process to resolve the issue <process ends>
6b	If the issue requires escalation but is not an ACR or non-PC3 contract claim for VISNs serviced by C4 inquiry, OCC Field Support Staff follows their internal process to resolve the issue <process ends>

(Post CCN)

The below flow chart are VA steps for warm transfers from the Contractor when a Veteran contacts the Contractor directly. To prepare for these different circumstances, the VA made assumptions for the role the Contractor may play in the overall process.



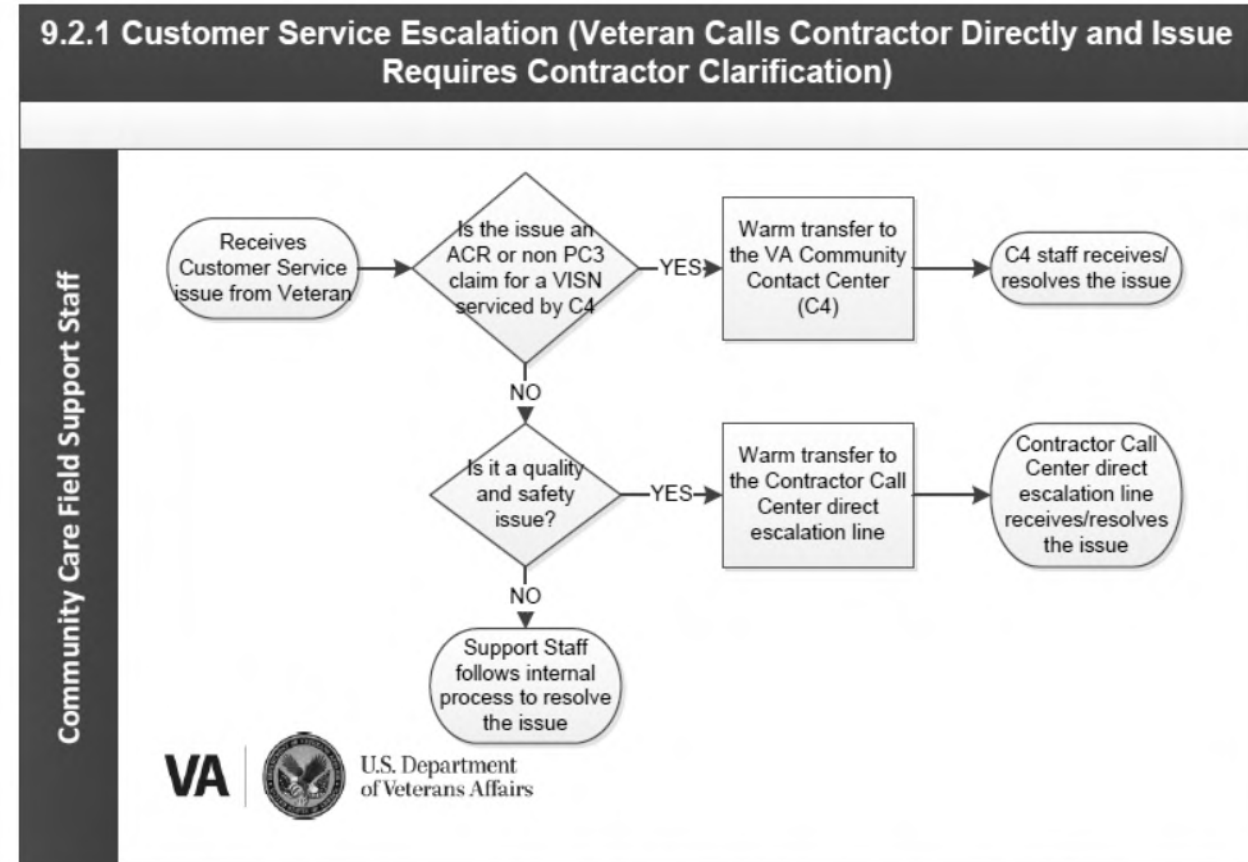
PROCEDURES	
Step	Activity
1	The Contractor receives a Veteran's customer service issue.

Last Updated on: Tuesday, August 3, 2021

2	<p>If the call is about an ACR issue or a Claim Inquiry:</p> <ul style="list-style-type: none"> • The Contractor transfers the call to the VA C4 • If it is not an urgent issue, the Contractor does cold transfer to C4 via (b)(6) • If it is an urgent issue, the Contractor does warm transfer to C4 via (b)(6) <p>Go to Step 3.</p> <p>If it is a Quality or Safety Issue:</p> <ul style="list-style-type: none"> • the Contractor documents the issue and performs appropriate next steps based on contractual requirements, organizational procedures, and the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>. Next steps may include reporting the issue as a Potential Quality Issue and/or reporting the event through organizational patient safety reporting systems and including in trend reporting shared with VHA staff at identified meetings • Note: TPA's are responsible for ensuring that safe medical care is provided to Veterans by providers in their network. Each TPA is responsible for investigating adverse events and close calls that occur to Veterans who see a provider in their network through the CCN program and to ensure that appropriate follow up actions are taken when necessary • process ends> <p>Otherwise:</p> <ul style="list-style-type: none"> • The Contractor warm transfers call to the appropriate C3. Go to Step 5.
3	A C4 CSR receives the call.
4	<p>If the issue is an actual ACR Issue or Claim Inquiry:</p> <p>C4 performs internal process to resolve issue. <process ends>.</p> <p>Otherwise:</p> <p>C4 staff transfers the call to C3. Go to Step 5.</p>
5	A C3 CSR receives the call.
6	<p>C3 performs internal process to resolve the issue.</p> <p><process ends>.</p>

The below flow chart illustrates the process for escalating customer service issues if a Veteran calls VA and the issue requires clarification from the Contractor.

Last Updated on: Tuesday, August 3, 2021



PROCEDURES - VETERAN CALLS OCC FIELD STAFF AND ISSUE REQUIRES CONTRACTOR CLARIFICATION

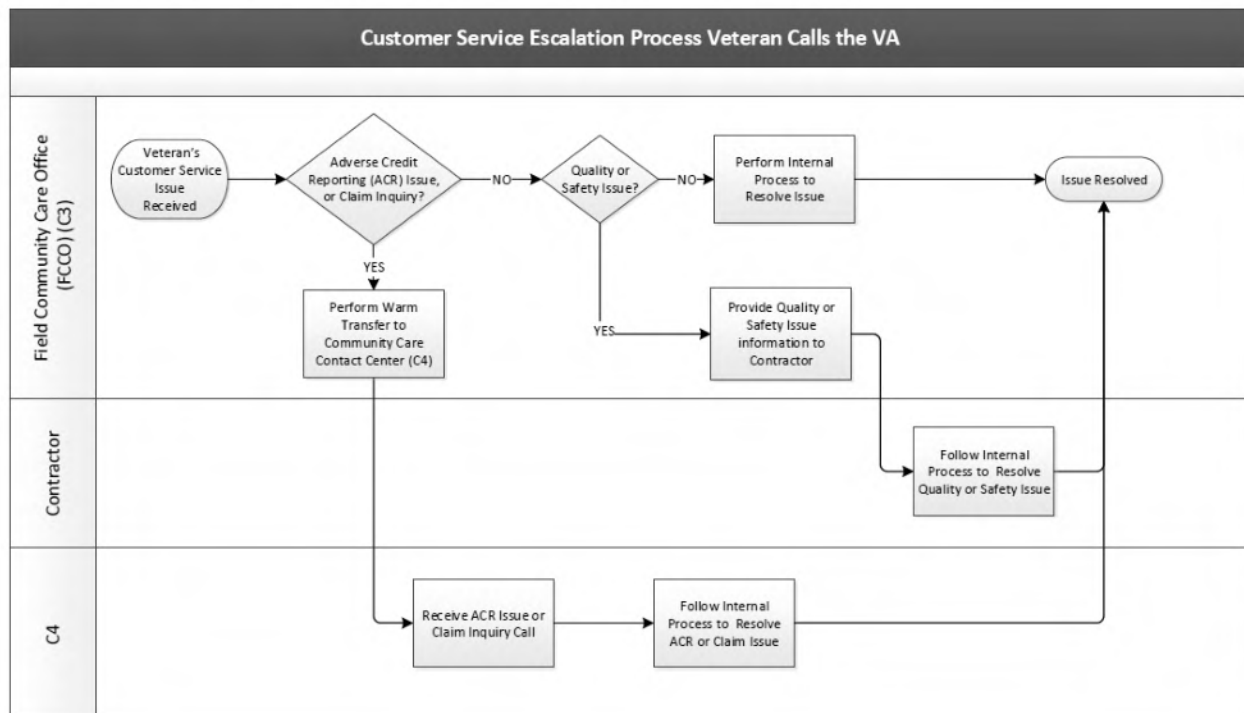
STEP	ACTIVITY
1	OCC Field Support Staff receives a customer service issue
2	Field Staff determines if the issue is an Adverse Credit Reporting (ACR) issue or non-PC3 contract claim related inquiry
3a	If the issue is an ACR or non-PC3 contract claim related inquiry for VISNs serviced by C4, OCC Field Support Staff provides a warm transfer to the Community Care Contact Center (C4) direct line
3b	If the issue is not an ACR issue, the OCC Field Support Staff determines if it is a quality and safety issue using guidance outlined in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>
4a	If the issue is an ACR or non-PC3 contract claim related inquiry for VISNs serviced by C4, the C4 CSR receives the issue
4b	If the issue is not an ACR issue but is a quality and safety issue that requires escalation and cannot be resolved using the guidance provided in the <u>Patient</u>

Last Updated on: Tuesday, August 3, 2021

PROCEDURES - VETERAN CALLS OCC FIELD STAFF AND ISSUE REQUIRES CONTRACTOR CLARIFICATION

	<u>Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u> , the OCC Field Support Staff provides a warm transfer to the Contractor Call Center direct escalation line
4c	If the issue is neither an ACR issue nor a quality and safety issue, the OCC Field Support Staff follows their internal process to resolve the issue <process ends>
5a	If the issue is an ACR or non-PC3 contract claim related inquiry for VISNs serviced by, the C4 CSR follows their internal process to resolve the issue <process ends>
5b	The Contractor receives the quality and safety issue
6	The Contractor documents the issue and performance of the Quality and Patient Safety Process <process ends>

The table below outlines how the VA intends to collaborate with the Contractor for Veteran inquiries that require Contractor clarification or input.



Last Updated on: Tuesday, August 3, 2021

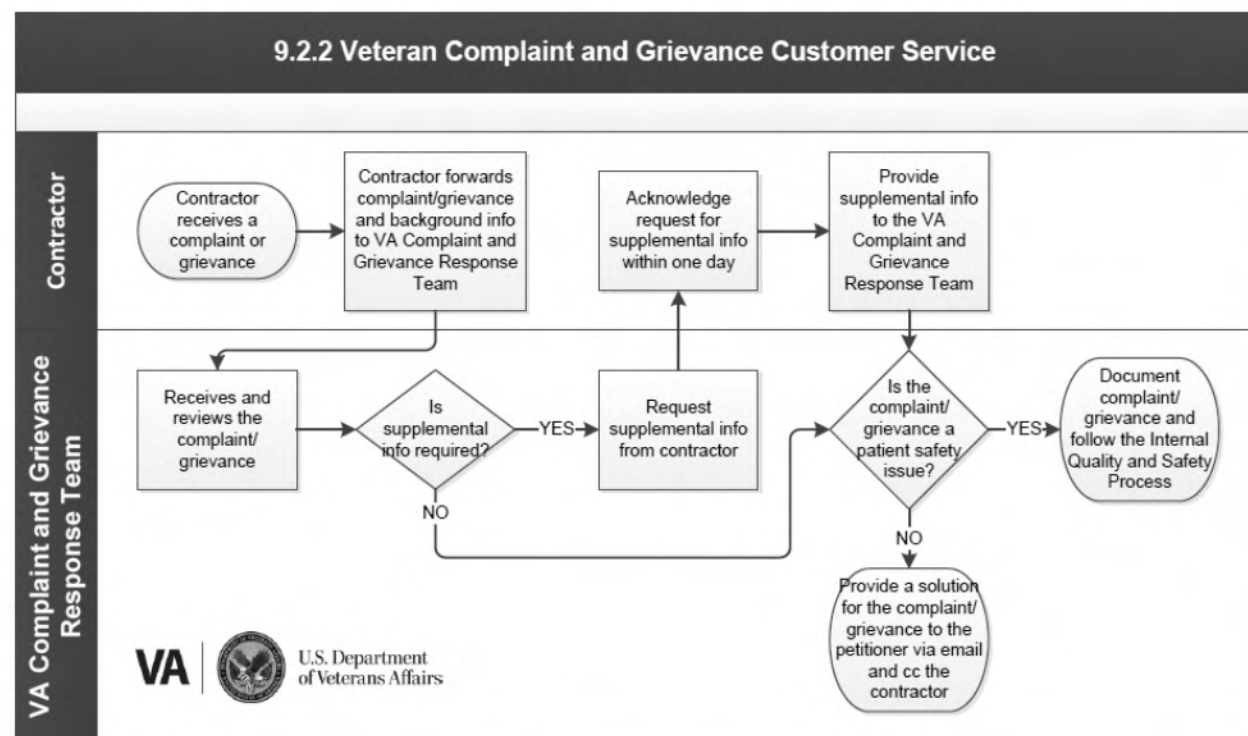
PROCEDURES - VETERAN CALLS OCC FIELD STAFF AND ISSUE REQUIRES CONTRACTOR CLARIFICATION	
Step	Activity
1	A C3 CSR receives a customer service issue.
2	C3 determines if the issue is an ACR issue or claim related inquiry.
3	<p>If the call is about an ACR issue or a Claim Inquiry:</p> <p>3a. C3 provides a warm transfer to the C4 line: 877-881-7618⁵. A Warm Transfer is defined as:</p> <ul style="list-style-type: none"> • C3 speaks directly to a C4 CSR to introduce the issue • C3 introduces the caller directly to a C4 CSR before completing the transfer. <p>Go to Step 4.</p> <p>If the call is about a Quality of Service of Safety issue:</p> <ul style="list-style-type: none"> • C3 determines if it is a quality and safety issue. If the issue cannot be resolved using guidance as provided in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>, then, • C3 may call the Contractor Call Center and provide this information. • The Contractor documents the issue and performs appropriate next steps based on contractual requirements, organizational procedures, and the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>. Next steps may include reporting the issue as a Potential Quality Issue and/or reporting the event through organizational patient safety reporting systems and including in trend reporting shared with VHA staff at identified meetings • Note: TPA's are responsible for ensuring that safe medical care is provided to Veterans by providers in their network. Each TPA is responsible for investigating adverse events and close calls that occur to Veterans who see a provider in their network through the CCN program and to ensure that appropriate follow up actions are taken when necessary • <process ends> <p>Otherwise:</p> <p>C3 follows processes outlined in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u> to resolve it.</p> <p><process ends></p>

Last Updated on: Tuesday, August 3, 2021

4	A C4 CSR receives the ACR issue or claim inquiry.
5	C4 follows their internal process to resolve the issue/inquiry. <process ends>

5.2 Veteran Complaint and Grievance Customer Service

The below flow chart illustrates the process for escalating customer service issues if a Veteran calls VA and the issue requires clarification from the Contractor.



PROCEDURES- VETERAN COMPLAINT AND GRIEVANCES	
STEP	ACTIVITY
1	The Contractor receives a complaint or grievance from the customer
2	<p>The Contractor forwards the complaint or grievance to the VA Complaint and Grievance Response Team within two (2) business days of receipt.</p> <p>A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of the PC3 contract coverage, staff supporting this program, or its providers, regardless of whether remedial action is requested.</p>

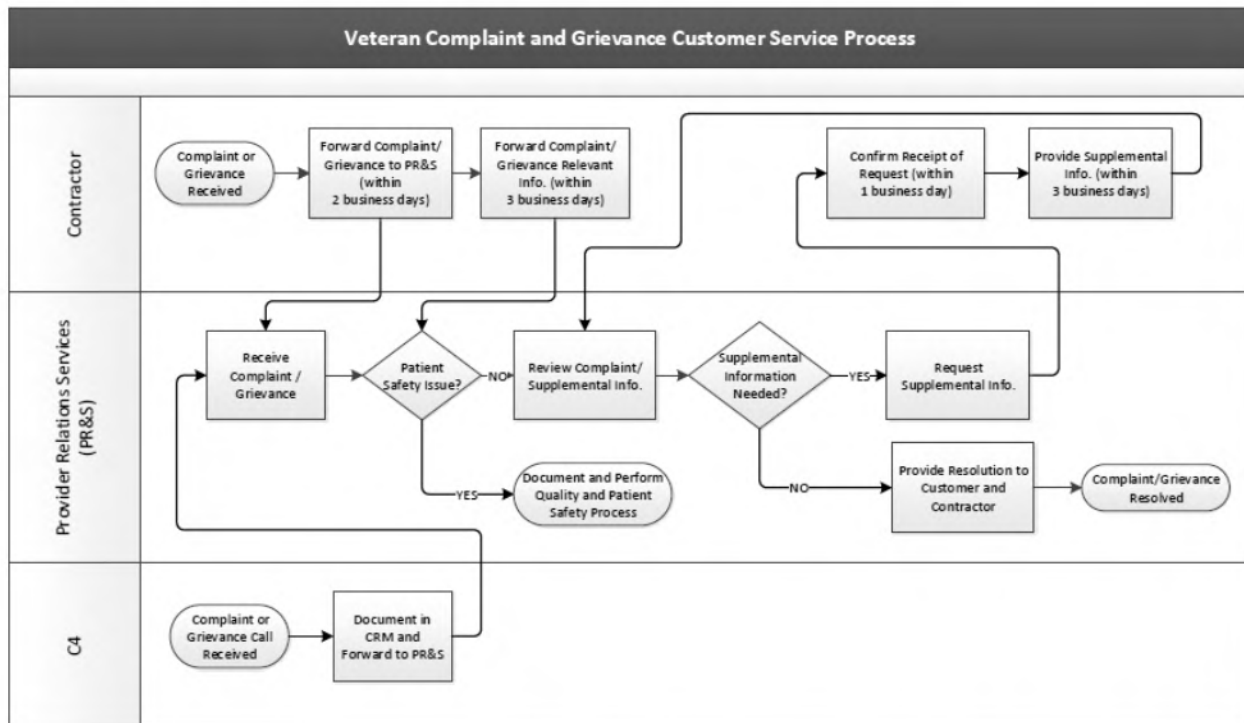
Last Updated on: Tuesday, August 3, 2021

PROCEDURES- VETERAN COMPLAINT AND GRIEVANCES	
	<p>The customer must file the grievance orally or in writing no later than one year (or 365 days) after the triggering event or incident precipitating the grievance.</p> <p>To file an oral grievance or request an appeal:</p> <ul style="list-style-type: none"> Call the Customer Service Center (or whatever it will be called) at 1-855-555-5555[®] (for TTY, please call XXX). Interpreter services are also available. A complaint or grievance may also be submitted in writing by mailing it to the following address: <p>Grievance & Appeals P.O. Box @@@@ Somewhere, USA 888888</p> <p>It can also be faxed to the following number: 222-222-2222[®]</p>
3	The Contractor forwards all background information for the complaint or grievance to the VA Complaint and Grievance Response Team within three (3) business days of forwarding the original complaint or grievance to VA
4	The VA Complaint and Grievance Response Team receives and reviews the complaint or grievance from the Contractor
5	<p>The VA Complaint and Grievance Response Team determines whether the complaint or grievance is a patient safety issue:</p> <p>If the complaint and grievance pertain to a patient safety issue, the VA Complaint and Grievance Response Team documents the complaint or grievance and follows the procedures outlined in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>. Additional guidance for reporting and investigating community care-related patient safety events can be found in Chapter 8, Section 8.3 of the Field Guidebook.</p> <p><process ends></p>
6	<p>The VA Complaint and Grievance Response Team forwards the request for supplemental information to the Contractor</p> <p>If no supplemental information is required, then the VA Complaint and Grievance Response Team will own the process for managing the resolution of all complaints and grievances, including those pertaining to a Contractor customer service agent</p> <p><process ends></p>

Last Updated on: Tuesday, August 3, 2021

PROCEDURES- VETERAN COMPLAINT AND GRIEVANCES	
7	The Contractor acknowledges the request for supplemental information within one (1) business day of receipt of the request
8	The Contractor provides supplemental information to the VA Complaint and Grievance Response Team within three (3) business days of receipt of the request
9	The VA Complaint and Grievance Response Team provides a solution for the complaint or grievance to the petitioner and CC's the Contractor via email

PR&S receives complaint and grievance information using the Complaints, Grievances and Inquires Cover Sheet template (see attachment C). The figures below outline how the VA intends to handle complaints and grievances received from Veterans. Complaint and grievance information will need to be transferred between VA and the Contractor via agreed upon secure means.



Procedure: Veteran Complaint and Grievance Customer Service Process

Steps	Activity
1	The Contractor receives a complaint or grievance from the customer.

Last Updated on: Tuesday, August 3, 2021

	<p>Or</p> <p>C4 receives a complaint or grievance from the customer.</p>
2	<p>The Contractor forwards the complaint or grievance via secure method to PR&S within two business days of receipt. See Attachment A, "Customer Service POC Sheet," for the VHA OCC Clinical Network Management, PR&S email address.</p> <p>C4 forwards the complaint or grievance via the Customer Relationship Management (CRM) to PR&S.</p> <p>A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of the CCN coverage, staff supporting this program, or its providers, regardless of whether remedial action is requested.</p>
3	<p>The Contractor forwards all background information for the complaint or grievance to PR&S within three business days of sending the original complaint or grievance to VA via secure method.</p>
4	<p>PR&S receives and reviews the complaint or grievance from the Contractor.</p>
5	<p>PR&S determines whether the complaint or grievance is a quality or patient safety issue using guidance provided in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>.</p> <p>5a. If the complaint and/or grievance pertains to a quality or patient safety issue, PR&S documents the complaint or grievance and follows the processes outlined in the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u>.</p> <p>5.b If the complaint or grievance does not pertain to quality or patient safety, PR&S determines if supplemental information is required. If required, PR&S requests supplemental information</p>
6	<p>The Contractor acknowledges the request for supplemental information within one business day of receipt of the request.</p>
7	<p>The Contractor provides supplemental information to PR&S within three business days of receipt of the request.</p>
8	<p>PR&S* provides a response for the complaint or grievance to the petitioner and CC's the Contractor via email. <process ends></p>

Note: PR&S owns the process for managing the resolution of all complaints and grievances, including those pertaining to a Contractor customer service agent.

Last Updated on: Tuesday, August 3, 2021

Adverse Credit:

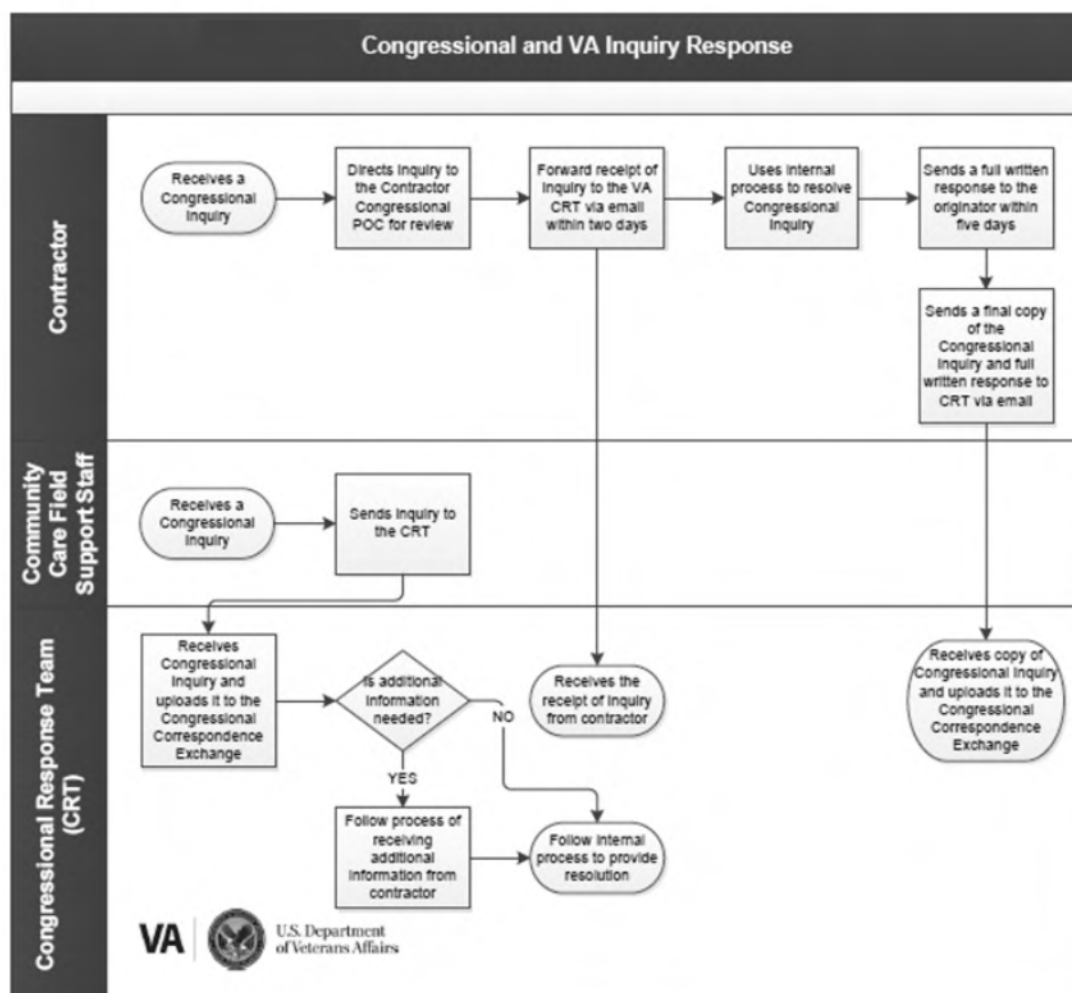
The Department of Veterans Affairs (VA) has established a Community Care Call Center for Veterans and providers to resolve debt collection issues resulting from inappropriate or delayed billing. Veterans and providers experiencing these problems can call 1-877-881-7618 (9 a.m. to 5 p.m. Eastern Time) for assistance. VA staff are also trained and ready to work with the medical providers to expunge adverse credit reporting on Veterans resulting from delayed payments to providers.

VA staff who need assistance can email the ops response closeout team:

(b)(6) @va.gov

5.3 Congressional and VA Inquiry Response

The flow chart below illustrates the way in which Congressional and VA inquiries can be received by the VA point of contact (POC) for Congressional VA Inquiries or by the Contractor directly.



Last Updated on: Tuesday, August 3, 2021

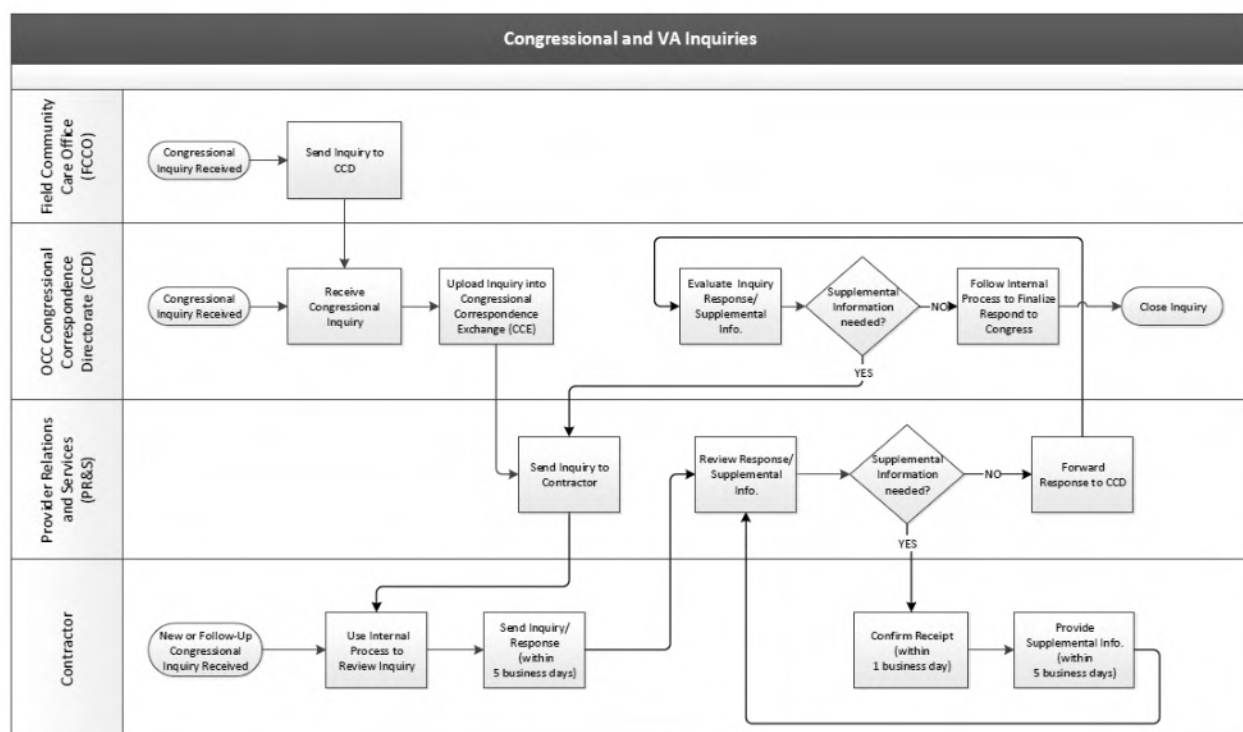
PROCEDURES - CONGRESSIONAL AND VA INQUIRY RESPONSE	
STEP	ACTIVITY
1a	OCC Field Support Staff receives a Congressional inquiry
1b	The Contractor receives a new or follow-up Congressional inquiry
2a	If the Congressional inquiry was sent to Field Support Staff, the Support Staff sends the inquiry to the Congressional Response Team (continue to step 7a)
2b	If the Congressional inquiry was sent to the Contractor, the Contractor directs the inquiry to the Contractor Congressional POC for review (continue to step 3)
3	The Contractor must acknowledge receipt of the inquiry and forward it to the VA Congressional Response Team (CRT) via email to (b)(6)@va.gov within two (2) business days and include the relevant COR
4	The Contractor uses internal process to resolve Congressional inquiry
5	The Contractor sends a full written response to the originator within five (5) business days, unless otherwise noted
6	The Contractor electronically sends a final copy of the Congressional Inquiry and full written response to CRT via email to (b)(6)@va.gov (continue to step 7b)
7a	CRT receives a Congressional inquiry from OCC Field Support Staff and uploads it. Congressional Correspondence Exchange (CCE)
7b	CRT receives a copy of a Congressional inquiry from the Contractor and uploads it to Congressional Correspondence Exchange (CCE) <process ends>
8	The CRT team evaluates the inquiry and determines if supplemental information is needed <ul style="list-style-type: none"> • If yes, a VA inquiry is created and sent to the Contractor (continue to step 9) • If no, CRT follows internal process to provide resolution <process ends>
9	The Contractor confirms receipt of the VA inquiry within one (1) business day of request

Last Updated on: Tuesday, August 3, 2021

PROCEDURES - CONGRESSIONAL AND VA INQUIRY RESPONSE	
10	<p>The Contractor provides the VA with supplemental information within three (3) business days and, if appropriate, a full written response within five (5) business days, unless otherwise noted</p> <ul style="list-style-type: none"> • CRT: Send response to (b)(6) @va.gov • Provider Relations and Services (PRS): Send response to the VA employee email address that sent the inquiry to the Contractor
11	<p>VA CRT determines if additional information is needed</p> <ul style="list-style-type: none"> • If no, CRT follows internal process to provide resolution <process ends> <p>If yes, CRT sends a VA inquiry to the Contractor (follow steps 9 and 10)</p>
12	PR&S receives an inquiry from a provider or Veteran
13	<p>PR&S determines if additional information is needed</p> <ul style="list-style-type: none"> • If no, PR&S follows internal process to provide resolution <process ends> • If yes, PR&S sends a VA inquiry to the Contractor (follow steps 9 and 10)

The table below outlines how the VA intends to process Congressional and VA Inquiries. The VA will work with the Contractor to determine a secure means to send/receive congressional and VA inquiry information between VA and the Contractor.

Last Updated on: Tuesday, August 3, 2021



Procedure: Congressional and VA Inquiry Process Description

Steps	Activity
1	<p>If facility community care office/VAMC/C3 receives a new or follow-up Congressional or VA inquiry, facility community care office/VAMC/C3 forwards inquiry to Congressional Correspondence Department (CCD); go to Step 2.</p> <p>If CCD receives a Congressional or VA inquiry, go to Step 2.</p> <p>If the Contractor receives a Congressional or VA inquiry, the Contractor sends the inquiry and any relevant information to PR&S within five business days, at (b)(6) @va.gov; go to Step 7.</p>
2	CCD uploads the inquiry into the Congressional Correspondence Exchange (CCE).
3	CCD forwards the inquiry to PR&S.
4	PR&S receives and forwards inquiry to the Contractor.
5	The Contractor uses internal processes to review the inquiry.
6	The Contractor electronically sends a full written response via secure method to PR&S within five business days.

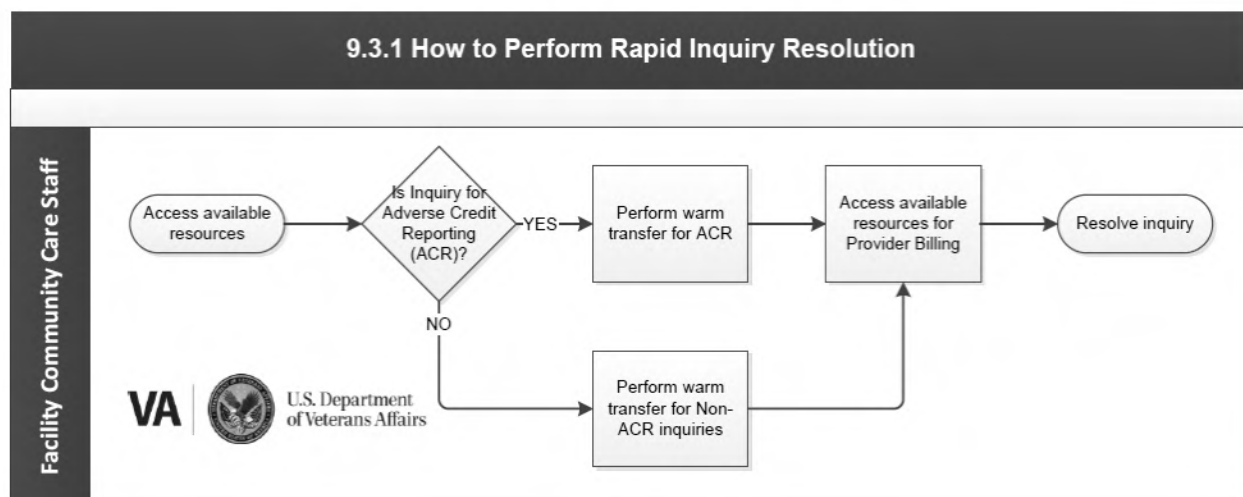
Last Updated on: Tuesday, August 3, 2021

7	<p>PR&S reviews the Contractor response:</p> <p>If supplemental information is needed, PR&S sends it back to the Contractor requesting additional data.</p> <p>If supplemental information is not needed, PR&S forwards the response to CCD; go to Step 11.</p>
8	<p>The Contractor acknowledges receipt via secure method within one business day.</p>
9	<p>The Contractor electronically sends full written response via secure method to PR&S within five business days.</p>
10	<p>PR&S reviews the Contractor response:</p> <p>If supplemental information is needed, PR&S sends it back to the Contractor; go to Step 8.</p> <p>If supplemental information is not needed, PR&S forwards the Contractor's response to CCD.</p>
11	<p>CCD evaluates the inquiry:</p> <p>If supplemental information is needed, CCD sends back to PR&S who sends to the Contractor; go to Step 8.</p> <p>If supplemental information is not needed, CCD follows internal process to finalize and submit response to Congress and close inquiry <process ends>.</p>




5.4 How to Perform Rapid Inquiry Resolution

VAMC and Facility Community Care Office staff will have quick access to updated program and clinical information to conduct rapid inquiry resolution, using community care tools including the Knowledge Management System (KMS), Community Care Hub, and the VA Community Care Website.

Last Updated on: Tuesday, August 3, 2021



PROCEDURES

STEP	ACTIVITY
1	Access Available Resources: Access information regarding VA Community Care Policy, procedures and job aids using the <u>Knowledge Management System</u> (KMS), and <u>VA Community Care Website</u> .
2	<p>Perform Warm Transfer for Adverse Credit Reporting (ACR): Warm transfer Veterans with Debt Collection or Adverse Credit Reporting to the Community Care Call Center (C4) 1-877-881-7618 .</p> <p>Community Care Contact Center</p> <ul style="list-style-type: none"> Perform Warm Transfer for non-ACR Inquiries: Warm transfer Patient Centered Community Care (PC3) general billing inquiries to 1-866-606-8198 . Warm transfer general billing inquiries outside of the PC3 to 1-866-400-1238 . Direct Veterans who would like to pay their bill to the correct resource: Online: https://www.pay.gov By Mail: Refer Veterans to the address on the patient statement
3	<p>Access Available Resources for Provider Billing: Reference the <u>Billing for VA Community Care Programs</u> Fact Sheet for Community Provider questions regarding how to file a claim.</p> <p>Providers with billing questions regarding claims paid by VA can be answered by calling the medical center and asking for VAMC office of community care.</p>

Last Updated on: Tuesday, August 3, 2021

PROCEDURES

4	Resolve Inquiry: Resolve and close inquiry using local processes and call scripting.
---	---

Best Practice: Many Facility Community Care Offices with automated call distribution (ACD) lines have identified quantifiable measures that they are able to capture and analyze. Some of these measures are: first call resolution (FCR), call abandonment rate (ABR), average speed of answer (ASA), blockage rate (or hold time), call volume, and customer satisfaction. By capturing these metrics, facility community care offices are able to measure their success in efficiently and effectively performing inquiry resolution. Additionally, routine reporting cycles allow community care leadership to review how areas of VA Community Care are meeting the expectations of stakeholders. By implementing a performance management process, facility community care offices are given a way to govern necessary adjustments or improvements to existing business processes.

5.5 How to Communicate Resolution and Conduct Follow Up with Veterans or Community Providers

Resolutions are either communicated real-time as the issue or inquiry has been resolved or a resolution message is initiated via the customer's preferred contact modality (i.e. email, text, phone call). For additional questions, please visit the [CI Solution](#) page for contact information for your Field Support Assistant and Contractor Point of Contact.

When a provider calls into the facility community care office for reimbursement (through TW or Optum) inform the provider the Office of Community Care reimburses in the following order:

- 1) Medicare rate
- 2) if no Medicare rate, VA fee schedule rate,
- 3) If neither, billed charges. The new fee rates are located

The new fee rates are located on the following website:

website: https://www.va.gov/communitycare/revenue_ops/fee_schedule.asp

Last Updated on: Tuesday, August 3, 2021

5.6 Claims Pending Authorization

The steps below must be followed, when the Payment Operations & Management (POM) Team are unable to process a claim for payment, for care that is considered pre-authorized. It is important for both POM and facility community care staff to follow this process, in order to ensure that claims that appear to be for pre-authorized care are appropriately reviewed and adjudicated.

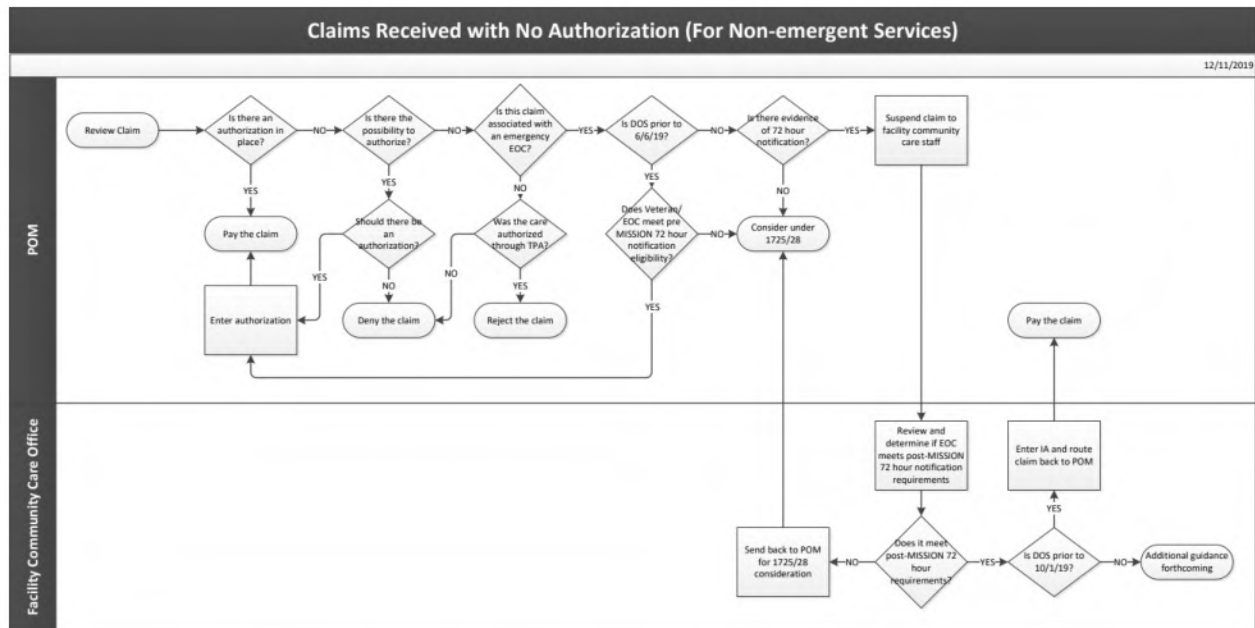
POM (Payment Operations) Responsibility

- Entry of inpatient authorizations/7078's with FY20 obligations to support SOAP process-POM staff will enter
- 7078's were entered with FY19 funding but need to be paid out of FY20 funding, thus a new authorization will be required
- Starting 10/24/19, any NEW claims (for outpatient or inpatient care) in FBCS in inventory that need an authorization entry or adjustment where either a consult exists approving the care or notification was made but not executed, POM staff will enter the auth in FBCS
- This ONLY applies to approved care with dates of service 9/30/19 and earlier. No Individual Authorizations for care are to be entered for services 10/1/19 and later.
- These claims will be suspended for POM 1703 Auth Entry queue

Facility Responsibility

- Review claims with 72-hour notification from 6/6/19-10/1/19 for eligibility determination and "in-network" review
- Maintain this gap process to ensure claims received for DOS prior to 10/1/19, but not referred to TPA or authorized, can be covered.

Last Updated on: Tuesday, August 3, 2021



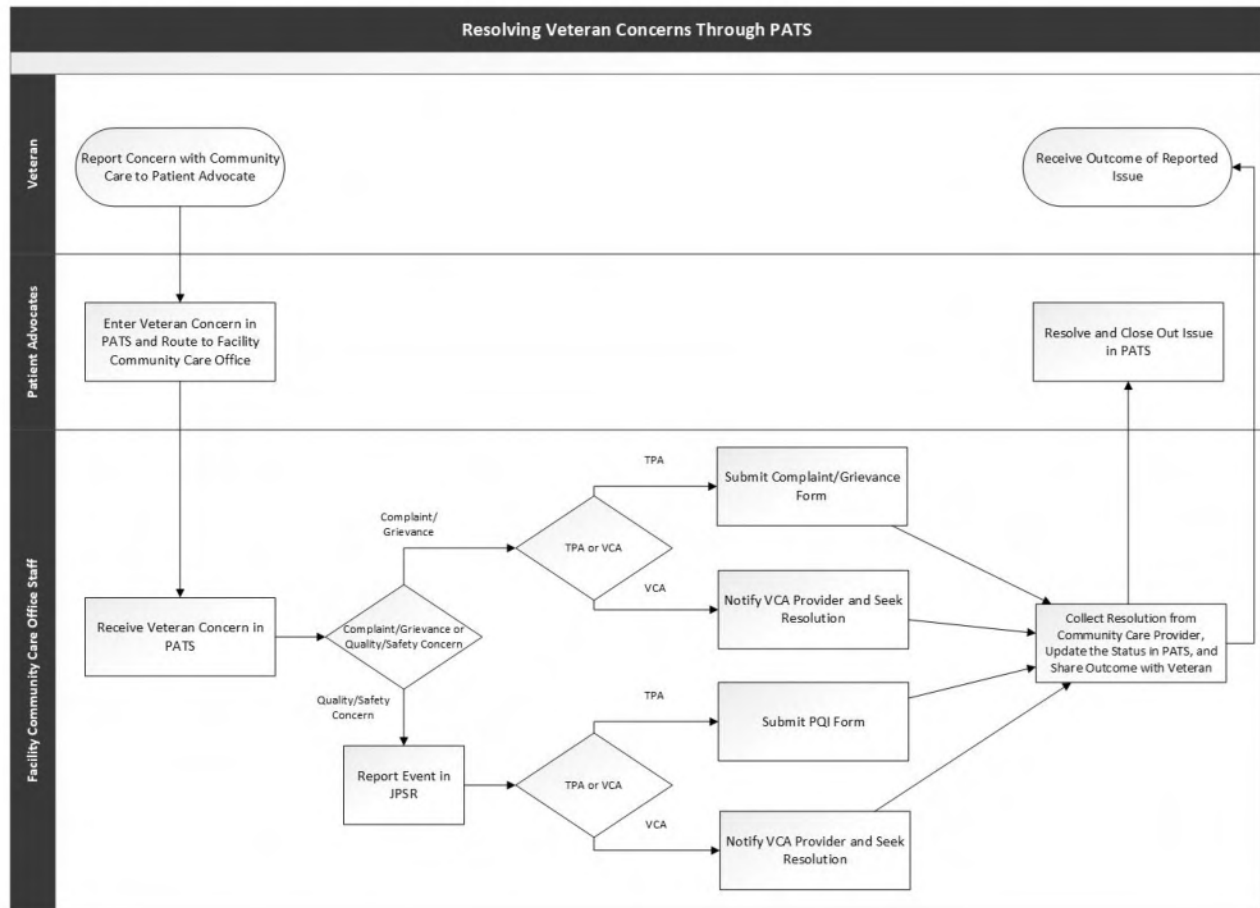
- Review claims currently suspended for authorization adjustment or entry in facility queues and enter an authorization, if prior to 10/1; or a VCA post 10/1.

NOTE: There is no specific claims process post 10/1 for 72h notifications for authorized emergency care if not referred to TPA timely. Solutions for legal remedies to cover unexecuted authorizations/referrals is being explored. For the process on authorized emergency care reference Chapter 6 of the Office of Community Care Field Guidebook.

Last Updated on: Tuesday, August 3, 2021

5.7 Patient Advocate Tracking System (PATS)

The steps below must be followed when a Veteran reports a concern regarding community care to a Patient Advocate (PA).



PROCEDURES

STEP	ACTIVITY
1	Veteran (or representative) reports a concern with community care to a PA.
2	<p>The PA documents the Veteran's concern in PATS.</p> <ul style="list-style-type: none"> The PA will assign the incident to the Community Care service line in PATS, which will route the concern to the facility Community Care office for resolution.

Last Updated on: Tuesday, August 3, 2021

PROCEDURES	
3	<p>Facility Community Care Office staff receive the Veteran Concern in PATS and determine if it is a complaint/grievance or a health care quality/patient safety concern.</p> <ul style="list-style-type: none"> • If the concern is a complaint/grievance, go to Step 4. • If the concern is a quality or patient safety concern, go to Step 5.
4	<p>For complaints and grievances related to a CCN Contractor, facility Community Care staff report as follows:</p> <ul style="list-style-type: none"> • To report for CCN Regions 1 through 3 (Optum): <ul style="list-style-type: none"> ○ Complete <u>Optum's Grievance Form</u>. ○ Submit to Optum per the form's instructions (i.e., mail or fax). Please note, fax is an electronically secured method of communication, protecting sensitive information included in the form (e.g., SSN and DOB). • To report for CCN Region 4 through 5 (TriWest): <ul style="list-style-type: none"> • Complete <u>TriWest's Complaint/Grievance Form</u>. • Submit to TriWest per for the form's instructions (i.e., mail or fax). Please note, fax is an electronically secured method of communication, protecting sensitive information included in the form (e.g., last four digits of SSN, DOB, and Member ID). <p>For complaints and grievances related to non-CCN community providers (e.g., VCA), contact the community provider, report the concern, and request resolution, if applicable.</p>
5	<p>For health care quality and patient safety concerns, facility Community Care staff report the issue in the <u>Joint Patient Safety Reporting System</u> (JPSR).</p> <p>For health care quality and patient safety concerns related to a CCN Contractor, facility Community Care staff also report as follows:</p> <p>To report for CCN Regions 1 through 3 (Optum):</p> <ul style="list-style-type: none"> • Complete <u>Optum's PQI Referral Form</u>. • Submit to Optum per the form's instructions (i.e., mail, fax, or e-mail). Please note, fax and e-mail submissions are electronically secured methods of communication, protecting sensitive information included in the form (e.g., Social Security Number [SSN] and Date of Birth [DOB]). <p>To report for CCN Regions 4 through 5 (TriWest):</p> <ul style="list-style-type: none"> • Complete TriWest's <u>Health Care Quality Concern Form</u>. • Submit to TriWest per for the form's instructions (i.e., mail, fax, or <u>email</u>). Email submissions must be sent as "encrypt only". Please note, fax and email submissions are electronically secured methods of communication,

Last Updated on: Tuesday, August 3, 2021

PROCEDURES	
	<p>protecting sensitive information included in the form (e.g., last four digits of SSN, DOB, and Member ID).</p> <p>For health care quality and patient safety concerns related to non-CCN community providers (e.g., VCA), contact the community provider, report the concern, and request resolution.</p> <p>Refer to the <u>Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook</u> for further guidance.</p>
6	<p>Upon receipt of the community provider's resolution or response:</p> <ul style="list-style-type: none"> • Facility Community Care staff document the community provider's resolution, as applicable, in PATS and submit (through PATS) to the PA for review and closure. • Facility Community Care staff share the outcome with the reporting Veteran (or representative).

5.8 Community Care Eligibility Appeals

In accordance with our regulation 38 CFR 17.4010(d) appeals for eligibility are subject to the VA clinical appeals process. The VA clinical appeals process follows VHA Directive 1041.

§17.4010 Veteran eligibility.

(d) Review of veteran eligibility determinations. The review of any decisions under paragraph (a) of this section are subject to VA's clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.

VHA Directive 1041:

a. **Community Care.** Decisions concerning eligibility for community care under the Veterans Community Care Program (VCCP) pursuant to 38 U.S.C. § 1703(d) and (e) are, by law, medical determinations and are subject to the clinical appeal process described in this directive. For more information, see 38 U.S.C. § 1703(f). Eligibility decisions determine whether the Veteran can elect to receive care in the community; not what care will be provided. **NOTE:** For specific questions about VCCP appeals, please contact (b)(6) @va.go

4. POLICY

a. It is VHA policy that VA employees follow procedures and timelines established in this directive to ensure that clinical appeals are processed and decided in a fair,

Last Updated on: Tuesday, August 3, 2021

impartial, and timely manner to promote, preserve, or restore the health of veterans. Employees should make every effort to resolve disputes at the lowest level possible.

b. Clinical appeals regarding decisions under 38 U.S.C. § 1703(d) and (e) concerning eligibility for community care under the Veterans Community Care Program will be adjudicated and decisions communicated to the person(s) submitting the appeal within 3 business days of receipt by the VA medical facility PA or VPAC. All other clinical appeals will be adjudicated, and decisions communicated to the person(s) submitting the appeal within 45 business days of receipt by the PA or VPAC, except in instances where an external review is necessary. If an external review is necessary for any appeal at the VISN, adjudication and communication must occur no more than 60 business days from the date the VPAC received the appeal. The VISN must provide updates to the person(s) submitting the appeal if the appeal requires an extended timeframe beyond the 45 business day

5.9 Customer Relationship Management (CRM)

Customer Relationship Management (CRM) will be utilized to document incoming calls. All medical information will be documented in a Veteran's electronic health record.

What is CRM?

The Customer Relationship Management (CRM) application is a tool to manage all VA community care interactions with Veterans and Providers. It is a tool that provides VA employees (local and national) a consistent way to manage customer interactions in real-time. CRM helps improve business relationships with our customers, specifically focusing on consistency in resolving Veteran needs. CRM is a product of Microsoft Dynamics and provides a comprehensive customer service solution that is familiar to users across the Veterans Health Administration (VHA). The application is completely customizable to VA business processes and scalable to meet our changing environment.

CRM delivers up-to-date information directly to all users' desktops giving them the tools to deliver accurate, consistent, efficient service that enhances customer confidence and loyalty.

What are the Benefits of CRM?

CRM is a web-based software application that makes day-to-day management of Veteran care easier by:

- Streamlining business processes
- Unifying data from various locations
- Providing a single consolidated view of stakeholder information
- Providing single sign-on access to VA systems
- Eliminating redundant data entry
- Improving quality of information provided/actions taken

Last Updated on: Tuesday, August 3, 2021

- Enhancing caller experience

Why use CRM?

All VHA offices and departments that support VA community care can use CRM to aid in facilitating processes for our Veterans and our Providers. The use of CRM provides one location to access information across all departments and provides cross-system coordination. Additional reasons include:

- Easy to access information that provides history of previous calls, escalated issues, and resolutions
- Standardized business processes to ensure accurate, consistent, and professional responses to all stakeholders
- Improved reporting by providing tracking numbers and capturing types of calls received
- Insight into why, when (time and frequency), and how customers contact VA, which can be used to help improve overall customer experience
- Improved communication between Veterans, community providers, VA employees, and credit agencies, when necessary

Additional information is located in the [CRM Standard Operating Procedure \(SOP\)](#).

5.10 Job Aids

The table below includes job aids that are currently available to all VA staff and can be accessed via any computer on the VA network. These job aids will assist in providing VA staff with accurate and consistent information to offer Veterans and Community Providers, with the goal of improving the overall customer experience

Document	Description	Audience
<u>Contractor Operation Guide</u>	This document is meant to supplement information provided in Section 6 of the Community Care Network (CCN) Contracts for Regions 1, 2 and 3 regarding Customer Service activities.	All VA Staff

Last Updated on: Tuesday, August 3, 2021

Additional Training



TMS	Community Care Hub
<ul style="list-style-type: none"> • TMS- 4411363 Customer Experience Overview • TMS VA 4444216 Communicating Effectively & Efficiently- Establishing Provider Relationships • TMS VA 4444217 How to Implement and Maintain Provider Relationships 	



ChjNote: 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 6: Managers and Leads References

Monitoring and Improving Community Care Performance	6.0	<u>Managers and Leads References</u>
	6.A	<u>Coronavirus (COVID 19) Guidance for Community Care Consult Referral Management</u>
	6.1	<u>Monitoring and Improving Community Care Performance</u>
	6.2	<u>How to Evaluate Site Performance Response</u>
	6.3	<u>How to Evaluate Referral Management Community Care Consults</u>
	6.4	<u>How to Evaluate Referral Management Timeliness</u>
	6.5	<u>How to Evaluate Secondary Authorizations Requests (SARs) / Notifications for TriWest</u>
	6.6	<u>How to Evaluate Health Share Referral Management (HSRM) Measures</u>
	6.7	<u>How to Use the Office of Community Care Top Metrics Report</u>
	6.8	<u>Enterprise Program Reporting System (EPRS)</u>
How to Implement Site Improvement Initiatives	6.9	<u>How to Manage Clinical Appeals for Eligibility</u>
	6.10	<u>PC3 Closeout Guidance</u>
	6.11	<u>How to Implement Site Improvement Initiatives</u>
	6.12	<u>How to Implement Improvement Action Plans (IAPS)</u>

How to Report and Investigate Community Care-related Veteran Safety Events	6.13	<u>How to Use the Community Care Support Center (CCSC) Consult Improvement Toolbox</u>
	6.14	<u>OCC Staffing Tool</u>
	6.15	<u>How to Report and Investigate Community Care-related Veteran Safety Events</u>
Best Practices	6.16	<u>Facility Best Practices</u>
Available Community Care Reports	6.17	<u>Community Care Reports</u>
OCC CACMI	6.18	<u>CACMI Process-Guidance-Artifacts</u>
Fee Schedule	6.19	<u>Published 2021 VA Fee Schedule</u>
Referral Coordination Initiative	6.20	<u>Veterans Integrated Service Network (VISN) Referral Coordination Initiative (RCI) Standards and Expectations for Fiscal Year (FY) 21</u>

6.0 Managers and Leads References

Community Care Network Access Extension Waiver Process: The purpose of this guidance is to provide managers and leads with information on the TriWest Transition Out Overlap Extension Waiver process. To ensure Veterans have access to quality health care while OPTUM continues to contract providers into identified service gaps, OCC is implementing a waiver request process for VAMCs in Regions 1, 2 and 3 to continue using the Patient Centered Community Care (PC3) TriWest network, for a designated timeframe, while Optum grows their network to meet each VAMC's network needs.

For additional information, please see the [10N Memo](#) released December 2019.

For additional guidance on how to execute the TriWest Healthcare Alliance Patient-Centered Community Care Network Extension Wavier Process, click [here](#).

Information Regarding the Administrative Closure Report

Note: Managers should make sure to convey to their staff that administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care. Below are instructions on how to run the Administrative Closure Report to view consults that were administratively closed without obtaining clinical documents.

This report must be ran at least monthly up to the ninety (90) day period from the scheduled appointment and efforts must be made and documented in the consult toolbox that the missing records were once again requested from the community provider.

Managers: After ensuring backlog has been reviewed, the Administrative Closure Report should be utilized in the monthly TPA/VA meetings in order to escalate med doc issues

The ability to run the report will require access to the Corporate Data Warehouse (CDW). For further instructions for CDW access, follow the link to the [CDW Support Site](#), then click "[CDW Guide: Introduction and Policies](#)", under Guides in the left-hand navigation pane.

Link to Report:

https://vaww.cc.cdw.va.gov/sites/CC_ConultsTB/Dashboards/CommCareClosedWoRecords.rdl?Web=1

Community Provider Resources:

- [VHA Community Care Provider Public Website](#)
 - This site provides the latest information for community providers. From here they can access the latest news, policy changes, and health care

program updates as well as learn how to join the VA Community Care Network.

- [HSRM Community Provider Information Sheet](#)
- [HSRM Account Creation Information Sheet](#)
- [HSRM Help Desk Support Information](#)
- [HSRM Community Provider Quick Reference Guide \(QRG\)](#)

6.A Coronavirus (COVID 19) Guidance for Community Care Consult Referral Management

- The [Internal VHA and Facility Community Care Open Office Hours PPT](#) from September 29 and September 30, 2020 is now available for review.
- The [Community Care Guidance for Changes to Consult Referral Management during COVID-19 PPT](#) is now available for review.

Updated Guidance on User of COVID-19 Priority Designations for Consults

As per the Memorandum titled “Use of COVID-19 Priority Designations for Consults” released on **May 13, 2021**, the memorandum is to provide updated guidance on the previously released DUSHOM Memo titled “[Changes to Consult/Referral Management during COVID-19](#)” published on September 15, 2020. This memorandum mandated that the Consult Toolbox (CTB) be used for all consults/referrals classified as Priority 1 or 2 for all services to ensure that Veterans’ care needs were scheduled according to priority and instructions provided during the COVID-19 pandemic.

- With the release of this updated guidance, services and specialties that have expanded care delivery to at least 90% of pre-pandemic volumes are no longer required to use the COVID-19 CTB tab Priority 1 and 2 designations for both direct and community care triage. Medical center leadership may continue to mandate the use of the COVID-19 CTB tab priority levels as deemed clinically necessary. It is the expectation that all sites are back to pre-pandemic volumes and standard business operations 3 months from the release date of this memorandum. This requirement may be re-assessed in 3 months, based on specific site needs.
- For current and future expansion statuses, sites should use the Expansion of Services Analysis Report:
 - <https://app.powerbigov.us/groups/me/apps/b908b748-e172-4073-af16-d8a5e580d013/reports/9be437ae-708f-4965-b03f-fcd386fa14b7/ReportSection9237426c223541d0a25b?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf>
- Requirements for consult/referral review when priorities are already designated remain as published in the DUSHOM Memo titled “National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065– COVID-19 Upgrades” on May 8, 2020 and are as follows:

- **Priority 1:** consults/referrals should be reviewed clinically to assure there is no change in clinical need for care if not scheduled.
 - Once clinically reviewed and documented, these should be reviewed administratively every 7 days until scheduled.
 - **Priority 2:** consults/referrals should be reviewed twice monthly until scheduled.
 - **Priority 3 and 4:** consults/referrals should be reviewed every 30 days until scheduled.
 - **Consults without designated priorities:** Consults should be reviewed every 30 days until scheduled.
- Additionally, the following guidance regarding the review of consults/referrals is outlined below:
 - If scheduled for care at some future date, then no further review is required.
 - If scheduled and linked to an appointment that was subsequently no showed/cancelled without rescheduling, local clinical leadership may mandate clinical review prior to rescheduling.
 - If scheduled and linked to an appointment in the past, then administrative review is required to determine if care was received.
 - If care was received, complete the consult.
 - If the care was not received local clinical leadership may mandate clinical review prior to rescheduling.
 - If in scheduled status but not linked to an appointment, an administrative review should be completed in advance of clinical review to identify scheduling needs.

Updated Guidance on Community Care Eligibility for Consults Impacted by COVID-19:

As per the Memorandum titled “Changes to Consult Referral Management During COVID-19” released on September 15, 2020 the following guidance applies to community care.

- Community Care wait time guidance for unscheduled internal consults impacted by COVID-19.
- Process for capturing the next available internal appointment date at the time of forwarding internal consult to community care.
- Guidance on when and how to capture community care scheduling challenges using the consult toolbox (CTB) and Provider Profile Management System (PPMS).
- Guidance on when and how to use the next available internal appointment date on a forwarded consult to assist Veterans when discussing their scheduling options.
- Process for scheduling the request if unable to schedule with Community Care Network (CCN) provider.

Wait Time Guidance for Unscheduled Consults Impacted by COVID-19

Per the memo released on 9/15/20 Veterans whose consults have been impacted by COVID-19 are wait time eligible for CC when an unscheduled consult/return to clinic date has a patient indicated date (PID) between 1/1/2020 – 9/15/2020.

How to Apply Community Care Wait Time Eligibility Guidance in Memo released 9/15/2020	
Patient Indicated Date (PID)/Return to Clinic Date	Community Care Wait Time Eligibility
1/1/2020-9/15/2020	Veteran is community care eligible.
Prior to 1/1/2020; or After 9/15/2020	<p>Standard MISSION Act guidance applies.</p> <p>The Wait Time Standard (WTS) for community care must be considered if both of the following applies:</p> <ol style="list-style-type: none"> 1.The PID/Return to clinic date is within 20 or 28 days (based on the type of care being requested) from the FED//RTC request date. 2.The appointment within the VA cannot be scheduled within the 20/28 days of the file entry date/RTC request date.
Effective 9/24/2020	

How to Apply Wait Time Eligibility for New vs. Established Patient

New patients

- If PID is within 1/1/2020-9/15/2020, community care wait time eligibility should be provided as an option to the Veteran.
 - Reminder – other community care eligibility must be reviewed and may still apply
- If PID is outside of 1/1/2020-9/15/2020, follow standard MISSION Act guidance.
 - If the PID is within 20/28 days of the File Entry Date (FED), and there is no internal appointment available within the wait time standards (WTS), there is wait time eligibility for CC.
 - If the PID is outside 20/28 days WTS of the FED, the Veteran is not wait time eligible for community care
- Established patients
 - If PID/Return to Clinic Date is within 1/1/2020- 9/15/2020, community care will only be discussed if the Veteran asks about community care eligibility to keep continuity of care within the VA

Note: This process is slightly different from standard practice and only applies to those consults/RTC Clinic Date between 1/1/2020 – 9/15/2020.

- **More information - Office of Community Care Field Guidebook Chapter 2, Section 2.0**

Capturing Next Available Internal Appointment Date

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



ADDED COMMENT 09/17/20 07:33
Next Available Internal VA Appointment Date: 10/25/20

Consults Impacted by COVID-19- Capturing Scheduling Challenges

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. As per the Memorandum titled "[Changes to Consult Referral Management During COVID-19](#)" open and unscheduled consults/referrals should now be dispositioned. Capturing Scheduling Challenges Training:

In response to the COVID-19 pandemic, March 2020 guidance advised that consults should not be cancelled or discontinued for COVID-19 related reasons. If Veterans still wanted care but did not want to schedule due to COVID-19 related concerns, that guidance instructed sites to leave consults/referrals open and to contact the Veteran on a regular basis to re-assess the clinical care needs and the Veteran's desire to schedule.

1. Any consult/referral left open per previous guidance that subsequently received a virtual care appointment (video to home, telephone, e-consult) within the same

stop code can be closed with documentation of a completed appointment if there is evidence upon clinical review that the care needs of the Veteran were met.

2. Any consult/referral for which a Veteran has been previously contacted and has declined in-person care due to COVID-19 related concerns should be addressed accordingly.
 - a. The Veteran should be contacted again and offered virtual care (VVC/telephone) in place of face-to-face care if clinically appropriate.
 - b. If the Veteran declines virtual care modalities due to COVID-19 related concerns the Veteran should be provided a choice to schedule an appointment in VA or in the community, if they are eligible.
 - c. If the Veteran is offered all clinically appropriate options for care and does not wish to schedule an appointment at VA or in the community the following actions should take place:
 - i. The specialty care team should make every effort to complete the internal consult/referral as an e-consult if clinically applicable.
 - ii. Community care consults/referrals will be cancelled, and the referring provider will be notified for any additional follow up actions needed.
 - d. If the consult/referral cannot be resolved by any of the above, the consult/referral should be cancelled.
 - e. All staff should communicate to the Veteran that VA will welcome them if they wish to seek this care in the future.
3. Clinical procedure consult/referrals that remain clinically indicated but are unable to be scheduled due to COVID-19 concerns may remain open or use future care consults. Further guidance will be forthcoming.

Capturing the next Available Internal Appointment Date

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

Guidance on Community Care Utilization of CTB Appointment Tracking Tab when unable to schedule community care consults.

In OIGs June 2020 "[Review of VHA's Appointment Management During COVID-19 Pandemic](#)" document, it is recommended the Office of Community Care monitor community care referrals impacted by COVID-19. In response and for the [OCC CACMI](#) efforts, OCC is mandating that facility community care staff utilize the Consult Toolbox

(CTB) Appointment Tracking tab, specifically the “Return from Community Care Provider” section to track scheduling challenges in the community. It is important to note that at this time and until the CTB can be updated, the Appointment Tracking Tab section titled “Return from Community Care Provider” within the CTB is being repurposed to monitor these scheduling challenges. This will enable local, regional, and national monitoring ability to work with the Community Care Network (CCN) Third Party Administrators (TPA) to enhance the Community Care Network through a better understanding of the local COVID-19 related or other network adequacy issues. More information can be found in the [Capturing Community Care Scheduling Challenges and Addressing Network Adequacy Reference Sheet](#).

Facility community care office staff will follow the process outlined in the [OCC SOP Guidance on Community Care Utilization of CTB Appointment Tracking Tab](#) once they have received a community care consult for scheduling purposes in order to capture this information. This guidance applies to future care consults when the CID is within 30 days of the date the community care staff is attempting to schedule the care. A comprehensive breakdown of this process is available via the Capturing Community Care Scheduling Challenges & Addressing Network Adequacy training recording.

At the time of scheduling a community care consult, facility community care staff will utilize the Provider Profile Management System (PPMS) to locate appropriate in-network providers that can render the care requested.

Facility community care office staff will follow the process outlined in the [OCC SOP Guidance on Community Care Utilization of CTB Appointment Tracking Tab](#) once they have received a community care consult for scheduling purposes in order to capture this information. This guidance applies to future care consults when the CID is within 30 days of the date the community care staff is attempting to schedule the care.

The Office of Community Care has created [the Scheduling Challenges Report in VSSC](#). This report is available to identify the specific community care consults that have a documented scheduling challenge.

[Capturing Community Care Scheduling Challenges and Addressing Network Adequacy Live Demo](#)

U.S. Department of Veterans Affairs | PPMS

Note: VA Facilities will always display on the locator. PPMS does not define specialties for VA Facilities.

Search Location (Required): (b)(3):38 U.S.C. 5701; (b)(6)

Specialty: POS Code: Sub-Service

Provider Specialty (Required):

- Clinic/Center - Multi-Specialty
- Dermatology
- Dermatology - MOHS-Micrographic Surgery
- General Acute Care Hospital
- General Acute Care Hospital - Critical Access
- General Acute Care Hospital - Rural
- Multi-Specialty

Provider Network:

- CCN Region 4

Provider Details:

Radius: Drive Time

Radius (Max 500 Miles): 25 Sort By: Distance

Search

When searching for an available community care provider, staff should:

1. Set the search parameter radius to their normal default settings (minimum of 25 miles).
2. Expand search parameters by *an additional 45 miles* if unable to locate in-network community providers within the default 25-mile radius.

Radius: Drive Time

Radius (Max 500 Miles): 70 Sort By: Distance

Search

3. Ensure that provider has available appointments within 90 days from the date the facility Community Care staff is calling to schedule.
 - a. If the provider is both in network and verifies appointments are available within 90 days, facility Community Care staff can proceed with scheduling appointment as normal, following the guidance in Chapter 3, of the Office of Community Care Field Guidebook.
4. If the provider is not currently scheduling appointments for routine care, has closed permanently due to COVID or does not have availability within 90 days:
 - a. Capture Activity in PPMS to document the outcome of the discussion with the provider's 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.
 - b. Proceed with contacting up to five (5) in-network community providers to secure and appointment.
 - c. If this is a recurring issue, request the local facility Community Care manager submit a Network Adequacy report via the SharePoint request.

If no in-network providers are found or no in-network provider has availability within 90 days of calling to schedule, staff will use the CTB to document the failed effort by selecting “Network Issues-No Network Provider Available” or “CCN Return Reason- No CCN Provider Available to Schedule Within Timeliness Standard” using the CTB Appt Tracking Tab.



CTB Version 1.9.0078

Community Care Comments - Consult Toolbox version 1.9.0078

MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | **Appt Tracking** | SAR/RFS | Consult Completion

☐ Provider requires records to review prior to scheduling
☐ Documents Uploaded to TPA Portal
☐ Records faxed/sent to Community Care Provider
☐ Follow up call made to provider/vendor to check on status
☐ Time sensitive appointment, NLT: Cal
☐ Community Care appt. has been ☒ scheduled ☐ re-scheduled
 Appt. Date: Cal
 Comment:

Actual/Approved Provider Information

☐ Update record with above information
 Available Community Care Facility & Provider Locator

☐ Veteran informed of scheduled appt by: Opt
☐ Referral Authorization Packet Mailed to Veteran

A failed scheduling effort occurs when calls and letters per VA policy have failed to result in a completed patient appointment or patient has exceeded the number of missed appointments allowed.

Returned from Community Care Provider:

Service Not Provided in CCN

- Referral Issues (select specific issue)
 - Network Issues (select specific issue)
 - No Network Provider Available
 - VA Requested Providers Outside of Network
 - Veteran Requested Specific Provider
 - Appointed with Incorrect Provider/Type of Care
 - Already Appointed
 - Veteran Declined (select specific reason)
 - Appointment Issues (select specific issue)
 - CCN Return Reasons (select specific issue)
 - No CCN Provider Available to Schedule Within Timeliness Standard
 - No CCN Providers Available to Schedule Within Drive Time Standard
 - Veteran Prefers CCN Provider Outside of Drive Time Standard
 - Veteran Willing to Accept CCN Provider Outside of Drive-Time Standard
 - Veteran Willing to Accept CCN Provider Outside of Timeliness Standard

Disposition of returned referral:

Missed Community Care Appointment, care still Active/Pending:

- ☐ Veteran declined/refused—using alternate source of payment
- ☐ Veteran declined/refused community care
- ☐ Refer to clinical reviewer for disposition after unsuccessful scheduling effort

Visit VA Consult Help Site for additional consult management guidance.

OK



CTB Version 2.0

If no in-network providers are found or no in-network provider has availability within 90 days of calling to schedule, staff will use the CTB to document the failed effort by selecting “No CCN Provider Available” or “No available appointments within 90 days” using the CTB Appt Tracking Tab.

Consult Toolbox v2.0.0

What's New TBD
 Help
 Logout

Veteran Name
PATIENT, TEST

 Date of Birth
Jan 1, 1900 (121)

Residential Address
 (b)(3):38 U.S.C.
5701; (b)(6)

Consult to Service/Specialty
cardiology

 Urgency
Routine

 CID
04/18/2021

 Seen As
Outpatient

Community Care Eligibility
 ? Not Established

CC CONSULT COMMENT

 Consult Review
 CC Eligibility (DST)
 Contact Attempts
 Patient Preferences
 Admin Screening
 Clinical Triage
 DoD Consult
Appointment Tracking
 Request for Service (RFS)
 Consult Completion
 View Consult History
 User Settings
 SAVE CHANGES

Appointment Tracking

Copy provider info from CPL and paste into text below
[Open Community Care Provider Locator](#)

Actual/Approved Provider Information

Appointment tracking details

☐ Provider requires records to review prior to scheduling
☐ Documents uploaded to HSRM
☐ Records faxed/sent to community care provider
☐ Follow-up call made to provider/vendor to check on status

Veteran informed of scheduled appointment via

-- Select --

Responsible for Scheduling *(required)*

-- Select --

Reason Referral could not be processed

-- Select --

Additional Comments

-- Select --

Already appointed
 DoD unable to schedule
 Duplicate referral
 Excluded CCN healthcare service
 Missing VA data
 No available appointments within 90 days
 No CCN provider available
 Unable to contact Veteran
 VA requested return
 Veteran canceled or did not attend appt.
 Veteran deceased or incapacitated

Staff Can Reference the [Network Adequacy Reference Sheet](#) to determine if care in the community is outside of Accessibility/Drive Time or Appointment Availability standards.

Potential Scheduling Actions to Take:

If no network provider is available within CCN drive time standards, or within 90 days of

If unable to schedule, Community Care staff may then follow their local process with guidance from the [Care Coordination](#) section of the Field Guidebook Chapter 3.

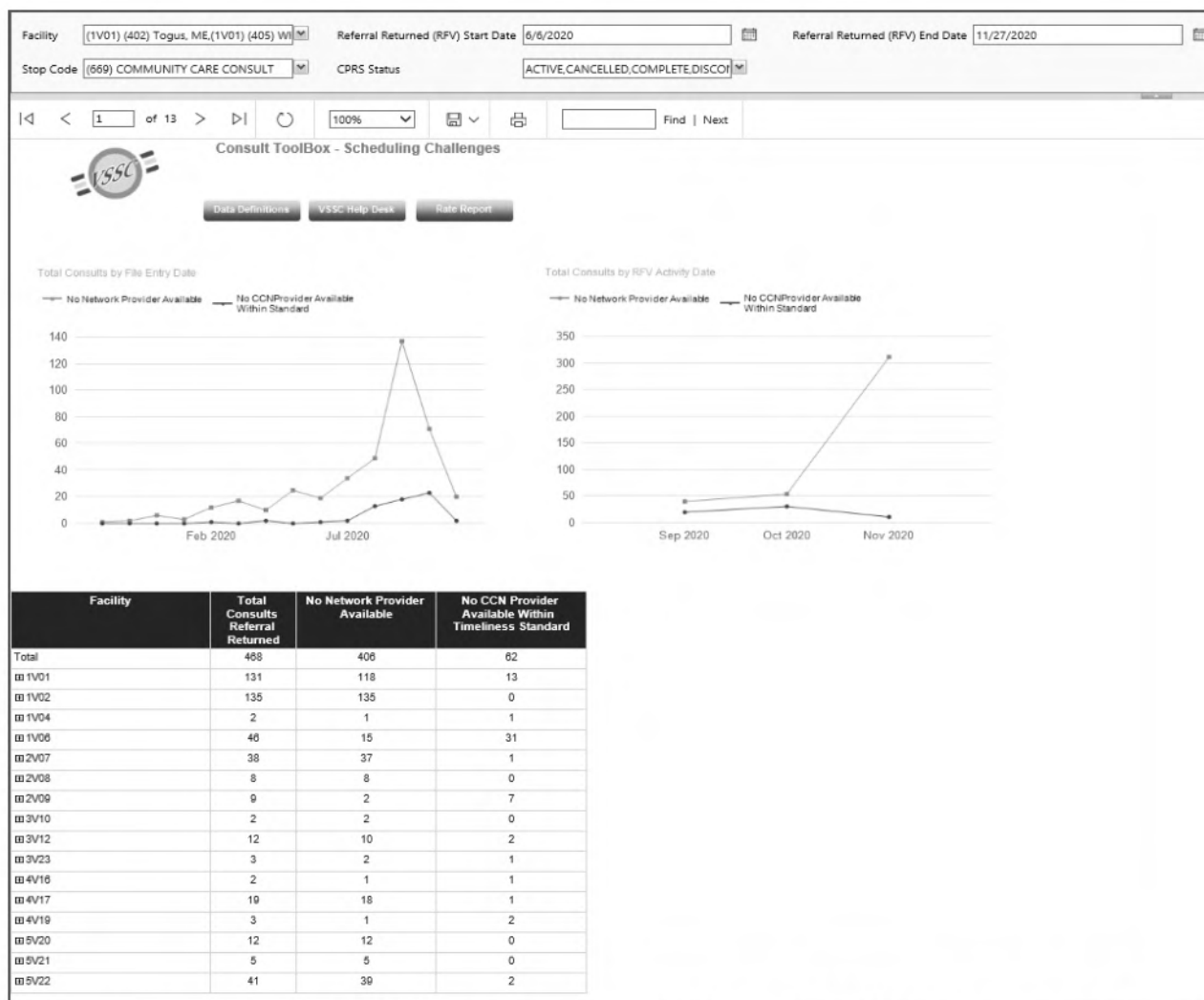
Scheduling Actions that should be taken:

- Confirm your search was expanded to utilize the maximum CCN drive time standards.
- [Document scheduling challenge using the CTB option indicated.](#)
- Determine if the care can be rendered by out of network provider utilizing a Veteran Care Agreement (VCA).
- If no network provider or VCA provider is available, determine if the care can be rendered within the VA, and if appropriate after discussion with the Veteran forward the consult back to the internal service for scheduling purposes.
- If the care is not available within the VA, ensure to follow the appropriate care coordination process including making the > 90-day appointment if Veteran agrees and adding Veteran concurrence as part of your comment.

SV-SPOKE TO VETERAN AND EXPLAINED PREFERRED PROVIDER DOES NOT HAVE ANY APPOINTMENTS AVAILABLE UNTIL 03/25/2020, VETERAN AGREES TO WAIT FOR APPOINTMENT WITH PREFERRED PROVIDER.

*NOTE: When scheduling with VCA provider, staff should still capture **network** scheduling challenges by documenting in CTB prior to scheduling the appointment with the VCA provider.*

The Office of Community Care has created [the Scheduling Challenges Report in VSSC](#). This report is available to identify the specific Community Care consults that have a documented scheduling challenge. This report will be shared by OCC to the TPA for review and follow up.



Please ensure to select all Stop Codes, not just Stop Code 669 for Community Care.

Network Adequacy SharePoint

<p>The purpose of the Network Adequacy SharePoint is to:</p>	<p>Document recurring CCN network access issues; SharePoint reporting should be utilized after network access concerns have been brought up to the TPAs during monthly Network Adequacy meetings and have not been resolved.</p> <p>OCC's Network Support team will review submissions and follow up with the facility and TPAs accordingly</p> <p>Document the contractually required Network Adequacy Monthly meetings</p>
<p>The <u>Network Adequacy SharePoint</u> is the one-stop-shop for all network adequacy resources to include:</p>	<ul style="list-style-type: none"> • Network Adequacy Overview • Network Adequacy Guidebook • Monthly Meeting Checklist • Monthly Reporting Form • VA Market Assessment Documents • CCN Require for Proposal (RFP/contract) • Network Adequacy Deviation Template • Regional and OCC Points of Contact

Community Care Eligibility as Part of the Moving Forward Plan

As VA Medical Centers begin to remodel and schedule Veterans for VA appointments the following process must be followed in order to determine community care eligibility based on wait time standards:

- **New Patients with Consults:**

- When internal VA consults are cancelled or when new consults with no initial appointment scheduled due to COVID-19 and there is no new PID documented by a clinician, the original File Entry Date (the date the consult was entered) in comparison to the original PID is used to determine community care eligibility based on wait time standards.
- If a new PID (documented by a clinician in the consult comments or using the Consult Toolbox COVID 19 options) is within 20/28 days of the File Entry Date, and there is no internal appt available within the WTS, there is wait time eligibility for CC.
- If the new PID is outside 20/28 days WTS of the File Entry Date, the Veteran is not wait time eligible for community care

- **Established Patients:**

- When established Veteran appointments are canceled by clinic (including those canceled due to COVID-19) the date of the appointment request (i.e. RTC order or recall date) is used to determine community care eligibility based on wait time standards
- When rescheduling appointments cancelled due to the pandemic, community care eligibility based on WTS depends on eligibility at the time the original appointment was scheduled
- If the veteran was eligible for community care, due to wait time, at the time the original appointment was scheduled they are still eligible when rescheduling
- If the veteran was not originally eligible for community care, due to wait time, then then they are still not eligible when rescheduling

- **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

In light of the COVID-19 Pandemic, the Veterans Health Administration (VHA) must take action to ensure the clinical needs of Veterans are met and that Veteran safety is protected to the greatest degree possible. In many instances, protecting Veteran safety will mean postponing non-urgent, routine care. This is particularly true for Veterans who are in a high-risk category for COVID-19. This action is consistent with current Centers for Disease Control and Prevention (CDC) recommendations.

The CDC guidance for Clinics and Healthcare Facilities is:

- Healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment, and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic:
 - Delay all elective ambulatory provider visits
 - Reschedule elective and non-urgent admissions
 - Delay inpatient and outpatient elective surgical and procedural cases
 - Postpone routine dental and eyecare visits¹

Many community health care systems are implementing CDC recommendations, which will affect capacity for referrals for non-urgent and non-emergent care.

Veterans are also following CDC guidance for personal protection to prevent the spread of COVID-19 (including frequent hand washing and putting distance between yourself and other people particularly for those at higher risk of illness)² and VA anticipates that most Veterans have already made decisions to postpone elective and non-urgent care in light of the pandemic.

The current risk of exposure to COVID-19 will often outweigh the benefits associated with in-person delivery of certain routine, elective, and non-emergency appointments, whether delivered at VA or in the community through the Veterans Community Care Program (VCCP). Thus, this care will be shifted to e-consults, telephone, and telehealth care whenever possible. When the immediacy or severity of the Veteran's condition necessitates in-person care despite the risk of COVID-19, this care will be scheduled in VA facilities or in the community as appropriate and as available.

¹ <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>

² <https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>

VHA has taken steps at our facilities to protect Veterans by enhancing screening at entrances and prior to visits via telephone calls, limiting visitors, and launching a robust communications campaign on how to limit exposure to COVID-19. As noted, consistent with current CDC recommendations, VHA is also postponing all non-urgent procedures and studies. Before adjusting any current schedules, each facility is reviewing scheduled care and studies to determine if the care can safely be postponed or provided through virtual visits. All Veterans with non-urgent needs are encouraged to have virtual outpatient visits instead of their previously scheduled face to face appointments. VA is already seeing a rapid and encouraging rise in telephone and telehealth care. VA will also be communicating with Veterans regularly and through multiple means (email, telephone, text message and mail) in order to ensure that they are fully aware of and understand how to utilize these telehealth and e-consult services and so that any changes in health status are addressed throughout the course of the pandemic.

VHA issues the following guidance to assist VA providers with clinical determinations regarding individual Veteran care:

- Referral to the community for emergent or urgent clinical needs will continue, and VA will work to ensure care coordination and safety given the increased risk environment with COVID-19. VA's network of emergency care and urgent care providers in the community is available for eligible Veterans.
- **For routine care:**
 - VA providers should use e-consults, VA telehealth, or telephone visits for routine visits, provided the Veteran has the technological means to connect and a virtual visit is clinically appropriate.
 - Scheduling decisions should be reviewed on a case-by-case basis and should take into account the individual Veteran's needs, including COVID-19 related risks, market variation regarding local community provider availability, or community level emergency response efforts including social distancing. Where the severity or immediacy of the Veteran's medical need (e.g. certain chronic disease management, maternity care, pain management therapies) outweighs the COVID-19 related risks, care should be scheduled within VA or in the community as appropriate. Non-urgent procedures and studies previously scheduled in VA and postponed due to COVID-19 will be rescheduled in VA, or in the community if VCCP eligibility is met, once services are resumed.
 - Facility community care offices should be scheduling routine care based on community provider availability in their local market, to include scheduling telehealth appointments and scheduling community care appointments into the future, when clinically appropriate.

Veterans receiving care in the community for prior referrals including but not limited to chemotherapy, dialysis, and other chronic conditions should continue with this care, and are encouraged to take advantage of community provider telehealth capacity when appropriate.

The duration of any surge in cases and acute demand due to COVID-19 is unknown. VA will assess the care environments continuously and communicate decisions every 30 days. VA will continue to provide real-time updates on the status of care in VA facilities and in our community network, ensuring Veterans are informed and empowered during this time of national challenge.

COVID-19 Referral Extension –

In response to delays in treatment due to COVID-19, all HSRM referrals (except those in a cancelled or EOC complete status) that have an expiration date between March 1st to July 31st will be extended to now expire on September 30th, 2020.

This update will occur in HSRM and does not require action from facilities.

The following SEOC groups will be excluded from the extension:

- Emergency Care
- Unauthorized Emergency Care
- Inpatient
- Transportation
- Adult Day Health Care
- Homemaker-Home Health Aide
- In Home Respite Care

Updates will include CCN, PC3 and VCA referrals in HSRM. TriWest will update PC3 referrals entered in the TW portal. VCA's entered in to FBCS are not included in the automated extension but facilities can adjust manually if needed. Episodes of care in HSRM cannot exceed 365 days in total, although some referrals may have automatically been extended beyond 365 days based on the SEOC duration.

Community Care Telehealth Guidance:

- Office of Community Care is currently working with TriWest and Optum to enhance telehealth capabilities in the community. It is important to note, telehealth is an option for community care appointments under CCN and PC3, to include the first appointment when clinically appropriate.
 - Telehealth services may be provided through both CCN and PC3 utilizing the Medicare guidelines*
 - Optum and TriWest will be able to pay for the telehealth services if the Veteran agrees, the scope of services is appropriate for a telehealth visit and the parties have the ability to have the services be performed as a telehealth service
 - The CPT codes on the SEOCs do not need to be updated for TH appointments. Both TPAs have been directed to pay telehealth visits even though the CPT codes are not explicitly listed in the SEOC.

- It is important to note, many CCN and PC3 providers may not be aware of the ability to provide community care services via telehealth due to the rapid pace of changes, both TriWest and Optum are working diligently to communicate this to providers.
- Providers can bill using the Medicare telemedicine methodology and guidance
 - CMS Telemedicine Healthcare Provider Fact Sheet
 - CMS Telehealth Codes

If the community care scheduling actions are being done by the Third-Party Administrator (TPA), the facility community care management must coordinate with the TPA to understand the community capacity and any specific actions being taken by the community providers for cancelling or rescheduling community care appointments.

If the TPA is conducting scheduling actions for community care, the same protocols would be used as if the VA was scheduling, meaning only urgent/emergent referrals should be coordinated by the TPAs to reduce the burden on health care resources in your community.

It is important to note, if the care is appropriate for community care the consult should still be routed for action, based on clinical urgency.

Facility community care management should be working side-by-side with the facility clinical leadership to provide timely information regarding community care appointment availability for care deemed medically necessary for community care, to include any availability communicated by the TPA, when appropriate.

If the community care requested is not considered to be time- sensitive, based on clinical review, the consult shall be kept in an active status with COVID19 added as a consult comment and the community care appointment should be scheduled at a later time, based on local determinations taking into account the current status of the COVID pandemic. It is important to note, the clinical review process must be completed prior to the COVID19 comment being added to the consult. The clinical reviewer must determine and communicate scheduling urgency on the consult. If it is determined the care is routine and can be scheduled later, then the COVID19 comment can be added. For consults considered urgent/emergent for scheduling purposes the facility community care staff must prioritize the scheduling action.

If community care is the appropriate option after other appointment modalities have been considered, the consult must still be routed to community care office for action. It is important to note, the referral coordination team or specialty clinic should review the consult to determine if the care being requested can be delivered within the VA, when appropriate.

All consults for outpatient community care, without a scheduled appointment care must be clinically reviewed for clinical urgency, based on clinical triage and the consult placed in an active status. This includes consults for care not available within the VAMC.

If the care is clinically appropriate to coordinate later, based on the clinical review outcome, a comment must be added to the consult, which states COVID19. This will allow facilities to track the affected consults for coordination of the community care appointment later. It is important to note, the clinical review process must be completed prior to the COVID19 comment being added to the consult. The clinical reviewer must determine and communicate scheduling urgency on the consult. If it is determined the care is routine and can be scheduled later, then the COVID19 comment can be added. For consults considered urgent/emergent for scheduling purposes, the facility community care staff must prioritize the scheduling action.

This same guidance applies for consults in a scheduled status, where the first community care appointment is cancelled due to COVID 19.

Guidance: When to Refer to Community Care during the COVID-19 Pandemic:

- Referrals to community care will be based on MISSION Act eligibility.
- Community care eligibility is a factor in the following scenarios:
 - Service is not available within the VAMC - if the service is not scheduling appointments due to the Pandemic, the service is considered not available and therefore the care can be referred to the community.
 - Veteran is being scheduled for a face to face VA appointment
 - Best Medical Interest (BMI) for the patient based on clinical review-after review by specialty clinic or Referral Coordination Team, and Veteran opt-in to community care
- Community care eligibility may not be a factor when the Veteran is being scheduled for a virtual appointment within the VA, i.e. VA Video Connect (VVC), Telehealth (TH), Telephone
 - If the Veteran requests to know his/her community care eligibility or states he/she is eligible for community and would like to be seen in the community, then at that time we do have to honor the Veteran's request. It is important to ensure that the Veteran is aware of the available appointment modality options within the VA and that staff share any safety considerations and appointment availability in the community.
- Referrals to community care will be scheduled based on clinical urgency and market availability and safety considerations
- If the Facility is in the Moving Forward Phase and due to local market surge of COVID-19, is required to pause their Moving Forward plans the above also applies.

Community care wait time eligibility for Veterans whose internal VA appointments were canceled by clinic.

- When internal appointments are canceled by clinic the original file entry date (the date the consult was signed) or for established Veterans, the date of the appointment requests (based on the Return to Clinic Order or Recall Date) is used to determine community care eligibility. If a rescheduled appointment cannot be made within 20 days for primary care mental health or 28 days for specialty care from the

file entry date for new or appointment request date for established Veterans, the Veteran will be wait time eligible for the rescheduled appointment.

- However, if the original consult/appointment request for that appointment had a PID greater than 20 or 28 days from the day the consult was signed or appointment request was made (RTC Order or recall date), the Veteran is not wait time eligible for community care even for the rescheduled appointment.

VSSC Reports for to track consults with COVID-19 comment or CTB scheduling priority designation and cancelled appointments with COVID-19 comment:

Below is the step by step process on how to run this report for your facility:

1. Access the report using this link
<https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Access/Appointment+-+COVID+Cancellations&rs:Command=Render>.
2. Set the parameters for your facility. Please work with your facility Clinical Applications Coordinator (CAC) to identify the primary stop codes for all your community care consults, in order to ensure proper selection. Most community care consults are set to the 669-stop code as primary, but there are some nuances that may apply. Display SSN Details should be set to true in order to get patient SSN level data.

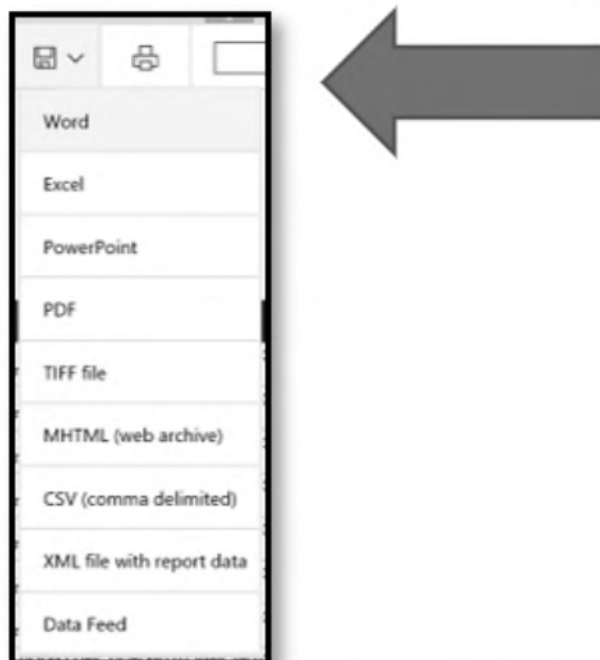
The screenshot shows a web-based report viewer interface. It includes several input fields for search criteria:

- Facility:** A dropdown menu with the selected value "(4V19) (554) Aurora, CO HCS".
- Primary Stop Code:** A dropdown menu with the selected value "(102) ADMITTING/SCREENING,(103) TE".
- Start Date:** A date input field with the value "3/20/2019" and a calendar icon.
- End Date:** A date input field with the value "3/20/2021" and a calendar icon.
- Display SSN Details:** A radio button group with "True" selected (indicated by a filled circle) and "False" (indicated by an empty circle).
- View Report:** A button located on the right side of the form.

3. Once all your parameters are set, click view report and the SSN level data will be provided (you must have SSN level access). Click on the floppy disk and select your export option in order to export to a workable file (recommend exporting to Excel or CSV).

For guidance on how to obtain SSN level data access please reference the following link:

<https://vaww.vhadataportal.med.va.gov/Support/FAQs.aspx#DataAccessVSSC>



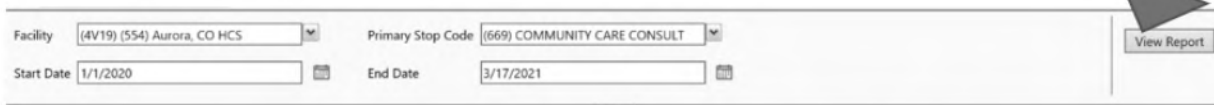
4. Facility community care offices and facility leadership can use this report to determine the number of consults with COVID19 comment added, by consult status. This report can serve as a worklist once the facility begins to address these consults for care coordination needs.
5. If the facility community care office is notified of a community provider appointment cancellation due to COVID 19 preventative actions or due to patient preference, the facility community care office must cancel the community care appointment in the system by taking the following actions:
 - a. Cancel the appointment by clinic, with a reason of other and capture COVID19 in the appointment cancellation comment. The appointment should be cancelled in VSE or VistA by facility community care staff.
 - b. Clinical triage to determine rescheduling urgency must be done in order to identify the timeframe in which the care should be delivered.
 - c. A comment must be added to the consult, which states COVID19. This will allow for consult tracking for coordination of the community care appointment later. It is important to note, the clinical review process must be completed prior to the COVID19 comment being added to the consult. The clinical reviewer must determine and communicate scheduling urgency on the consult. If it is determined the care is routine and can be scheduled later, then the COVID19 comment can be added. For consults considered urgent/emergent for scheduling purposes the facility community care staff must prioritize the scheduling action.
 - d. It is important to confirm that the first appointment has not taken place. Once the first appointment has taken place, the referral should not be modified, and the consult should remain in a scheduled status. The

Veteran should work with the community provider to schedule any additional appointments, as appropriate.

- e. All appointments cancelled due to COVID 19 are available as a sub report. Link:

[https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fAccess%2fAppointment+-+VA+Video+Connect+\(VVC\)+Recovery&rs:Command=Render](https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fAccess%2fAppointment+-+VA+Video+Connect+(VVC)+Recovery&rs:Command=Render)

When running this report ensure to select the appropriate facility and 669 as the primary stop code. Additionally, the appointment start and end date is based on the scheduled appointment date. Once the appropriate parameters are set click "view report".



- f. If a Veteran's community care appointment is cancelled, it is important for a clinical triage to take place to determine the Veteran's clinical needs and if rescheduling with another community provider is appropriate. Clinical triage should be documented appropriately in the Veterans medical record.
- g. A [letter](#) for community providers has been developed by the Office of Community Care in order to assist facility community care offices with communicating with community providers regarding community care appointment cancellations.

Note: Once the appointment is cancelled using VSE or VistA the following actions MUST be taken in HSRM for the referral to reflect the appropriate status:

- In HSRM find the appropriate referral using the Unique Consult ID
- Once the correct referral is selected, on the far-right hand column select the 3 horizontal dots and select "Additional Referral Information"
- Locate the appointment listing
- Select the appointment impacted by selecting booked under the status column
- Click Change status
- Update to cancelled and give reason of COVID 19
- DO NOT cancel the HSRM referral- Only the appointment needs to be cancelled

Note: In the cases where the community provider is not available for the appointment (i.e. due to provider illness), the appointment would be cancelled by clinic. The same process outlined in section b above would be followed, the only difference is that the appointment is cancelled by clinic.

For PC3 referrals scheduled utilizing HSRM, when the initial appointment is cancelled due to circumstances derived from COVID-19, do not cancel the appointment in HSRM. This would result in TriWest returning the referral. Instead, cancel the appointment in VSE or VistA in order for the consult to reflect an active status and add comment to the consult to state COVID19 for tracking and follow-up.

Guidance for existing consults that are associated with a cancelled appointment

1. After clinical triage for urgency has been complete, the consult should be kept in active status and COVID19 entered as a comment on the consult. It is important to note, the consult actions and appointment cancellation is only required if it is the first community care appointment. It is important to note, the clinical review process must be completed prior to the COVID19 comment being added to the consult. The clinical reviewer must determine and communicate scheduling urgency on the consult. If it is determined the care is routine and can be scheduled later, then the COVID19 comment can be added. For consults considered urgent/emergent for scheduling purposes the facility community care staff must prioritize the scheduling action.
2. If the cancellation is for a subsequent appointment the cancellation will be captured in HSRM (if appropriate) with COVID 19 FOLLOW UP added to the HSRM comments. No appointment actions are needed in VSE or VistA, as the initial care has already been given. A comment of COVID19 must be added to the consult for tracking purposes.

In the cases, where the Third-Party Administrator (TPA) is responsible for scheduling the community appointment, the facility will also need to monitor notifications to capture any notifications for cancellations of the first community care appointment. Once notified, the facility should follow the steps outlined in a and b above and ensure to work with the TPA to reschedule the community appointment, once appropriate.

1. The ability for eligible Veterans to request community care appointment through VA Online Scheduling (VAOS) will be turned off. This is in order to ensure that referrals to the community are being appropriately reviewed and clinically triaged for clinical appropriateness and urgency. **VAOS has been turned back on effective 8/17/2020.**
2. If a consult is in place for the care, the consult will be placed and kept in an active status with COVID19 added as a consult comment and clinically evaluated and prioritized, as appropriate based on clinical review. It is important to note, the clinical review process must be completed prior to the COVID19 comment being added to the consult. The clinical reviewer must determine and communicate scheduling urgency on the consult. If it is determined the care is routine and can be scheduled later, then the COVID19 comment can be added. For consults considered urgent/emergent for scheduling purposes, the facility community care staff must prioritize the scheduling action.
3. Emergency Care Treatment: At this time, there is no change to VAs existing emergency care authorities related to COVID 19. VAMCs are not permitted to refer patients for out of network emergency Care at VA expense. All instances of

a Veteran reporting to a local emergency room will be evaluated for authorization and payment as per existing emergency treatment authorities.

4. Community care emergency treatment guidance is available in chapter 3 of the Office of Community Care Field Guidebook
5. Resources have been developed to provide community providers with COVID 19 guidance regarding the VA actions and coverage for COVID 19 testing in the community.

https://www.va.gov/COMMUNITYCARE/providers/COVID-19_Guidance.asp

NOTE: The following three (3) letters have been developed for facility community care offices to send to Veterans regarding their status of community care referrals and/or appointments:

- **Letter to Veterans Active Consult for Routine Care on Hold**
 - This letter should be used for those Veterans that have a consult in Active status and that consult has been clinically reviewed and determined to be for routine care. This letter explains to the Veteran their Active consult has been determined to be for routine care and due to COVID 19 situation, routine appointments are not being scheduled in the community at this time. This letter informs the patient that their facility community care office will contact them with details and to coordinate a community care appointment when appropriate.
- **Letter to Veterans First Community Appointment Scheduled and Cancelled due to COVID 19**
 - This letter should be used for those Veterans that have their first routine community care appointment scheduled and that appointment has been cancelled due to the COVID 19 situation. This letter explains to the Veteran their community care appointment was cancelled, why the appointment was cancelled, and informs them their facility community care office will contact them to coordinate this care when appropriate.
- **Letter to Veterans to Notify of Action for an Approved Referral**
 - This letter should be used for Veterans who have an ongoing episode of care, where the community care appointment was cancelled. This letter will explain they need to contact the community provider to reschedule and that the facility community care office will work with the Veteran and the community provider to ensure that they have an active referral for the rescheduled appointment.

Resources

- Frequently Asked Questions (FAQs) regarding consults, scheduling, etc. may be reviewed on the COVID 19 FAQ document.
- The Community Care-COVID 19 Consult and Referral Management Office Hours PowerPoint is also available for review.
- Community Care COVID Testing Consult Process PPT

Guidance on Handheld Fetal Doppler for Virtual Maternity Care; COVID-19

- The tele-health landscape is evolving rapidly in response to the COVID 19 global pandemic. Maternity care in the community is increasingly being provided virtually. Some community OB providers have requested that patients obtain hand-held fetal dopplers for guided use during virtual prenatal visits. The FDA has recently updated their guidance for use of these devices, in response to the COVID 19 pandemic. VA should support the OB provider and Veteran by obtaining the (prescription) devices and shipping directly to the Veteran's residence.
- Hand-held fetal dopplers should not be ordered for use outside of virtual visits or telehealth and should only be used with real time guidance from a maternity care provider. Outside of the global pandemic, it would not be recommended that pregnant patients attempt assessing the fetal heartrate at home, given the risk for error, and false reassurance (mistaking maternal heartbeat for fetal heartbeat).
- **Process for Obtaining Handheld Fetal Doppler:**
 - Veteran's Maternity Care Coordinator (MCC) will obtain a prescription or order for hand-held fetal doppler from the Veteran's maternity care provider in the community (usually by fax).
 - The MCC at the VA facility will then enter a request to Prosthetic and Sensory Aids Service (PSAS). PSAS will support a consult requests for these devices during Covid-19 pandemic (short term) and the consult to PSAS must indicate the ICD 10 code U07.1 COVID-19 to ensure proper accountability and authority to provide the fetal doppler during this time.
 - Local PSAS services will procure the device and drop ship to the Veterans address. Same business practices for all other DME.
 - MCC to inform the Veteran that the order has been placed, and to expect a delivery.
 - MCC to remind the Veteran that the hand-held doppler is to be used only with real time guidance from their maternity care provider.
- **Reasonable Models:**
 - There are many products on the market for listening to fetal heartbeats. Not all of them are appropriate or FDA-approved for this purpose. Two reasonable options that would meet the needs for virtual visits are below. There may be other models that are reasonable, if you are unsure, please reach out to (b)(6) at (b)(6)@va.gov for assistance.
 - Sonotrax Basic A Fetal Doppler Baby Heart Monitor (approx. \$200.00)
 - Sonoline B Fetal Doppler (approx. \$70.00)
 - Please contact (b)(6) Senior Maternity Care Consultant-WHS (Central Office) with additional questions at (b)(6)@va.gov

Consult Toolbox (CTB) COVID-19 Tab

Background

On March 30, 2020 a memorandum titled “Guidance on Access Standards in response to Coronavirus (COVID-19) Updated” was released, which provided guidance to assist VA providers with clinical determinations regarding individual Veteran care during the COVID-19 pandemic.

The memorandum specifically provides guidance on the scheduling prioritization of care considered urgent/emergent and clinical factors to consider for care considered to be routine for clinical purposes.

In support of this guidance the Office of Veterans Access to Care (OVAC) and Office of Community Care (OCC) have partnered to create the Consult Toolbox COVID-19 tab in order to allow designated end users to document the clinical review and scheduling guidance for scheduling requests both within the VA and community care.

The COVID-19 tab was made available with the release of Consult Toolbox (CTB) 1.9.0063 and all subsequent versions.

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.

Implementation

- Users who have not enabled the toolbox will need to follow the guidance in the [Consult Toolbox SharePoint Site](#) to enable the CTB.
- CTB 1.9.0072 was pushed out to users with the COVID-19 tabs already enabled
- The CTB Community Care COVID-19 Priority tab is accessed from the Community Care Functions and was removed from the Receive Consult menu option.
- COVID-19 Priority 2, 3, 4 descriptions and associated consult factor text will be updated for clarity, as follows:
 - COVID-19 Priority 1: Care should be appointed despite COVID-19
 - COVID-19 Priority 2: For scheduling once authorized by clinical review: New patient visits for conditions with possible decline and for community care consult scheduling based on local market availability.
 - COVID-19 Priority 3: Optional grouper, your department defines what this means: Routine clinical practices for care of complex chronic diseases, new or established. Postponing by months likely not to affect patient health status.

- COVID-19 Priority 4: Optional grouper, your department defines what this means: Less urgent than Priority 3. Substantial delays unlikely to lead to decline in health status (screening). Note: CTB verbiage cannot be changed to reflect local guidance issued by the department/clinical service for Priority 3 and 4.)

All specialty care teams should use the associated prioritization document to assist with clinical triage found here:

https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NA/ACAO/ConsultManagement/SiteAssets/SitePages/Consult%20Toolbox/Prioritization%20for%20Consultations%20Procedures%20and%20Appointments_v3.pdf

Facility community care offices should schedule all care based on scheduling urgency, community provider availability in their local market. In addition, schedule telehealth appointments and community care appointments in the future, when clinically appropriate.

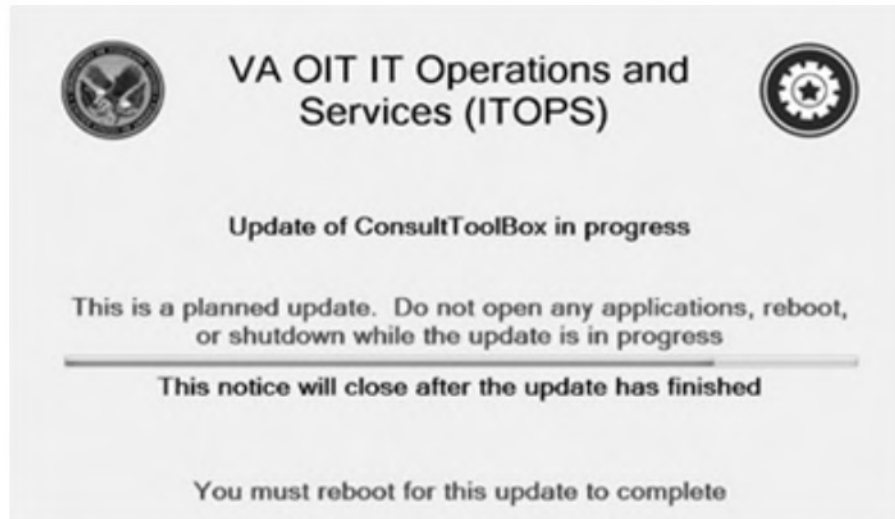
- New screens will appear to prompt users to select Receive Consults or Add Comments with the COVID 19 options enabled
- Use of CTB COVID-19 tab is highly encouraged, however if CTB is not used **you must capture the COVID19 comment on the consults for reporting/tracking purposes**
- For additional information on the use of the COVID19 tab to include guidance on the use of CTB to capture scheduling priority during the pandemic, an overview of CTB and CTB COVID19 scheduling priority reports and an implementation timeline and requirements please refer to the following training:

VA 4557774 [Webinar: Consult
Toolbox and the
Use of COVID-19
Tab](#)

- All end-users can assist by keeping their devices 'ON' and connected to the VA network.
- Remote users who access the VA network through RESCUE (Cisco AnyConnect) can assist by remaining logged in (leave your PIV card inserted and connected) during off hours, continuously. When finishing with their tour of duty, remote users should reconnect to Rescue which will extend their network access by 23 additional hours.
- **Note: Important Deployment & Reboot Information:** All existing maintenance windows will be ignored until this deployment is complete. A restart (reboot) of affected workstations is required to complete installation of CTB.
- A warning message (see screen shot below) will display to the users indicating a reboot is required.
- User may choose to delay the reboot; however, a reboot will occur within 60 minutes after the warning message displays. A 60-minute countdown clock will display in the

lower right-hand corner of the user's display. This will allow providers and users time to prepare for the reboot.

- Usage of Consult Toolbox should not occur until after a system reboot. This is necessary because profile configuration settings are saved during the post reboot installation.



When taking action on a Community Care consult, there are two (2) options within the Community Care Referrals Sub-Tab to move the consult from pending status to active status; Receive Consult or Add Comments. It is important to note both options will move the consult from a pending status to an active status.

Facility community care offices will need to ensure to monitor both pending and active consult to take appropriate consult management actions in a timely manner.

Items to note:

- Consults for Community Care should be clinically reviewed by the Delegation of Authority or designated clinical staff.
- At the time of review scheduling priority should be assigned based on clinical needs
- Telehealth options in the community will be used when available and clinically appropriate

Receive Consult- Community Care Functions Option

Open Community Care Consult

- Action
- Consult Tracking
- Receive Consult

Receive Consult

Comments

- Copy
- Paste
- Cut
- Undo
- Receive Consult**
- Community Care Functions
- Settings

Date/time of this action: Now

Action by: (b)(6) PHYSICIAN ASSISTANT

OK Cancel

You must choose the Community Care Functions Option

- Click the box next to Accept new consult, received during COVID-19 Pandemic
- Select priority of the consult

Receiving and Rescheduling Consult Options

☐ Accept new consult, received during COVID-19 Pandemic

☐ Established pt., please schedule when appropriate then discontinue consult
(Leave consult active until scheduled according to priority below. For established patient D/C consult after appointment has been made.)

Scheduling/Rescheduling Instructions (Selecting a Priority Automatically Accepts Consult)

☐ COVID-19 Priority 1 - Care should be appointed despite COVID-19

☐ COVID-19 Priority 2 - For appointing per clinical appropriateness and scheduling capacity

☐ COVID-19 Priority 3 - Make appointment as Priority 3 status, per local guidance

☐ COVID-19 Priority 4 - Make appointment as Priority 4 status, per local guidance

As an alternative to a face-to-face appointment, the Veteran may be offered:

☐ Telehealth ☐ Telephone ☐ Video Appt (VVC)

Additional Scheduling Instructions and Comments

For Priority 1 - you may indicate a specific date for overbook:

☐ Schedule on , ok to overbook

Additional Flags

☐ This consult may be D/C'd after mandated scheduling effort

☐ Scheduling plans discussed with ordering provider

Consults May Be Marked "High Risk" for Tracking and Extra Scheduling Effort

☐ High Risk Consult--Extra scheduling effort warranted

☐ Extra scheduling effort

[Further Information regarding Consult management during COVID-19 Pandemic](#)



CTB Version 1.9.0078

Click on the Community Care Functions option

Receive Consult

Comments

CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic
CVI-COVID-19 Priority 1-Urgent or emergent
Schedule appointment despite COVID-19 restrictions

Copy
Paste
Cut
Undo
Receive Consult
Community Care Functions
Settings

Date/time of this action: Now
Action by: (b)(6) PHYSICIAN ASSISTANT

OK Cancel

Resume current procedures to process the consult

Add Comment- Community Care Referrals Sub-Tab

Receiving and Rescheduling Consult Options

VA Clinic Referrals **Community Care Referrals**

The clinical triage for Community Care scheduling priority must be completed and documented by a clinician
(follow guidance in Chapter 6, Section 6A of the Office of Community Care [Community Care Field Guide](#) for consult management guidance)

Scheduling/Rescheduling Instructions

☐ COVID-19 Priority 1 - Urgent or emergent scheduling despite COVID-19
☐ COVID-19 Priority 2 - Make appointment when regular scheduling operations resume.
☐ COVID-19 Priority 3 - (Optional grouper, your department defines what this means)
☐ COVID-19 Priority 4 - (Optional grouper, your department defines what this means)

As an alternative to a face-to-face appointment, the veteran may be offered:
☐ Telehealth ☐ Telephone

Reference the [CMS Virtual Care Guidelines](#) regarding virtual appointment options in the community for additional information.

Additional Scheduling Instructions and Comments

Further Information regarding Consult management during COVID-19 Pandemic

OK

MSA Elig. Verification | **COVID-19 Priority** | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult Completion |

The clinical triage for Community Care scheduling priority must be completed and documented by a clinician

☐ Accept new consult, received during COVID-19 Pandemic
(follow guidance in Chapter 6, Section 6A of the Office of Community Care [Community Care Field Guide](#) for consult management guidance)

Scheduling/Rescheduling Instructions (Selecting a Priority Automatically Accepts Consult)

☐ COVID-19 Priority 1 - Care should be appointed despite COVID-19

☐ COVID-19 Priority 2 - For appointing per clinical appropriateness and scheduling capacity

☐ COVID-19 Priority 3 - Make appointment as Priority 3 status, per local guidance

☐ COVID-19 Priority 4 - Make appointment as Priority 4 status, per local guidance

As an alternative to a face-to-face appointment, the Veteran may be offered:

☐ Telehealth ☐ Telephone

Reference the [CMS Virtual Care Guidelines](#) regarding virtual appointment options in the community for additional information.

Additional Scheduling Instructions and Comments

[Further Information regarding Consult management during COVID-19 Pandemic](#)

Note: Users must identify as clinical staff member in CTB settings to see/use this COVID-19 Priority Tab.

Note: The same as the Community Care receive consult without the Receive Consult checkbox.

Example: Comments Box- Clinical Review

Add Comment to Consult

Comments

Scheduling prioritized during COVID-19 Pandemic
CV2-COVID-19 Priority 2
Make appointment when regular scheduling operations resume
As an alternative to a face-to-face appointment:
TEL-Telephone Appointment may be offered to the Veteran
TEL-Telehealth Appointment may be offered to the Veteran

Example: Comments Box- Receive Consult

APR 14, 20 (P) COMMUNITY CARE/ALLEGOT & IMMUNOLOGIST CONS CONSULT# 9127113

Receive Consult

Comments

CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic

CV2-COVID-19 Priority 2

Make appointment when regular scheduling operations resume

As an alternative to a face-to-face appointment:

TEL-Telephone Appointment may be offered to the Veteran

THL-Telehealth Appointment may be offered to the Veteran

Tips for Use of Add Comments-Community Care Referrals Sub-Tab

- Specific scheduling date is intended for Priority 1 to be scheduled now
- Avoid confusing comments that are ambiguous
- If the duration of the clinic closures is extended, review Priority 2 consults periodically looking for consults needing upgrade to Priority 1

MSA Elig. Verification | COVID-19 Priority | Consult Review | Authorization | DoD | MSA Pt Contacts | Appt Tracking | SAR/RFS | Consult Completion |

☐ Specific Eligibility Verified:
☐ Presumed eligible, HEC Update Pending
☐ Unable to Verify Eligibility
 Staff must contact local enrollment and eligibility office before proceeding

Delegation of Authority Medical Services List Reviewed

☐ Clinical review required ☐ Does not require clinical review

Document Administrative Screening

Previous Admin Care Coordination Level: not done
 Previous Clinical Care Coordination Level: not done
 Most Recent Assessment: none
 Clinical Triage: Need Undetermined

[Visit VA Consult Help Site for additional consult management guidance.](#)

OK

Note: CTB verbiage cannot be changed to reflect local guidance issued by the department/clinical service for Priority 3 and 4.

COVID-19 Scheduling Priority Designation Reports

- There are currently two reports available to capture the use of the COVID-19 tab and the designated priority groups:
 - VSSC COVID-19 Consult Report

Facility	(4V19) (554) Aurora, CO HCS	Type of Care	Community Care	Stop Code	Unknown,Unknown,Unknown,Unknown	View Report
Activity Start Date	1/1/2020	Activity End Date	4/24/2020	CPRSStatus	ACTIVE,CANCELLED,COMPLETE,DISCO	

Consult Toolbox

COVID Priority

- Consult Toolbox Report-Consults W/COVID Priority



Parameters

VISN
VISN19

Station(s):
(554) Eastern Colorado HCS (De

Include Stop Code
(0) Missing Stop Code,(000) Mis

Urgency:
STAT,OTHER,ROUTINE

SchedulingPriority

Days Old (at least)

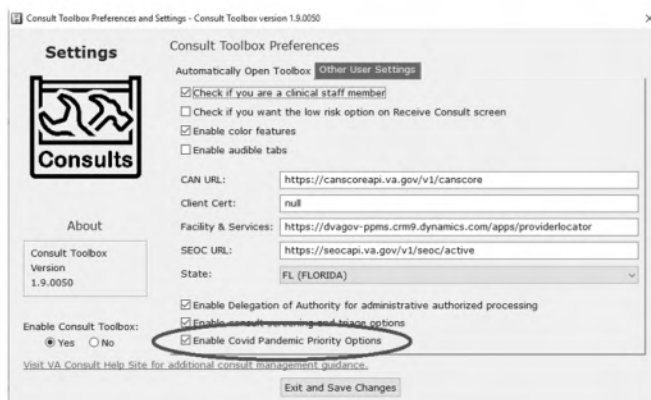
CPRS Status
ACTIVE,PENDING

Type of Consult
Regular,Future Care,Comm Care

- These reports are to be used by VA Medical Centers in order to determine scheduling priority for internal and community care consults and take appropriate actions.

Disable COVID-19 Tab Post Pandemic

COVID-19 Options can be turned off when the pandemic ends by unchecking the Enable COVID Pandemic Priority Options on Tab 2 of the CTB Settings. Unchecking this box will revert CTB back to its prior behavior.



Consult Toolbox Preferences and Settings - Consult Toolbox version 1.9.0050

Settings

Consults

About

Consult Toolbox Version 1.9.0050

Enable Consult Toolbox: ☒ Yes ☐ No

Visit VA Consult Help Site for additional consult management guidance.

Consult Toolbox Preferences

Automatically Open Toolbox: **Other User Settings:**

☒ Check if you are a clinical staff member

☐ Check if you want the low risk option on Receive Consult screen

☒ Enable color features

☐ Enable audible tabs

CAN URL:

Client Cert:

Facility & Services:

SEOC URL:

State:

☒ Enable Delegation of Authority for administrative authorized processing

☒ Enable consult review and triage options

☒ Enable Covid Pandemic Priority Options

Exit and Save Changes

- Setting Preferences Can Save A Few Clicks
 - Open CPRS
 - Press both the “Windows” key and the letter “V” at the same time
 - You should see the screen below if you have the new Consult Toolbox set up properly
 - Click on “Settings”



- Setting Preferences (Most Clinicians)
 - If you want the toolbox to open automatically when you add a comment or receive a consult, you should use the settings that are shown below (other options exist, such as for Community Care staff)



CTB Version 2.0

User Role – User roles in CTB v2.0 are self-assigned. They are not intended to fully restrict access to functionality but to guide users in functionality appropriate to their self-assigned role.

- **Enable COVID-19 scheduling triage workflow** - Check this box to access the Coronavirus Disease of 2019 (COVID-19) specific triage options for the consult review screen. ***This is required for use during the COVID-19 Pandemic.***

Consult Toolbox v0.0.395

What's New TBD Help Logout

Veteran Name
PATIENT, TEST

Date of Birth
Jan 1, 1990 (121)

Residential Address
(b)(3):38
U.S.C. 5701;
(b)(6)

Consult to Service/Specialty
audiology

Urgency
Routine

CID
04/09/2021

Seen As
Outpatient

Community Care Eligibility
? Not Established

Receive VA Consult

Consult Review
CC Eligibility (DST)
Contact Attempts
Patient Preferences
View Consult History
User Settings

SAVE CHANGES

User Role
☐ MSA/Clerk
☐ RN
☒ Provider

Default clinical staff member

Default scheduling staff member

☒ **Enable COVID-19 scheduling triage workflow**

☐ **Enable button to toggle between VA (in-house) and Community Care workflow**

CHANGES NOT SAVED

Receiving VA Consult Review for COVID-19

Consult Toolbox v2.0.0

What's New TBD Help Logout

Veteran Name
PATIENT, TEST

Date of Birth
Jan 1, 1990 (121)

Residential Address
(b)(3):38
U.S.C. 5701;
(b)(6)

Consult to Service/Specialty
cardiology

Urgency
Routine

CID
04/12/2021

Seen As
Outpatient

Community Care Eligibility
? Not Established

Receive VA Consult

Consult Review
CC Eligibility (DST)
Contact Attempts
Patient Preferences
View Consult History
User Settings

SAVE CHANGES

☐ **Established patient, schedule then cancel consult**

COVID-19 Scheduling Triage (required)

☐ Priority 1 - Proceed with scheduling
☐ Priority 2 - Schedule after clinical review
☐ Priority 3 - Schedule per department policy, if locally defined
☐ Priority 4 - Schedule per department policy, if locally defined

If appointment is not available within wait time standard

☐ Forward to community care
☐ Discuss with clinical staff

☐ **Scheduling plans discussed with ordering provider**

☐ **UNABLE TO SCHEDULE APPOINTMENT (No appts within 390 days and CC not applicable)**

Reasons appointment cannot be scheduled
Prefers VA/No capacity
No comparable service in the community
Receiving care/Awaiting specialized service

Preferred modality options for this consult (required)

☐ Any modality/patient choice
☐ In-person appointment
☐ Telephone appointment
☐ Video appointment

Cancellation Authorization (required)

☐ High risk consult - extra scheduling effort warranted
☐ Cancel after mandated scheduling effort
☐ Low risk clinic - may cancel after one missed appointment

Additional Comments

COVID-19 Scheduling Triage (required) – *This option is not available for the MSA/Clerk user role.*

- **Priority 1 – Proceed with scheduling** - do not wait until normal operations, schedule appointment now.
- ☐ **Schedule on a specific date, ok to overbook** – provider has determined that the Veteran's medical condition warrants them being seen and should be overbooked if needed to accomplish that effect.
- **Priority 2 – Schedule after clinical review** - first group to schedule when normal operations begin. Community Care consults should also be scheduled based on local market availability.
- **Priority 3 – Schedule per department policy, if locally defined** - optional, but a way to separate less urgent consults from the Priority 2. Your department can define criteria on how to separate 2 from 3.
- **Priority 4 – Schedule per department policy, if locally defined** - optional, a way to separate non-urgent consults from the Priority 3. Again, you can define which ones belong to this category or **if you use it at all**.
- If no appointment is available within wait time standard
 - Forward to community care
 - Discuss with clinical staff
- Scheduling plans discussed with ordering provider
- **UNABLE TO SCHEDULE APPOINTMENT** (No appts within 390 days and CC not applicable)
- Preferred modality options for this consult (required) - *This option is not available for the MSA/Clerk user role.*
 - Any modality/patient choice
 - In-person appointment
 - Telephone appointment - Telephone appointment offered to the Veteran.
 - Video appointment - VA Video Connect (VVC) appointment offered to the Veteran.
- **Cancellation Authorization (required)** - *This option is not available for the MSA/Clerk user role.*
 - High-risk consult – extra scheduling effort warranted - this will flag the consult as medically high-risk warranting additional calls to the Veteran beyond the mandated Minimum Scheduling Effort (MSE) guidance. It also allows the receiving service to flag certain consults for closer follow-up when the Veteran fails to keep appointments. Each service may define what high-risk means to them. This is simply a way of segregating higher risk consults from the rest and notifying staff to expend additional effort.
 - Cancel after mandated scheduling effort
 - Low risk clinic – may cancel after one missed appointment - An additional option for low-risk clinics for cancellation after one missed appointment. This screen auto populates from settings described above.
 - Extra scheduling effort (required) – This option displays when High risk consult – extra scheduling effort warranted is selected above.
 - 1 additional call
 - 1 additional letter
 - 2 additional calls

- Continue calling while waiting on response from letter
- Other (explanation required) o Explanation (required)
- Additional Comments – Field to enter additional comments.

Receiving VA Consult Review Steps

To receive a VA consult, follow the steps listed below:

- From the Action menu in CPRS, select Consult Tracking..., and then select Receive. The Receive Consult dialog box opens.

Receive Consult

Comments

Date/time of this action Action by

Now User Name

Open Consult Toolbox OK Cancel

- Click Open Consult Toolbox. The Receive VA Consult dashboard opens.
- From the workflow menu, select Consult Review. The Receive VA Consult Review Dashboard Screen displays.

Consult Toolbox v2.0.0 What's New TBD Help Logout

Veteran Name: PATIENT, TEST
 Date of Birth: Jan 1, 1900 (121)

Residential Address: (b)(3):38
 U.S.C. 5701;
 (h)(6)

Consult to Service/Specialty: cardiology
 Urgency: Routine
 CID: 04/12/2021
 Seen As: Outpatient

Community Care Eligibility: ? Not Established

Receive VA Consult

Consult Review

CC Eligibility (DST)

Contact Attempts

Patient Preferences

View Consult History

User Settings

SAVE CHANGES

☐ Established patient, schedule then cancel consult

COVID-19 Scheduling Triage (required)

☐ Priority 1 - Proceed with scheduling

☐ Priority 2 - Schedule after clinical review

☐ Priority 3 - Schedule per department policy, if locally defined

☐ Priority 4 - Schedule per department policy, if locally defined

If appointment is not available within wait time standard

☐ Forward to community care

☐ Discuss with clinical staff

☐ Scheduling plans discussed with ordering provider

☐ **UNABLE TO SCHEDULE APPOINTMENT**
 (No appts within 390 days and CC not applicable)

Reasons appointment cannot be scheduled

☐ Prefers VA/No capacity

☐ No comparable service in the community

☐ Receiving care/awaiting specialized service

Preferred modality options for this consult (required)

☐ Any modality/patient choice

☐ In-person appointment

☐ Telephone appointment

☐ Video appointment

Cancellation Authorization (required)

☐ High risk consult - extra scheduling effort warranted

☐ Cancel after mandated scheduling effort

☐ Low risk clinic - may cancel after one missed appointment

Additional Comments

- Select the **Established patient, schedule then cancel consult** check box if the consult received is for an established patient.
- From the **COVID-19 Scheduling Triage (required)** section, select the option.
- If you selected **Priority 1 – Proceed with scheduling**, enter/select a date in the **Schedule on a specific date, ok to overbook** field.
- From the **If no appointment is available within wait time standard** section, select the option.
- 8. Select the **Scheduling plans discussed with ordering provider** check box if the discussed with the ordering provider.
- 9. Select the **UNABLE TO SCHEDULE APPOINTMENT** check box if no appts within 390 days and CC not applicable.
- 10. From the **Preferred modality options for this consult** section, select the modality. *This is a required field.*
- 11. From the **Cancellation Authorization** section, select the authorization option.
- 12. If **High risk consult – extra scheduling effort** is selected, you are required to select an option from the **Extra Scheduling Effort** drop-down menu.
- 13. In the **Additional Comments** section, enter any comments pertaining to the consult.
- 14. Click **SAVE CHANGES**.

Disable COVID-19 Tab Post Pandemic

COVID-19 Options can be turned off when the pandemic ends by unchecking the Enable COVID Pandemic Priority Options on CTB "User Settings" tabs. Unchecking this box will revert CTB back to its prior behavior.

CTB Version 1.9.0078 & CTB Version 2.0

Resources

- **[Consult Toolbox SharePoint Site](#)**
- **[CPRS: Consult/Request Tracking \(VA Software Document Library\)](#)**
- **[CTB COVID-19 Consult Tab OCC Office Hours Training Slides](#)**
- **[Recording of Office Of Community Care Consult Toolbox COVID-19 Tab Training](#)**

Troubleshooting:

- For issues related to the Consult Toolbox that cannot be resolved by reviewing the user guide, process guidance or the site administrator, please contact the Enterprise Service Desk at 855-NSD-HELP (673-4357).

Community Care COVID-19 Testing Guidance-

Due to the COVID-19 Pandemic the Office of Community Care has put processes in place to allow for Veterans to obtain COVID-19 Testing in the community when the following applies:

- Service is not offered within the VAMC
- It is clinically appropriate for the Veteran to obtain the services in the community.

There are four options for a Veteran to obtain COVID-19 Testing in the community using community care services:

1. VA provider identified Veteran needs COVID-19 Testing, services are not available within the VA or patient meets Community Care eligibility based on MISSION Act criteria and therefore an urgent Community Care- COVID 19 Testing Consult is placed.
2. Veteran has an approved community care referral and the community provider is requesting COVID-19 Testing prior to the community care appointment taking place.
3. Veteran presents to an in-network community Urgent Care site.
4. Veteran presents to an in-network community ER for emergent care.

COVID-19 Testing Parameters:

- It is important to note, COVID-19 testing should be based on clinical appropriateness, as directed by a clinical member of the team and should be done within the VA when possible.
- Veteran's must have an approved consult in place prior to the testing being rendered in the community. **It is important to note: if the consult is not in place prior to the testing being completed in the community, the claim should still be submitted to the VA for consideration.**
- If referred to the community for testing, all attempts should be made to coordinate the care with an in-network lab and the referral should be processed in HSRM.
- The facility community care office or ordering provider (designee) will provide the necessary billing instructions by providing the Veteran with the "Community Care COVID-19 Test Billing Info" note.
 - This must be provided to the Veteran either in person (if Veteran is in clinic), via My HealtheVet or other appropriate options to provide the Veteran with the necessary information in a timely manner.
 - This will allow the Veteran to obtain the necessary testing and the community provider to have guidance on where to bill for this out of network care. The Community Care COVID-19 Testing Consult must also be placed prior to the Veteran being tested in the community.

Scenarios/Coverage:

VA Provider Initiates Request:

- In the instances where the VA provider identifies a Veteran needs COVID-19 Testing and the services are not available within the VA or patient meets Community Care eligibility based on MISSION Act criteria the following process should be followed:
 - VA Provider to enter an urgent Community Care- COVID 19 Testing Consult. The consult must be processed as an urgent consult and the VA provider should contact the facility community care office to identify an in-network community provider/lab location that can render this care.
 - A warm hand off when possible is key in this process, to ensure timely care is delivered.
 - In the instances where the facility community care office is not available to accept a call to discuss the request, the ordering provider (clinic team) will place the Community Care COVID-19 Testing Consult, identify an appropriate testing site and the Veteran/identified testing site will be provided with the Community Care- COVID 19 Test Billing note that includes information on where to bill.
 - A Pathology and Laboratory Standardized Episode of Care (SEOC) should be added to this consult.
 - Once the consult is entered, the consult will be addressed by the facility community care office to identify an in-network community care lab location or a community lab location with an approved VCA, in PPMS and process the referral using the Health Share Referral Manager (HSRM).
 - If unable to find an in-network lab, the Veteran/identified testing site will be provided with a cover letter that includes information on where to bill.

Note: The Payment Operations and Management (POM) Office within OCC will be receiving these claims and processing for payment. A community care consult to cover the COVID-19 Testing must be entered, prior to the testing occurring in the community, in order for payment to be approved.

- A consult to approve the COVID-19 Test in the community must be in place, prior to the Veteran receiving any services in the community. This will ensure that payment can occur for this care in the community. If the Veteran obtains the COVID-19 test in the community, prior to a consult being placed, the claim will be denied due to no approval.
- If consult is received after a Veteran has gone to a testing center, the facility community care office will follow up with the Veteran to identify where they received the test or guide them to an in-network site if they had not yet gotten tested.

Veteran with Active Referral:

- In the instances where the Veteran has a approved community care referral and the community provider who is requesting COVID-19 Testing prior to the community care appointment the following process should be followed based on the specific scenario that applies:

Scenario	Coverage
a. COVID-19 Testing covered with current referral/SEOC	Covered/paid by TPA under diagnostic testing in medical and surgical SEOCs
b. COVID-19 Testing not covered within current referral/SEOC (i.e. dental)	Test performed through VAMC or a separate community care consult/referral can be issued specifically for testing: <ul style="list-style-type: none"> • Option 1: VA testing coordinated by VAMC within the VA • Option 2: VA staff enters a Community Care COVID-19 testing consult and assigns a Pathology and Lab SEOC. Care in the community to be coordinated by the facility community care office.

- In the instances when the COVID-19 Testing is done by an out of network provider:
 - The Veteran must be provided with the ordering provider (designee) will provide the necessary billing instructions by providing the Veteran with the “Community Care COVID-19 Test Billing Info” note. This must be provided to the Veteran either in person (if Veteran is in clinic), via My HealtheVet or other appropriate options to provide the Veteran with the necessary information in a timely manner.
 - The Veteran will provide the community testing center with the Community Care COVID-19 Testing Consult and Community Care- COVID 19 Test Billing” note to assist the community testing site with identifying the appropriate billing process.
- If the Veteran has an approved community care referral, that does not cover diagnostic test, facility community care staff will need to take the following actions:
- Facility community care staff to work with internal clinic to determine if the COVID-19 Test can be done within the VA.
- If the test cannot be de within the VA, a designated clinician/RN will enter a Community Care- COVID 19 Testing Consult.
- A Pathology and Laboratory Standardized Episode of Care (SEOC) should be added to this consult.
- Once the consult is entered, the consult will be addressed by the facility community care office to identify an in-network community care lab location, in PPMS and process the referral using the Health Share Referral Manager (HSRM).
- If unable to find an in-network lab, the Veteran/identified testing site will be provided with a cover letter that includes information on where to bill.
- **Note:** POM will be receiving these claims and processing for payment.

Veteran Presents to Urgent Care Center:

- In the instances where the Veteran presents to an in-network community Urgent Care site the following process applies:
 - If the testing is rendered by an in network urgent care location, the test would be covered as part of the episode of care.
 - In network urgent care locations can be found in [VA.gov-Find VA Locations](#) - Select Community Care Providers- Service Type= Urgent Care. Facility community care offices should use PPMS to identify in-network locations.
 - It is important to note, currently COVID-19 Testing is not covered as a stand-alone visit for urgent care and must be part of a visit for another illness/health concern and the COVID-19 test was done as part of that visit.

Search by city, state or postal Code

Washington, DC

Choose a VA facility type

Community providers (in VA's network)

Service type (*Required)

Clinic/Center - Urgent Care

Search

- More guidance on the Community Care Urgent Care process, to include the eligibility criteria can be found in chapter 3, section 3.7.
- **It is important to note: The COVID-19 Testing will not be approved for payment in the community if the urgent care location is out of network.**
- If the care occurs at an out of network urgent care site, the claim should still be submitted to the VA for consideration.

Testing completed at in in-network Emergency Room Location:

- In the instances where the Veteran presents to an in-network community ER for emergent care the following process applies:
- If the emergency episode of care meets the eligibility criteria under the Authorized Emergency Treatment process (38 CFR 17.4020(c) the COVID-19 test will be covered under that episode of care.
- The emergency care must be rendered by an in-network ER. In network ED locations can be found in [VA.gov-Find VA Locations](#) -Select Community Care Providers- Service Type= General Acute Care Hospital. Facility community care offices should use PPMS to identify in-network locations.

Search by city, state or postal Code

Washington, DC

Choose a VA facility type

Community providers (in VA's network)

Service type (*Required)

General Acute Care Hospital

Search

- More guidance on the Community Care Authorized Emergency Treatment process, to include the eligibility criteria can be found in chapter 3, section 3.6.
- If the care occurs at an out of network hospital the claim should still be submitted to the VA for consideration.

Community Care-COVID 19 Testing Consult

A Community Care-COVID 19 Testing Consult is necessary in the following scenarios:

1. Veteran has an approved referral for community care with a SEOC that does not cover diagnostic testing.
2. VA provider identified Veteran needs COVID-19 Testing and the services are not available within the VA.

Template: COMMUNITY CARE-COVID 19 TESTING

☒ Justification for Community Care: *

Type of Service: *
(If diagnostic or treatment option is selected a procedure entry is required)

Chief Complaint: *

Patient History / Clinical Findings / Diagnosis (Co-Morbidities):
(Include Relevant Dx Test and Treatment to Date)

Third Party Liability: (Examples: Motor Vehicle Accident, Work Related Injury, Other)
* ☐ Yes ☐ No

LAB TEST:
Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel

SELECT CDC/VA PRIORITY FOR TESTING

☐ PRIORITY 1 Hospitalized patients
Symptomatic healthcare workers

☒ PRIORITY 2 Patients in long-term care facilities with symptoms
Patients 65 years of age and older with symptoms
Patients with underlying conditions with symptoms
First responders with symptoms

☒ SYMPTOMS: *

☐ Fever
☐ Cough
☐ SOB
☐ Nausea
☐ Diarrhea
☐ Other:

☐ PRIORITY 3
Critical infrastructure workers with symptoms
Individuals who do not meet any of the above categories with symptoms
Health care workers and first responders
Individuals with mild symptoms in communities experiencing high COVID 19 hospitalizations.

☐ NON PRIORITY Individuals without symptoms

All None * Indicates a Required Field Preview OK Cancel

- The Community Care- COVID 19 Testing Consult template consists of the 5 mandatory OCC fields
- Specifies the requested lab test: 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel
- Requires VA clinician to indicate testing priority based on CDC/VA Guidelines and provides the option to capture the associated symptoms for the Veteran.
- A Pathology and Laboratory Standardized Episode of Care (SEOC) should be added to this consult.


- Facility community care staff should process these consults as an urgent request:
 - If the VA provider refers a Veteran to a community testing site, and the facility community care office is not able to coordinate that care with the Veteran prior to the test being done, the facility community care office will need to follow up with the Veteran to determine if the COVID-19 test was completed.
 - If the test was completed, the facility community care staff will determine if the care was rendered in an in-network or out of network location.
 - In-Network: Process the referral in HSRM and ensure to capture the in-network provider.
 - Out of Network: The Veteran/identified testing site will be provided with a cover letter that includes information on where to bill.

Note: POM will be receiving these claims and processing for payment.

- If consult is received after a Veteran has gone to a testing center, the facility community care office will follow up with the Veteran to identify where they received the test or guide them to an in-network site if they had not yet gotten tested.

Community Care-Covid-19 Test Billing Info

The facility community care office or ordering provider (designee) will provide the necessary billing instructions by providing the Veteran with the “Community Care COVID-19 Test Billing Info” note. This will allow the Veteran to obtain the necessary testing and the community provider to have guidance on where to bill for this out of network care. The Community Care COVID-19 Testing Consult must also be placed prior to the Veteran being tested in the community.


Title: COMMUNITY CARE-COVID-19 TEST BILLING INFO

Dear Community Provider

Thank you for assisting with COVID-19 Lab testing for our Veteran. Results for all COVID-19 testing and medical documentation MUST be sent ASAP to the VA at the following location:

(Enter the location to send results) *

May be hard-coded by CACs or as determined by Facility leadership

Please follow this guidance for submitting COVID-19 testing claims:

Submitting Claims:

- Providers in-network with TriWest Healthcare Alliance must submit claims resulting from this order to TriWest. (CCN Regions 4/ PC3)
TriWest EDI payer ID: VAPCCC3
Mail: WPS MVH-VAPCCC
P.O. Box 7926
Madison, WI 53707-7926
- Providers in-network with Optum United Health Care must submit claims resulting from this order to Optum. (CCN Regions 1-3)
Optum EDI payer ID: VACCN
Fnx: (608) 792-2143 - Specify VACCN on Fax
Mail: VA CCN OPTUM
P.O. Box 202117
Florence, SC 29502
- Out of network providers must submit claims resulting from this order to the VA. VA EDI payer ID: 12115 (Veteran Care Agreement/Local Contract)
VA EDI payer ID: 12115
Mail to: VHA Office of Community Care
P.O. Box 30780
Tampa, FL 33630-3780

Should you have questions, please contact us at *

May be hard coded by CACs or as determined by Facility Leadership

to speak with a patient service representative.

* Indicates a Required Field

Preview

OK

Cancel

Department of Veterans Affairs Medical Center
7305 N. Military Trail
West Palm Beach, FL 33410-6400

Dear Community Provider

Thank you for assisting with COVID-19 Lab testing for our Veteran. Results for all COVID-19 testing and medical documentation MUST be sent ASAP to the VA at the following location:

May be hard-coded by CACs or as determined by Facility leadership

Please follow this guidance for submitting COVID-19 testing claims:

Submitting Claims:

- Providers in-network with TriWest Healthcare Alliance must submit claims resulting from this order to TriWest. (CCN Regions 4/ PC3)
TriWest EDI payer ID: VAPCCC3
Mail: WFS MWH-VAPCCC
P.O. Box 7926
Madison, WI 53707-7926
- Providers in-network with Optum United Health Care must submit claims resulting from this order to Optum. (CCN Regions 1-3)
Optum EDI payer ID: VACCN
Fax: (608) 792-2143 - Specify VACCN on Fax
Mail: VA CCN OPTUM
P.O. Box 202117
Florence, SC 29502
- Out of network providers must submit claims resulting from this order to the VA. VA EDI payer ID: 12115 (Veteran Care Agreement/Local Contract)
VA EDI payer ID: 12115
Mail to: VHA Office of Community Care
P.O. Box 30780
Tampa, FL 33630-3780

Should you have questions, please contact us at May be hard coded by CACs or as determined by Facility Leadership to speak with a patient service representative.

Sincerely

Community Care- COVID 19 Test Results

- The ordering provider or designee should use one of the following reminder dialogues within CPRS. to capture the outcome of the Veteran's test results.
 - VA-COVID-19 STATUS ADJUSTMENT
 - VA- COVID-19 OUTSIDE TEST RESULTS
- The use of this reminder dialogue will populate the CPRS COVID-19 Status Indicator Banner. Note the information captured on the banner will vary, based on the results documented by the end user.

COVID-19

Clinically POSITIVE

- Facility community care offices will need to monitor these consults to track when the CPRS COVID-19 Status Indicator Banner is populated. Once the facility community care staff see the banner generated, they should review the CPRS progress notes to find a note for Outside Results Note. If the note is found, confirm that the dates of the note is after the Community Care COVID-19 Testing consult create date. Once confirmed, facility community care staff can use this information to complete the consult.
- In some cases the test results will be sent directly to the facility community care offices in those instances the facility community care office will need to take timely action in order to ensure that the results are appropriately captured using the reminder dialogue and the consult is appropriately completed. Facility community care staff should use the COMMUNITY CARE- COVID 19 LAB RESULT Note in order to capture the test results and appropriately close out the Community Care COVID-19 Testing Consult.
- Facility community care offices should follow the guidance in chapter 3 for appropriate records retrieval and consult closure for a community care episode of care.
- Guidance for the Clinical Application Coordinators (CACs) on the creation of these consults can be found in the [Community Care COVID 19 Testing Technical guide](#).

COVID-19 Antibody Testing in the Community

Antibody testing can be performed using a Community Care-Lab and Pathology consult with a provider writing in specifically the COVID antibody test request into the reason for request field and select the Lab and Pathology SEOC 1.0.6.

VA providers should use this capability thoughtfully and sparingly as there is no clear guidance from the CDC on the level of antibody titers that indicate true immunity, nor if the specific antibodies tested for are neutralizing antibodies that provide protection from reinfection.

Guidance for Clinical Application Coordinators for Creating Community Care COVID-19 Testing Consult and Notes:

In order to facilitate the tracking of community care referrals, specific for COVID-19 testing (Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel) the Office of Community Care has created a COMMUNITY CARE- COVID 19 TESTING consult template. Guidance on the referral process for COVID-19 testing in the community care be found on chapter 6, section 6A.

Please review the [Community Care COVID 19 Testing Technical guide](#) for further information.

This consult will allow VA Medical Centers to appropriately track the number of Veterans being referred to the community for this testing. When referring a Veteran to community care for COVID-19 testing, the COMMUNITY CARE- COVID 19 TESTING consult should be used in conjunction with the laboratory and pathology SEOC.

Additionally, the Office of Community Care has created the Community Care COVID-19 Test Billing Info Note and the COVID-19 Outside Results Note, the template for both can be found [here](#).

Reimbursement

To expedite COVID-19 testing and services for Veterans early in the pandemic, when coverage in VA was limited, VA decided in 2020 to temporarily reimburse all COVID-19 testing, urgent and emergent care claims for eligible Veterans, including claims made without a VA referral. This means that COVID-19 testing and services with dates of service prior to January 1, 2021 that were not authorized (do not have a VA referral) can be submitted to VA for payment. However, now that coverage is more widely available, claims for reimbursement for COVID-19 testing and services on and after January 1, 2021 must be approved via VA referral or meet urgent or emergent care eligibility requirements in order to receive payment.

If you are filing a claim for authorized COVID-19 testing and services, please ensure the claim meets all requirements, including timely filing, and is submitted to the appropriate payer (i.e. Third-Party Administrator or VA). For more information on how to properly file a claim, visit our [File a Claim for Veteran Care](#) webpage. Questions? Please call VA Customer Service 877-881-7618 or contact ProviderComms@va.gov.

Interim Guidance on Safe Practices Activities in the Era of COVID-19 vaccination **Memorandum – Released February 7, 2021**

The first priority of the Veteran's Health Administration (VHA) throughout the COVID-19 pandemic is safety of Veterans and staff. It is critical that VHA continue to support existing COVID-19 protocols even as vaccination of Veterans and staff expands.

VHA has surpassed 1 million doses of vaccine administered against COVID-19. Both available vaccines received Emergency Use Authorization (EUA) from the Food and Drug Administration (FDA) for prevention of *symptomatic* COVID-19 disease. Information on the prevention of *asymptomatic* SARS-CoV-2 infection, prevention of transmission, and duration of protection from vaccine are unknown.

Three major variants of SARS-CoV-2, the virus that causes COVID-19 infection, have been recently identified in the United States that may be more easily transmitted than the original SARS-CoV2 strain. Vaccine manufacturers are working to understand if there could be a change in efficacy against COVID-19 for their products.

Department of Veterans Affairs (VA) facilities **must** continue all existing prevention activities against COVID-19 without regard to the individual's vaccination status, until

additional information is known about how vaccination or antibody status affects COVID-19 transmission. Several of the key prevention strategies are listed below.

- Facility screening: Facilities must continue screening protocols for all individuals entering a facility per VHA guidelines set forth in the VHA Moving Forward Plan: COVID Screening in VHA. Screening can be conducted by face-to-face screeners or a combination of screeners (for visitors) and app-based self-screening (staff).
- Masking: Facilities must continue to require Centers for Disease Control and Prevention (CDC)-compliant masks for everyone entering a VHA facility, per VHA guidelines, set forth in the Moving Forward Plan COVID Screening in VHA and VA AUSHO Memo, Update: Coronavirus (COVID-19) Mask Use in Veterans Health Administration (VHA) Facilities dated May 1, 2020, which require that all staff, trainees, volunteers, Veterans, inpatient residents, and visitors wear a face covering during their time at the VHA facility. Additional information on efficacy of wearing a face mask is available from the Centers for Disease Control and Prevention (CDC) here.
- Face Shield and Eye Protection: Health care providers involved in patient care or who will be in close proximity to patients or visitors should wear eye protection in addition to wearing a face mask. VHA guidance on eye protection can be found here.
- Physical Distancing: Facilities must continue to provide adequate space or limit the number of individuals to achieve safe physical distancing throughout their facilities including common space (e.g., hallways, cafeteria), areas frequented by Veterans (e.g., waiting areas), and space used by VHA staff (e.g., break rooms, nursing stations, office space).
- Hand hygiene: Facilities should continue to provide access to handwashing stations, bathrooms, and alcohol-based hand sanitizer.
- Restrictions on visitation: Facilities should continue to enforce local visitation policies in accordance with local disease prevalence. Visitor access to VHA facilities in outpatient and inpatient (acute and non-acute) should continue to be limited per VHA guidelines set forth in Revised Visitation to VHA Facilities During COVID-19.
- Personal Protective Equipment (PPE) for employees: VHA remains in CDC contingency strategy for medical gloves and N95 respirators and facilities should continue to protect staff and conserve all PPE. VHA facilities should follow PPE guidelines in the VHA Moving Forward Plan: PPE in the Ambulatory Care Settings and Resumption of Procedures for Non-urgent and Elective Indications. PPE is to be worn according to current CDC guidance available from the CDC here.
- Testing: VHA facilities should continue to follow existing guidance and protocols to triage symptomatic individuals. Monitoring for CLC and SCI residents should continue as outlined in Guidance on COVID-19 Testing for CLC and SCI Units. Persons who present with symptoms of COVID-19 should be tested regardless of vaccination status. Cohorting should continue as currently practiced. Vaccination or antibody status should not be used to

- cohort Veterans in acute or non-acute areas. Current guidance on testing in VHA can be found in [Guidebook to COVID Testing](#).
- [Return-to-work guidance](#): VHA guidance for returning exposure or infected staff to work remains unchanged, per VHA guidance in [AUSHO: Updated Guidance for Return-to-Work Recommendations for Healthcare](#)
 - [Personnel after Exposure to or Infection with Novel Coronavirus 2019](#)
 - [Telework and providing virtual care](#): VHA facilities should continue to follow existing guidance on maximizing telework for all staff and increasing virtual care whenever feasible, per VHA guidelines: [Ad Hoc Telework for Supervisors & Employees in Preparation for Emergencies](#). Additional guidance on protecting Veterans and VA staff is available on the [VHA High Consequence Infection \(HCI\) Preparedness Program SharePoint](#).
 - [Surveillance/Monitoring](#): Monitoring Veterans and staff should continue as established in existing local policy. Monitoring staff in CLC and SCI/D units should follow local COVID-19 testing positivity rates. Vaccinated staff or Veterans with COVID-19 symptoms should be tested for COVID-19. Current guidance on testing in VHA can be found in [Guidebook to COVID Testing](#).

Information on COVID-19 vaccines and virus variants will likely evolve at a rapid pace. VHA guidance presented in this memorandum may be updated to reflect change in Food and Drug Administration or CDC guidance, breaking links provided above. Please go to the [Moving Forward Guidebook](#) for up-to-date VHA guidance on COVID-19 prevention and management strategies and the [VHA COVID-19 vaccine](#) SharePoint for vaccine related information. Current VHA guidance on COVID-19 aligns with the administration's *National Strategy for the COVID-19 Response and Pandemic Preparedness*.

Questions can be submitted to the COVID-19 Resource Room via this [form](#).

CCN urgent care and retail pharmacies to provider COVID-19 vaccinations

VA's Community Care Network (CCN) urgent care locations and retail pharmacies now offer COVID-19 vaccinations nationwide for eligible Veterans in accordance with local, state or territorial vaccination plans.

VA is working closely with the Centers for Disease Control and Prevention (CDC) and other federal partners to provide COVID-19 vaccines to eligible Veterans at VA medical facilities and in-network community locations. VA is currently distributing COVID-19 vaccines to Veterans who receive care at VA and are at a high risk from COVID-19 based on VA and CDC risk criteria. As more vaccines become available, VA remains committed to providing vaccinations to all eligible Veterans.

By enabling CCN providers and pharmacies to deliver free vaccine-only services to Veterans, VA is directly contributing to the nation's critical need for additional inoculation locations. This opportunity does not give eligible Veterans priority over others seeking vaccinations at any location.

Community care eligible Veterans can identify in-network urgent care facilities and retail pharmacies by using VA's facility locator. Eligible Veterans are encouraged to call the community care provider of choice to ensure the site has vaccines available and to determine if an appointment is available. Veterans are encouraged to download the pharmacy information card to present at the community care location where the vaccine is being administered.

As with all health care in the community, Veterans are encouraged to consult local and state resources for COVID-19 vaccination availability and consider VA facilities for the vaccination.

6.1 Monitoring and Improving Community Care Performance

The results generated from reports should be thoroughly analyzed to determine the effectiveness and efficiency of current operations, compliance with applicable regulations, and the reliability of reporting. Trend analysis should be performed to observe changes in reporting results over time and to determine the root causes behind inadequate performance. VA Staff perform the following procedures to evaluate site performance reports using data to conduct internal audits of VA Community Care, processes, and functional areas are essential components of managing community care and ensuring visibility, accountability, and that corrective actions are implemented. In addition, consistent, and standardized analysis and reporting practices enable managers to identify opportunities to improve processes through training or other corrective actions. Data analysis can also provide predictive projections of audits such as the Improper Payment Elimination and Recovery Improvement Act (IPERIA).

This chapter is intended to provide field managers with the reporting tools necessary to monitor the performance of different areas of their community care programs including Referral Management, TPA Return and Notification actions, and Claims.

6.2 How to Evaluate Site Performance Reports

The results generated from reports should be thoroughly analyzed to determine the effectiveness and efficiency of current operations, compliance with applicable regulations, and the reliability of reporting. Trend analysis should be performed to observe changes in reporting results over time and to determine the root causes behind inadequate performance. VA Staff perform the following procedures to evaluate site performance reports:

- **How to Evaluate Referral Management Community Care Consults (8.1.1):**
How to run and interpret reports on consult management performance for Community Care Consults.
- **How to Evaluate Referral Management Timeliness (8.1.2):**
How to run and interpret reports on referral timeliness from care request to upload and/or scheduled
- **How to Evaluate Secondary Authorizations Requests (SARs) / Notifications for TriWest (TW):**

How to measure the timeline from request for additional services or action needed from TPA/ contractor until action is taken to adjudicate that request

- **How to Evaluate Claims Without Authorization (POM Tab):**
How to view and interpret reports on authorized suspended claims awaiting authorization against all authorized claims inventory
- **How to Evaluate Claims Batch Backlog (POM Tab):**
How to view and interpret reports on aging batches awaiting release and payment
- **How to Evaluate Facility Third Party Administrator (TPA) Funds:** How VA Community Care managers can assist with the monitoring of TPA fund usage on a daily and weekly basis. This tool should be used to track authorizations, authorization returns, associated cost of authorizations and remaining TPA budget left for the facility based on this usage tracking.

6.3 How to Evaluate Referral Management Community Care Consults

Impact and Performance Benchmarks

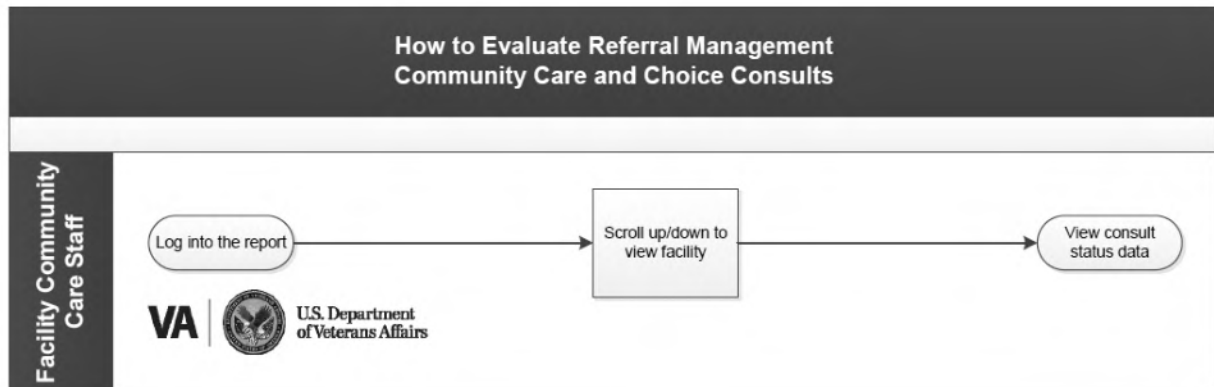
Monitoring referral management for Community Care Consults is essential because delays in consult management lead to extended wait times for Veterans to receive an appointment. See below for the steps to access and view referral management data. Once consult data is available in the necessary reporting formats, the consult metric timeline and guidance to the field will be modified to capture not only initial care request date, but also timeline from when care was forwarded to the Facility Community Care Office for action. This will be a subset of the current metric timeliness and information will be included in this section, as well as the top 8 metric definitions.

Site Target(s):

- 90% of consults should be reviewed and moved to active or scheduled within 2 days
- 90% of consults should be scheduled within 30 days
- 90% of consults should be scheduled and no greater than 90 days old

Site Performance Goals:

- Pending consults should remain in PENDING status no more than 2 business days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 2 business days (see VHA Directive 1232(2) for additional guidance).
- Active consults no greater than 30 days
- Scheduled consults no greater than 90 days



PROCEDURES

General Considerations:

- This report changes daily as consult status changes and consult age increases
- Each target focuses on a different element of consult management
- This report requires Pyramid access
 - Use this [Pyramid self-registration link](#) to obtain access

STEP	ACTIVITY
1	<p>Log into the report: Use this Pyramid Consult Status Report link to log in to the report.</p> <ul style="list-style-type: none"> • Click on the “All Consults” tab:

- All Consults**

By Status: **Timeliness** | Stat Trend | Trend by File Entry Date | Trend By Closure Date | Consult Performance

Receiving Facility District - Receiving Facility: All Facility
Primary Request Type - Receiving Service: All
Primary Stop Clinic Type - Receiving Service - StopCode: All Clinics
File Entry Date - File E.: FY19

Consults, Average Days From First Entry To First Active, Average Days from First Active to First Scheduled, Average Days from File Entry To First Forwarded From, Average Days from First Forwarded From to First Scheduled, Av

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From File Entry To Appointment	Average Days From First Canceled to First EditResubmit	Average Days From Earliest Date to Completed Consult	Average Days From First Forwarded From to Closed
Administrative	3,689,238	1.9	6.1	1.9	7.2	4.8	8.4	28.5	28.8	1.1	16.3
Clinical/Consult	15,587,356	2.1	5.6	3.8	7.3	6.0	10.6	32.6	15.5	12.6	26.7
Clinical/Procedure	1,574,035	4.3	7.6	12.1	27.6	7.3	13.4	40.4	8.3	11.4	86.7
Community/Care	4,806,083	2.4	26.1	6.0	29.6	28.2	32.1	41.1	13.6	71.6	82.0
Prosthetics	8,301,823	2.6	5.1	2.8	5.0	4.6	5.1	13.5	4.0	10.5	21.3

Use the Receiving Facility District drop down: To select the facility: facilities are listed on the left-hand side of the report; be sure to deselect the All Facility option first, then use the drop-down arrows to select the appropriate VISN and then facility.

PROCEDURES

Status **Timeliness** Stat Trend Trend by

Receiving Facility District - Location - Receiving Facility

All Facility

Search (Use * for contains)

☐ Default Member

☒ All Facility

☒ District 1

▶ ☐ 1V01

▶ ☐ 1V02

▶ ☐ 1V04

☒ 1V05

▶ ☐ (1V05) (512) Baltimore, MD HCS

▶ ☐ (1V05) (517) Beckley, WV HCS

▶ ☐ (1V05) (540) Clarksburg, WV HCS

☒ (1V05) (581) Huntington, WV HCS

▶ ☐ (1V05) (613) Martinsburg, WV HCS

▶ ☐ (1V05) (688) Washington, DC HCS

▶ ☐ 1V06

▶ ☐ District 2

▶ ☐ District 3

- 3 **Select the Primary Type – Receiving Service drop down and select “Community Care”.**

PROCEDURES

By Status **Timeliness** Stat Trend Trend by File Entry Date Trend By Closure Date

Receiving Facility District - Location - Receiving Facility Primary Request Type - Receiving Servi... Primary Stop

Multiple Selections All All Clinics

Search (Use * for contains)

(All)

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From File Entry To Appointment
<input type="checkbox"/> Administrative	3,689,238							7.2
<input type="checkbox"/> ClinicalConsult	15,587,356							7.3
<input type="checkbox"/> ClinicalProcedure	1,574,035							27.6
<input type="checkbox"/> CommunityCare	4,806,083							29.6
<input type="checkbox"/> Prosthetics	8,301,823							5.0

Default Member

☒ All

☐ Administrative

☐ ClinicalConsult

☐ ClinicalProcedure

☒ CommunityCare

☐ Prosthetics

☐ Unknown

3

Select the File Entry Date drop down: Select the FY for the data view.

By Status **Timeliness** Stat Trend Trend by File Entry Date Trend By Closure Date Consult Performance

Receiving Facility District - Location - Receiving Facility Primary Request Type - Receiving Servi... Primary Stop Clinic Type - Receiving Service - StopCode File Entry Date - File E...

Multiple Selections Multiple Selections All Clinics FY20

Search (Use * for contains)

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled, Average Days From File Entry To First Scheduled, Average Days From File Entry To Appointment Made, Average Days From File Entry To Appointment

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From File Entry To Appointment
<input type="checkbox"/> Administrative	1,987,155	1.8	5.1	2.1	5.2	4.2	7.7	30.5
<input type="checkbox"/> ClinicalConsult	8,223,925	1.8	5.0	3.9	6.1	5.5	11.4	35.7
<input type="checkbox"/> ClinicalProcedure	807,564	3.0	5.0	6.8	12.8	4.8	11.5	46.9
<input type="checkbox"/> CommunityCare	3,474,694	2.0	17.0	4.0	20.1	18.7	21.6	29.1
<input type="checkbox"/> Prosthetics	4,585,609	2.7	4.1	1.9	3.7	4.2	4.6	14.5

FY12

FY13

FY14

FY15

FY16

FY17

FY18

FY19

☒ FY20

FY34

6 Months...

6 Months...

Change 6...

% Change...

Named Sets/Lists

4

The report is automatically queried when selections are made.

PROCEDURES

Receiving Facility District - Location - Receiving Facility Primary Request Type - Receiving Ser... Primary Stop Clinic Type - Receiving Service - StopCode File Entry Date - File...

Multiple Selections CommunityCare All Clinics FY20

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled, A

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From First Appointment Made to Appointment	Average Days From First Appointment Made to First Edit/Resubmit	Average Days From First Edit/Resubmit to Completed Consult	Average Days From First Forwarded From to Closed
CommunityCare	1,348,311	2.3	17.6	4.3	21.8	19.5	22.3	30.5	4.8	50.4	63.7

5

From the Query Report Results:

1. Right click in the Consults total for Community Care,
2. Click on "Action"
3. Select "Consult Patient SSN Report" by moving the mouse to the right

Pyramid Analytics

Right click and select Analyze Further to "create your own view" from an existing report

Home Open Consults Unscheduled All Consults RC

By Status Timeliness Stat Trend Trend By File Entry Date Trend By Closure Date Consult Performance

Receiving Facility District - Location - Receiving Facility Primary Request Type - Receiving Ser... Primary Stop Clinic Type - Receiving Service - StopCode File Entry Date - File...

Multiple Selections CommunityCare All Clinics FY20

Consults, Average Days From File Entry To First Active, Average Days From First Active to First Scheduled, Average Days From File Entry To First Forwarded From, Average Days From First Forwarded From to First Scheduled, Average Days From File Entry To First Scheduled, Average Days From File Entry To Appointment...

Receiving Service Classification	Consults	Average Days From File Entry To First Active	Average Days From First Active to First Scheduled	Average Days From File Entry To First Forwarded From	Average Days From First Forwarded From to First Scheduled	Average Days From File Entry To First Scheduled	Average Days From File Entry To Appointment Made	Average Days From First Appointment Made to Appointment	Average Days From First Appointment Made to First Edit/Resubmit	Average Days From First Edit/Resubmit to Completed Consult	Average Days From First Forwarded From to Closed
CommunityCare	1,348,311	2.3	17.6	4.3	21.8	19.5	22.3	30.5	4.8	50.4	63.7

Interact

- Focus Data Point
- Download Data Point
- Drill Down
- Drill Up
- Drill To Level
- Filter
- Expand Down
- Member Selection
- Actions
 - Data Definitions
 - YOSC Help Desk
 - Consult Patient SSN Report
- Change Visual
- Build New Alert
- Analyze Further
- Information

6

Review the Consult Patient SSN Report:

- From the results on the computer screen
- Export data to one of the formats available from the Save Icon drop down options

PROCEDURES

The screenshot shows a web application titled "ConsultCellAction". It features a navigation bar with buttons for "Data Definitions", "VSSC Help Desk", and "Rate Report". Below the navigation bar is a table with columns: "Sending Staff", "Sending Location", "From Stop Code", "Ordering Provider", "Consult SID", "Patient SSN", and "Patient Name". The first row of data shows "402" for Sending Staff, "TOG MED ONCO MD LEE COBI" for Sending Location, and "316" for From Stop Code. A download menu is open, showing options: Word, Excel, PowerPoint, PDF, TIFF file, MHTML (web archive), CSV (comma delimited), XML file with report data, and Data Feed.

Sending Staff	Sending Location	From Stop Code	Ordering Provider	Consult SID	Patient SSN	Patient Name
402	TOG MED ONCO MD LEE COBI	316				

For information on performance improvement, please see Section 8.2.

Analysis

Pending: When viewing pending consults, note that in these cases the consult has not been actioned by the Facility Community Care Office. Pending consults should remain in PENDING status no more than 2 business days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 2 business days. Analysis of these consults would include reviewing by consult specialty to determine specialty and/ or assigned community care staff workload assignment to identify possible delays in consult flow.

Note: If a consult is not received in the toolbox, it will not change into an active status

Active: Review by specialty and/or Community Care staff workload assignment to determine delays in scheduling appointments. This could include vendor and/ or network analysis as well.

Note: If you notice a high number of Community Care consults, the Transparency Tool has the ability to view where the Veteran is in the scheduling process, by using the consult ID number.

Scheduled: Generally, high numbers in this section indicate an issue with medical record receipt. Review possible scanning backlogs and utilize tools such as TPA Med

Record Reconciliation Report (link to be added when available) close consults with medical records.

Reference Documents

- [VHA Directive 1232\(1\): Consult Policy and Procedures \(Amended 09/23/2016\)](#)

6.4 How to Evaluate Referral Management Timeliness

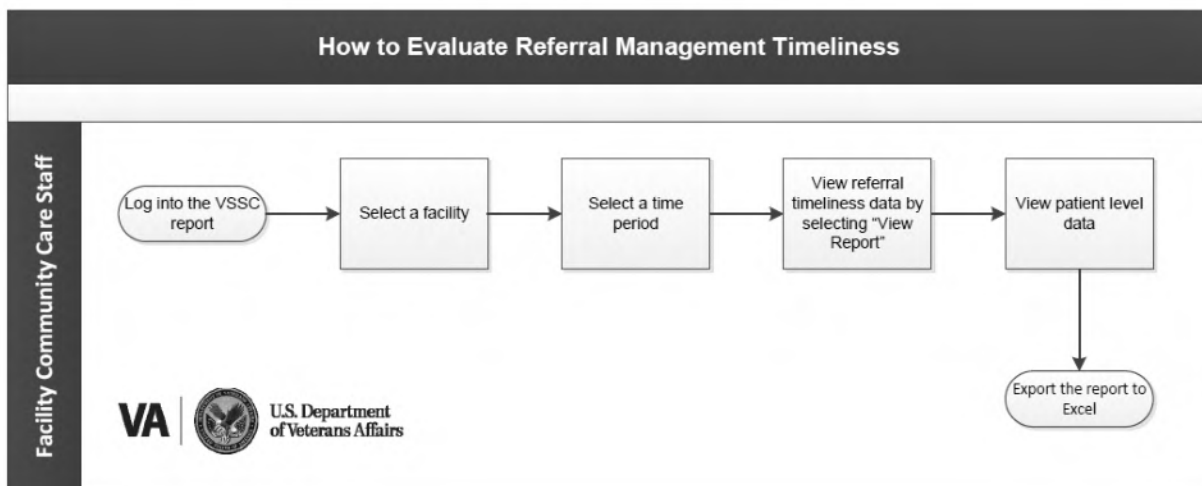
Impact and Performance Benchmarks

Monitoring referral management timeliness is essential to avoid delays in consult management resulting in extended wait times for Veterans to receive an appointment. See below for the steps to access and view referral timeliness data.

While the current report only provides timeliness metrics for Community Care consults, a multidisciplinary team from the VHA Office of Community Care is planning to deploy enhanced VSSC reports that will have more granular timelines measures and data for all Community Care consults.

Site Target(s):

- 90% of consults should be scheduled within 30 days



PROCEDURES

General Considerations:

- This report currently tracks Community Care referrals for services unavailable and for Wait Time Eligible Veterans;
- Upon national implementation of One Consult and the Consult Toolbox, reports for additional programs will be made available

PROCEDURES	
<ul style="list-style-type: none"> ○ The data reliability of this report is dependent on the appropriate entry of the unique ID by VA staff • To view facility level and national timeliness data, VSSC access is required • To view Veteran level data, SSN level access is required <ul style="list-style-type: none"> ○ Please use this link to access instructions on obtaining VSSC and SSN level access 	
STEP	ACTIVITY
1	Login into the VSSC report: Use this Consult Reports link to access the Consult Timeliness report.
2	Select a facility: Select the desired facility.
3	Select a time period: Select the month(s) of data to be viewed.
4	View referral timeliness data by selecting 'View Report': View the referral timeliness data for the selected facility, all VISNs, and the nation.
5	View Veteran level data
6	Export the report to Excel: Click on the 'Export to Data Feed' to export the report.

Analysis:

Once data has been exported it should be analyzed to determine delays in specific categories of care and/or to isolate extreme timeliness outliers affecting facility averages.

Reference Documents

- VHA Directive 1232(1): Consult Policy and Procedures (Amended 09/23/2016)
- [Interim Solution to Track Referral Timelines](#) (update in process)
- [TPA Timeliness Report Fact Sheet](#) (update in process)

6.5 How to Evaluate Secondary Authorizations Requests (SARs) / Notifications for TriWest (TW)

Impact and Performance Benchmarks

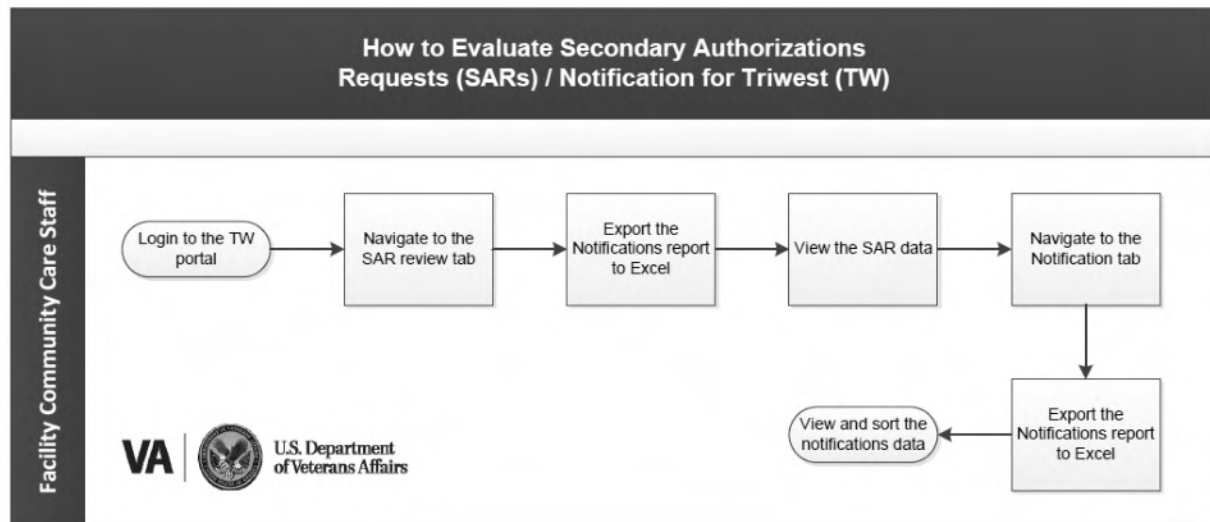
Monitoring SARs, returns, and notifications is essential because SARs and notifications not adjudicated will result in Veteran care delay. See below for the steps to access and view SARs and notifications for TW.

Site Target:

- 90% of SARs, returns, and notifications should be actioned no later than 5 days from receipt

Site Performance Goals:

- All pending SARs, returns, and notifications should be actioned no later than 5 days from receipt



PROCEDURES

General Considerations:

- Only applicable to TPA processes, when the TPA is scheduling the appointment.

Note: For sites doing self-scheduling, the SAR is being sent directly to the VA facility.

- For every return an associated notification will be created
- If the process for completing a return or notifications is not followed currently the return or notification will not be removed from the count
- Users can obtain access to the TriWest portal by referencing the TW Portal User Request Process

PROCEDURES	
STEP	ACTIVITY
1	Log into the TW portal: Log into the TriWest Portal .
2	Navigate to the SAR review tab: Click on the 'SAR Review' tab; Data is divided into two sections: <ul style="list-style-type: none"> • SARs awaiting adjudication • SARs that have been reviewed and adjudicated within 30 days
3	Export the Notifications report to Excel: Click on the 'Export to Excel Icon' and select 'Open' to view the reports within Excel.
4	View the SAR data: View the SAR data and sort using the columns within the report to identify specific sets of SARs.
5	Navigate to the Notification tab: From the homepage of the TriWest Portal, click on the 'Notifications tab'.
6	Export the Notifications report to Excel: Click on the 'Export to Excel Icon' and select 'Open' to view the reports within Excel.
7	View and sort the notifications data: View the notification data and sort using the columns within the report to identify specific sets notifications.

Analysis:

Review pending SAR/notifications to determine the correct process for completion was followed. Additionally, when looking at returns, evaluate the age of the returns to ensure that Veterans waiting for care the longest are adjudicated first. Review and analyze return reasons to determine cause and corrective action if applicable. Ensure staff are using TPA chat rooms to prevent returns when appropriate.

Resources:

TriWest Portal Notifications – Instructions for retrieving returns from the TriWest portal is located in the [TriWest Returns SOP](#).

6.6 How to Evaluate Health Share Referral Management (HSRM) Measures

When the Health Share Referral Management (HSRM) tool is implemented, there will be a period where data on referral management will need to be accessed within HSRM. Users will be able to view various reports on the steps of the referral process that occur

in HSRM and are relevant to their position. Shortly after, HSRM data will be pulled into future state dashboards that show data on the full lifecycle of care in one location.

Task Management and Oversight Reports

1) Recommended Reports for Facility Community Care Staff and Supervisors:

HSRM Reports Reference Guide

Title	Type of Staff	Frequency of Report	Definition	Primary Use
Referral Care Coordination Task History Report	VA Staff	Run as needed per local guidance	This report is not listed under the list of Reports in HSRM, but staff can download it from the Referral Details screen and see all of the history on the tasks of a referral.	This report provides users with a list of the changes made against care coordination tasks associated with a referral, including when the task was made and by whom, as well as old and new values.
Provider Exclusionary Management Report	VA Staff	At minimum, run report once a week according to Provider Exclusionary Report Standardized Operating Procedure, or per local leadership guidance	The Provider Exclusionary Management Report contains a list of referrals and past and/or future appointments scheduled with providers or community locations that have since been inactivated in HSRM or PPMS.	VA staff can use the Provider Exclusionary Management Report to identify when a Veteran was treated or is scheduled to be seen by providers that are no longer active in VA systems. A provider or community location can be inactivated for a number of reasons, including be added to the LEIE list. This information provides report users with insights as to how often excluded providers have been seeing Veterans. The report can be used to review past appointments with providers that were later inactivated to identify Veterans that may need to be followed up with to discuss previous care

				provided. The report can also be used to identify appointments that need to be re-scheduled or referrals that need to be reassigned because the provider or location is no longer active.
Clinical Staff Pending Status Report	VA Clinical Staff	Run as needed per local guidance	The Clinical Staff Pending Status Report allows VA staff and supervisors to generate a tailored list of referrals based on how long referrals have been pending in the current referral status. The Days on List field from the HSRM UI Referral List screen is a count of days since the referral was first created,	The Clinical Staff Pending Status Report will be primarily used to allow VA staff to quickly identify which referrals in their queue require action or follow-up.
	Supervisors	Daily		

			which corresponds with the date that either a) a community care consult was signed or b) an in-house consult was forwarded to community care. The Days in Current Status field on this report allows staff to view the number of days that a referral has been in its current HSRM referral status.	
Expiring Referrals Report	VA Staff / Supervisors	Run as needed per local guidance	The Expiring Referrals Report allows VA staff and supervisors to generate a list of referrals that are due to expire within the selected date range. The Days until Expiration field calculates the number of days from the current date to the referral expiration date.	The Expiring Referrals Report will be primarily used to allow VA staff to quickly identify referrals that need to be reauthorized to prevent a lapse in authorized services.
Community Provider Referral Summary Report	VA Staff / Supervisors	Monthly (present to Oversight Council)	The Community Provider Referral Summary Report allows VA staff and community	The Community Provider Referral Summary Report is used to generate a list of all referrals that have been sent to a particular community provider/facility via HSRM. This includes referrals where the community provider/facility

			providers to generate a tailored list of referrals that have been sent to a community provider/facility.	was set as the primary treating facility on the referral, as well as referrals for which the community provider/facility was associated with the referral via a subsequent appointment within the episode of care.
--	--	--	--	--

Appointment Status Reconciliation Report	VA Staff/ Supervisors	Weekly	The Appointment Status Reconciliation Report contains a list of all appointment dates in the past that still have a 'Booked' appointment status in HSRM.	Community care staff can use the Appointment Status Reconciliation Report to identify past appointments that have not had an outcome documented in HSRM. The report provides details about the appointment such as the appointment date, appointment time, and appointment location, as well as details about who scheduled the appointment. This report provides for accountability, so that users understand who ought to address the appointment status issues identified by the report.
---	--------------------------	--------	---	---

Referral Volume Report	VA Staff/ Supervisors	Run as needed per local guidance	Allows VA supervisors and leadership to review SEOC and Category of Care volume by VA Facility and VISN for a selected date range.	The Referral Volume Report is used by VA supervisors and leadership to review the number of referrals created for selected VA Facilities during a selected range, as well as the current status of those referrals. The report is further broken down by SEOC and Category of Care to allow for comparison of volume by VA Facility and over time. The report contains a summary table with a breakdown of referral volume by VA facility, as well as a detailed table with the SEOC and Category of Care information.
---------------------------	--------------------------	---	---	---

Referral Processing Details Report	VA Staff/ Supervisors	Run as needed per local guidance	The Referral Processing Details Report allows VA supervisors to review and analyze referral-level processing timeliness details.	VA supervisors and leadership can use the Referral Processing Details Report to review and analyze detailed information about processing timeliness. The report contains referral level timestamps across the full referral lifecycle, from community care consult creation/receipt, to closure of an episode of care. The report contains calculations on key processing periods (e.g. days from referral approval to first appointment scheduled, days from consult creation to initial care given), but the data contains key timestamps from the referral lifecycle that can be leveraged for additional analysis on processing timeliness. The report does not capture processing
------------------------------------	-----------------------	----------------------------------	--	--

				timeliness data for referrals that were suspended prior to being either completed or canceled.
--	--	--	--	--

VA Community Care Staff	Daily	Care Coordination Tasks Detail Report	Allows VA Community Care staff and supervisors to review detailed information about open and completed care Coordination tasks in HSRM	The Care Coordination Tasks Detail Report will be primarily used when VA Facility Community Care Staff and Supervisors need to export detailed task information to review and analyze completed and ongoing work. For example, the report can be used to review specific types of tasks that are pending for a facility. In this scenario, a supervisor may run the report to return all uncompleted "Follow Up with Veteran" tasks to review with staff and assign tasks accordingly amongst the team. A supervisor may also run the report to analyze how long it is taking to complete tasks, review who tasks are being assigned to, and identify tasks that have been pending for a
Supervisors	Run as needed per local guidance			

				certain number of days and do not have an assigned user. Staff-level HSRM end users will only be able to view results for tasks that are currently assigned to them. Exporting a list of assigned tasks as a report will allow staff to view other details about the referrals that their tasks are linked to that are not visible on the HSRM task list screen (e.g. referral number, Veteran name, SEO
VA Staff / Supervisors	Run as needed per local guidance	VCA Eligibility	The VCA Eligibility Report contains details on affiliations returned,	VA Supervisors can use the report to analyze whether referrals sent to VCA

			affiliations selected, and reasons for selecting a provider when the PPMS Provider Search is used in HSRM.	providers could have been sent to CCN or local contract providers within the CCN QASP drive time standard. The report will indicate whether the PPMS Provider Search was used for each referral or scheduled appointment within the selected parameters. For referrals and appointments where the PPMS Provider Search was used, supervisors can analyze whether national contract providers (e.g. CCN) were available within drive time standards and if they were, why the VA scheduler elected to use a VCA provider instead of a national contract provider.
VA Staff / Supervisors	At a minimum weekly	Appointments Scheduled after Expiration Date Report	The Appointments Scheduled after Expiration Date Report provides a list of referrals with appointments	VA staff can utilize the Appointments Scheduled after Expiration Date Report to identify appointments that are

			scheduled after the referral expiration date.	scheduled after the referral expiration date, so that the appointment can either be re-scheduled or a new referral can be issued with a new referral data and expiration date. The report provides details on the referral such as its service requested and associated VA facility, as well as high level information on the associated appointment including the appointment date and appointment status.
VA Staff	Run as needed or per local guidance	Community Provider User Provisioning Report	The Community Provider User Provisioning Report provides a list of all community	VA and contractor staff can use this report to understand which providers
Supervisors	Daily			

			provider/facilities in HSRM and identifies whether the listed facilities have at least one active HSRM user.	within their network are have active HSRM accounts. For example, an end user could enter a parameter value of "No" in "Location Has Active Users?" to generate a list of all community providers that are not using HSRM. Further, the report users can identify if a community provider is actively receiving referrals via HSRM.
VA Staff / Supervisors	Run as needed per local guidance	Referral Date Change Audit	The Referral Date Change Audit Report describes all date changes made against referrals, including the type of date change, the old and new date values, when the change was made, and by whom it was made.	The Referral Date Change Audit Report enables VA staff to review and understand how referral dates have evolved.
VA Supervisors	Run as needed per local guidance	Level of Care Coordination Report	Allows VA supervisors to review the levels of care	The Level of Care Coordination Report will be

			coordination for active referrals.	primarily used when VA supervisors need to review the levels of care coordination for active referrals and the VA staff that are assigned to those referrals. The report also allows supervisors to identify referrals that have a no value selected for the level of care coordination. VA supervisors can use the report to determine whether users from the appropriate HSRM security group are assigned to the referral based on the level of care coordination. While a supervisor could see the assigned user for a referral from the HSRM referral list screen, this report also identified the security group that the assigned user belongs to, so that a supervisor can be informed
--	--	--	------------------------------------	---

				when non-clinical staff are assigned to referrals with a moderate, urgent, or complex level of care coordination.
VA Supervisors	Weekly	Task Review	Allows VA supervisors to analyze staff productivity related to task assignment and completion.	The Task Review Report will be primarily used when supervisory staff want to identify the tasks pending on VA staff task lists to appropriately allocate work. The report can be filtered by specific task categories and types to meet the supervisors reporting needs. The report also allows supervisors to see what tasks are unassigned so that work can be allocated accordingly.
VA Supervisors	2 x / week-Tuesdays & Fridays	Care Coordination Task Workload Report	Allows VA supervisors to analyze staff workload based on the quantity of open tasks assigned to them.	The Care Coordination Task Workload Report will be primarily used by supervisory staff when they want to understand the tasks VA staff are addressing. The report contains a

				Summary tab which quantifies specifics task be individual members of the VA staff. And specifics regarding assigned tasks can be analyzed by filtering the detail tab. The report also allows supervisors to see what tasks are unassigned so that work can be allocated accordingly.
VA Staff, VA Supervisors, Community Providers	Run as needed per local guidance	Veteran Appointments Report	Allows VA staff, VA supervisors, and Community Providers to review the recent and upcoming Veteran appointments that are scheduled in HSRM.	The Veteran Appointments Report is used to generate a list of Veteran appointments that are scheduled in HSRM. VA staff and supervisors can generate a report for past and future appointments for referrals originated from their facility. Community providers can generate an appointment list for appointments scheduled at their facility. An example of a scenario where VA staff can

				utilize the report would be to generate a list of all appointments that were scheduled during the prior two business days in order to follow up with the Veteran to confirm that they attended the appointment. Community providers can use the report to generate a list of all Veteran appointments scheduled in HSRM for their facility for the upcoming week. The report also contains additional details about the Veteran, episode of care, and specific location/care site of the appointment.
VA Staff / Supervisors/ Community Providers	Run as needed per local guidance	Community Wait Times Report	The Community Wait Times Report contains information on historical wait times for community appointments.	VA staff and community providers can use the Community Wait Times Report to review the average number of days that it takes community providers to see a Veteran after accepting a

				referral from the VA. The report contains appointment details such as provider specialty, SEOC, Category of Care, provider affiliation, and geographic details to help VA staff identify providers and areas that have been historically able to provide services to Veterans quickly and within Clinically Indicated Date threshold targets.
CAR Staff		CAR Referrals Report	Allows VA CAR Staff to review detailed information about completed and in process HSRM referrals.	VA CAR Staff can use this report to review detailed information about completed and in process referrals for unauthorized emergency care in HSRM. The data export can be filtered to review completed work and identify referrals that need to be completed. For example, the report can be used to find

				referrals that are approved (SEOC and magic checkbox selected) but need to be completed (e.g. still missing program authority, EOC Complete status, and community provider selection). The report can also be used to find referrals that have an Emergency Non-SC 1725 program authority or denial SEOC but were last updated by a non-CAR user. Users can also use parameters to “pre-filter” the report results to return only referrals with specific program authority, SEOC, or status values.
Accounting of Disclosure	VA Supervisors / HIMS	Weekly	The Accounting of Disclosure Report contains a list of all documents that are created by VA HSRM end users that are shared by VA HSRM end users with either community	VA supervisors can use this report to account for the disclosure of medical documents to external entities. A “sharing of documents” occurs if a TPA or community provider/facility

			<p>provider/facilities or Third-Party Administrators (TPA). The report also contains a list of end users that are external to the VA that have viewed the documents from the documents shared list. The report will not contain document sharing information for documents uploaded to HSRM by external to the VA users or that are shared by external to the VA users.</p>	<p>has access to a referral by way of being listed as the network, listed as the initial community provider facility, or receiving a Veteran appointment in HSRM but not listed as the initial provider on the referral details screen. This definition is valid because any HSRM end user for a community site or TPA will have access to the documents uploaded to the referral. So, document sharing is defined as any referral that has been allocated to a TPA or community facility that has had at least one document uploaded to it by a VA end user.</p>
Medical Documentation Report	VA Staff/ Supervisors	Run as needed per local guidance	<p>This report shows all referrals and appointments that received Medical Documents in the past two days.</p>	<p>This report provides users with the ability to see if any action was taken on these appointments with medical documents to see if staff</p>

				reviewed and loaded documents back to VistA.
--	--	--	--	--

Note: For more information regarding additional reports available in HSRM, please see the HSRM Reports Reference Guide.

Note: The timing out of reports is a known issue and is being addressed. To mitigate the timing out, please condense the timeframe for the request. It is recommended to use the available filtering options on the parameters screen before exporting the report requested.

HSRM Referral – Actions when a Community Provider is Deactivated in PPMS after an Appointment is scheduled and still Pending.

There is an auto task that is generated by HSRM. We do know field users have challenges with the task list at this point because of the large volume of task and the inability to sort and filter the list for an effective workflow. CI has been working with the HSRM team to remedy this issue and hope to have resolved with the 9.0 release in June 2020.

In the interim a supervisor or manager can run a daily-weekly report that shows when a veteran is scheduled in HSRM with a Community Provider who is no longer active in PPMS.

- Managers or supervisor should routinely run the HSRM Provider Exclusionary Management Report 1-2 times a week to validate that no Community Providers for which their VAMC has any future appointments scheduled in HSRM and that Community Provider have been recently deactivated in VA systems (PPMS).
- When there is a provider found that has been recently deactivated and there is a pending Veterans appointment - the MSA must take actions cancelling appointment in HSRM - notifying Veteran & vendor of the action and why.
- When notifying the Veteran, the MSA should obtain the veterans new appointing preference and follow the FGB Chapter 3.9 – 3.15 How to Schedule process.
- HSRM Report Name and Parameters:

Report: Provider Exclusionary Management Report

Definition: The Provider Exclusionary Management Report contains a list of referrals and past and/or future appointments scheduled with providers or community locations that have since been inactivated in HSRM or PPMS.

Primary Use: VA staff can use the Provider Exclusionary Management Report to identify when a Veteran was treated, or is scheduled to be seen by providers that are no longer active in VA systems. A provider or community location can be inactivated for a number of reasons, including be added to the LEIE list. This information provides report users with insights as to how often excluded providers have been seeing Veterans. The report can be used to review past appointments with providers that were later inactivated to identify Veterans that may need to be followed up with to discuss previous care provided. The report can also be used to identify appointments that need to be re-scheduled or referrals that need to be reassigned because the provider or location is no longer active.

Output: Excel

Report Parameters: Format

Provider Inactivated in Last N Days: Numerical Entry; used to return providers inactivated in a certain number of days in the past

Referral or Appointment Date From: Calendar Selection; this is used to return Veteran appointments within a date range with providers inactivated within a certain number of days

Referral Appointment Date To: Calendar Selection; this is used to return Veteran appointments within a date range with providers inactivated within a certain number of days

VA Facility: List Drop Down; used to only return referrals originating from the selected VA facility/s

Auto Generated Tasks _HSRM

HSRM contains system-generated (automated) tasks. These automated tasks help streamline referral processing and enhance communication between community providers and VA, as well as within the facility community care office itself for efficient care coordination.

Note: There is a requirement to utilize the Screening Triage Tool in order to effectively utilize the HSRM Task List/Task Option. If an HSRM Task is not addressed within 10 days, the Task will disappear from the Task List.

Automated Tasks are generated with the following parameters:

- Based on specific system triggers
- Given a due date of one day after the automated task is created, but users may change the due date for tasks in Task Edit Screen
- Triggered for VA facility community care staff when medical documents have been received from a community provider
- Automated tasks may also be entered as a manual task

There are several types of automated tasks generated to help users complete appropriate care coordination activities for a Veteran's referral. All automated tasks can be sent as manual tasks.

Automated Task	Trigger	Actions	Receiver of Task
New Appointment Scheduled	When an appointment is scheduled, by community provider staff, at a location that is different from the initial provider.	Facility community care administrative staff receives an automated task to notify them the Veteran needs an appointment for a procedure which is not performed at the community provider's office. The community provider's office will coordinate this appointment and notify the VA. No action is needed from facility community care staff.	Facility community care staff
Review Returned Referral	When a community provider rejects a referral.	Review the returned referral Identify a new community provider, send the referral packet to the new community provider and notify the Veteran of the community provider change	Facility community care staff

		Mark the task as complete	
Reassign Referral to Another Provider	When a community provider has been made inactive (i.e., end dated) and is associated with a referral in the Sent, First Appointment Made, Initial Care Given or Accepted status.	<p>Open PPMS to find another community provider</p> <p>Contact the Veteran to confirm community provider preferences and select a High Performing Provider (HPP) if possible</p> <p>Update the referral with the new community provider's information and send the referral to the new community provider</p> <p>Mark the task as complete</p>	Facility community care clinical staff
Review Cancelled Referral	When a referral status is changed to Cancelled.	<p>Review the cancelled referral to determine if any appointments have been scheduled or attended for this referral</p> <p>Take actions to cancel any appointments in HSRM and notify the Veteran and TPA of the appointment cancellation</p> <p>Schedule a new appointment for the Veteran and reference the How-to Schedule process per the Field Guidebook 2.0, Chapter 3, Sections 3.9 – 3.15 if needed</p> <p>Document the contact in the CC-CCP Note</p> <p>Mark the task as complete</p>	Facility community care staff and TPA
Review RFS Document	When a Request for Service (RFS) document has been uploaded to a referral.	<p>Review the RFS form</p> <p>Send the RFS form for clinical review, if required</p>	Facility community care staff based on level of care

	Note: RFS was formerly known as Secondary Authorization Request (SAR)	Enter a new consult if services are approved Mark the task as complete	coordination assigned
Follow Up with Provider (2-Day Follow Up with Provider to Verify Attendance at the Appointment)	When two days have passed since the date of the Veteran's first appointment.	Contact the community provider staff to confirm that the appointment was attended Contact the Veteran and see if there are any additional appointments or services required Document the contacts with the Veteran and the community provider staff within the CC-CCP Note Mark the task as complete	Facility community care staff
Follow up with Provider (25-Day Follow Up for Medical Documentation - Subsequent Request)	When medical documentation has not been received from community provider staff, within 25 days of status change to Initial Care Given or within 25 days of the earliest appointment.	Contact community provider staff for medical documentation Document the request Mark the task as complete	Facility community care staff
Review Medical Documents from Community	When documents are uploaded to HSRM with the Medical Documentation type tag.	Locate the medical documents received for the Veteran Conduct a review of the documents If indicated, send medical documents for a clinical review	Facility community care staff
Submit Medical Documents to VA	When seven days have passed since the referral status was changed to Initial Care Given.	When a community provider determines additional services are not required for an episode of care, the facility community care administrative staff changes the status of the referral in	Community provider staff using HSRM

		<p>HSRM to EOC Complete on the Referrals Detail screen.</p> <p>Once the status is changed to EOC Complete, an automated task is sent to the facility community care administrative staff to send a request for medical documentation to the community provider if medical documentation is not received within seven days of this referral status change.</p> <p>Action required is for community provider staff using HSRM to submit medical documents to the VA.</p>	
Episode of Care (EOC) Complete-Follow-Up for Medical Documentation	When a referral status is changed to EOC Complete but does not have medical documentation attached	<p>Send a request for medical documents to community provider staff</p> <p>Set a manual task to follow up within 10 days</p> <p>Mark the task as complete (once all completed medical documents have been received)</p>	Facility community care staff

6.7 How to Use the Office of Community Care Top Metrics Report

Community Care Consult Timeliness is as follows:

- Pending Consults to Active Status within 2 days
- Active Consults to Scheduled Status within 30 days
- Scheduled Consults to Completed Status within 90 days

Note: These consult timeliness metrics are based on consult File Entry Date (FED), future care consults are not included within these timeliness metrics. These timeliness metrics are being reviewed and updated for FY 2021. The Office of Community Care will release a memorandum once updated metrics are released.

The Community Care Support Center has also developed a tool that has daily updates and displays the [Office of Community Care Top Metrics Dashboard and Summary Report](#). The views in the Dashboard and in the Summary, Report provide performance determinations on the Office of Community Care's top metrics at the National, Regional, VISN, and facility levels. Currently the report reflects performance metrics for community care consult timeliness. These consult timeliness metrics are a part of CCN Readiness scores, specifically the consult composite score.

CCN Readiness and Analysis has moved to a new format called Tableau. To get all the benefits use the directions below to view in Tableau Reader instead of using the PDF! More details and data visualizations are available.

- Download or request [Tableau Reader](#)
- Verify what version of Tableau Reader you have (2018.1, 10.5, etc.)
- Go to the [CCN SharePoint](#) and **download** and **save** the Tableau Packaged Workbook compatible with your version (i.e. if you have version 10.5 download and save file CCN Readiness Dashboard August 2018_TableauVersion10.5)
- Open the file in Tableau Reader and view the Dashboard. Change the filters as needed to create the views you need.

6.8 Enterprise program reporting system (EPRS)

WHAT IS EPRS:

The Enterprise Program Reporting System (EPRS) is a business analytics and reporting tool for the Veterans Health Administration (VHA) Veterans Community Care Program (VCCP). EPRS enables VHA Office of Community Care (OCC), Veterans Integrated Service Networks (VISN), and VA Medical Center (VAMC) personnel to access data and reports for Veteran and family member community care operations through a secure and centralized portal. EPRS integrates directly with the Corporate Data Warehouse (CDW) and Data Access Service (DAS), pulling in data elements captured in internal VA IT systems – such as CCRS, CPRS, CTB, eCAMS, and HSRM – in addition to external deliverables reported by the CCN Contractors.

EPRS is built upon Microsoft's Power BI solution, which delivers intuitive reporting functionalities such as interactive performance dashboards and secure, customizable access. Integration with SharePoint enables CORs to monitor CCN Contractor performance and administer the CCN Contract.

The data collected and reported by EPRS are essential for verifying timely and appropriate access to care. EPRS is a dynamic system that will continue to expand the availability of reports and dashboards as CCN matures.

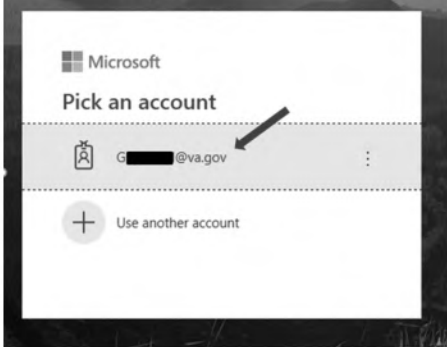
Standard Operating Procedure Process Flow: Accessing EPRS

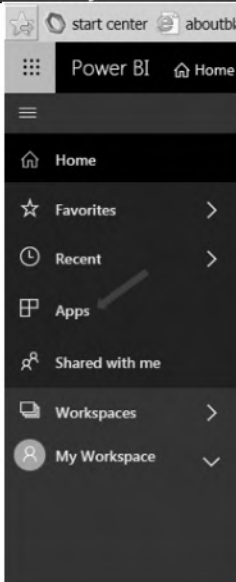
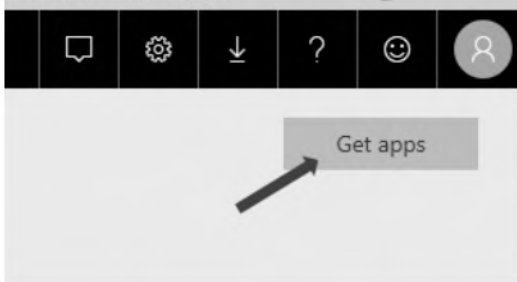

Procedures

General Considerations:

- This process is for an applicant to request Access to the EPRS application.
- Users must be logged into VA Intranet to submit an EPRS Access request or access the system itself.

Procedure for Accessing the EPRS Application:

Step	Activity
1.	Applicant and supervisor must first complete an Access Form, found on the EPRS Solutions SharePoint page (http://go.va.gov/rtx6).
2.	Applicant requests access to the EPRS application via a VA Help Desk request (with the completed Access Form attached) submitted via the <u>YourIT</u> web application (https://yourit.va.gov/va)
3.	Enterprise Help Desk staff assign help desk ticket number and notify applicant via email. Ticket and request are routed to the appropriate EPRS Application IT Staff for review and disposition.
4.	EPRS Application IT Staff will either approve or deny the access request. Upon disposition of request, applicant receives an automated email notification, and the Help desk ticket is closed.
5.	If approved, Applicant can access EPRS application via the following link: https://app.powerbigov.us/home
6.	Log into Power BI by selecting your account and using your PIV login credentials: 
7.	Once in the Power BI home page, select the "Apps" tab on the left side menu bar.

Step	Activity																																																																	
																																																																		
8.	<p>Once in the Apps space, select “Get apps” using the radio button on the top right side of the page. You will then have the opportunity to find and select the EPRS Production app.</p> 																																																																	
9.	<p>Once the EPRS app loads, you will be able to see the reports and datasets available to you based on your user access permission group classification level. To access a report or dataset, simply select the appropriate title under the dropdown menu.</p>  <table><thead><tr><th></th><th>NAME</th><th>ACTIONS</th><th>LAST ACCESS</th><th>LOCATION</th></tr></thead><tbody><tr><td></td><td>☆ EPRS-PreProduction</td><td></td><td>a day ago</td><td>Apps</td></tr><tr><td></td><td>☆ EPRS-test</td><td></td><td>a day ago</td><td>Apps</td></tr><tr><td></td><td>☆ CBOPC_PA</td><td></td><td>2 days ago</td><td>Apps</td></tr><tr><td></td><td>☆ EPRS-PreProd Attachment U</td><td></td><td>2 days ago</td><td>Apps</td></tr><tr><td></td><td>My workspace</td><td></td><td>2 days ago</td><td>Workspaces</td></tr><tr><td></td><td>EPRS-Production</td><td></td><td>2 days ago</td><td>Workspaces</td></tr><tr><td></td><td>EPRS-PreProd Attachment U</td><td></td><td>6 days ago</td><td>Workspaces</td></tr><tr><td></td><td>☆ TabularClosedConsults.pbix</td><td> </td><td>6 days ago</td><td>Shared with me</td></tr><tr><td></td><td>EPRS-PreProduction</td><td></td><td>6 days ago</td><td>Workspaces</td></tr><tr><td></td><td>☆ UM Metrics - Closed Consults</td><td> </td><td>9 days ago</td><td>Shared with me</td></tr><tr><td></td><td>☆ Attachment U Initial Alert</td><td> </td><td>9 days ago</td><td>Shared with me</td></tr><tr><td></td><td>☆ Enterprise Contact Centers & Digital...</td><td></td><td>a month ago</td><td>Apps</td></tr></tbody></table>		NAME	ACTIONS	LAST ACCESS	LOCATION		☆ EPRS-PreProduction		a day ago	Apps		☆ EPRS-test		a day ago	Apps		☆ CBOPC_PA		2 days ago	Apps		☆ EPRS-PreProd Attachment U		2 days ago	Apps		My workspace		2 days ago	Workspaces		EPRS-Production		2 days ago	Workspaces		EPRS-PreProd Attachment U		6 days ago	Workspaces		☆ TabularClosedConsults.pbix		6 days ago	Shared with me		EPRS-PreProduction		6 days ago	Workspaces		☆ UM Metrics - Closed Consults		9 days ago	Shared with me		☆ Attachment U Initial Alert		9 days ago	Shared with me		☆ Enterprise Contact Centers & Digital...		a month ago	Apps
	NAME	ACTIONS	LAST ACCESS	LOCATION																																																														
	☆ EPRS-PreProduction		a day ago	Apps																																																														
	☆ EPRS-test		a day ago	Apps																																																														
	☆ CBOPC_PA		2 days ago	Apps																																																														
	☆ EPRS-PreProd Attachment U		2 days ago	Apps																																																														
	My workspace		2 days ago	Workspaces																																																														
	EPRS-Production		2 days ago	Workspaces																																																														
	EPRS-PreProd Attachment U		6 days ago	Workspaces																																																														
	☆ TabularClosedConsults.pbix		6 days ago	Shared with me																																																														
	EPRS-PreProduction		6 days ago	Workspaces																																																														
	☆ UM Metrics - Closed Consults		9 days ago	Shared with me																																																														
	☆ Attachment U Initial Alert		9 days ago	Shared with me																																																														
	☆ Enterprise Contact Centers & Digital...		a month ago	Apps																																																														

Step	Activity
10.	If you need any assistance, please contact the VA ESD Help Desk via the YourIT application to request assistance (or copy/paste the following URL into your browser while logged onto the VA intranet: https://yourit.va.gov/va)
11.	Once EPRS access is no longer required for the fulfillment of the user's responsibilities, the user (or their supervisor) is requested to submit another VA Help Desk request via YourIT (https://yourit.va.gov/va), to have their access revoked.

User Eligibility for Reports and Functionalities Available in EPRS

Access to EPRS is based on user roles and responsibilities and requires supervisor approval. The EPRS product owner maintains a matrix aligning current-state EPRS functionalities and reports with eligible user groups within OCC, in addition to a registry of currently available reports. These documents are maintained on the [EPRS Solutions SharePoint page](#).

Reference Documents

Helpful Links and Resources

- [EPRS Access Criteria & Request Form](#)
- [EPRS Reference Sheet](#)
- [EPRS Comprehensive User Guide](#)
- [EPRS eLearning Module](#) (TMS ID 4533297)

Involved Tools and Systems

- [VA Enterprise Cloud Power BI Informational Site](#)
- [What is Power BI? \(Microsoft reference material\)](#)
- [Get Started with Power BI \(Microsoft reference material\)](#)
- [Power BI Guided Learning \(Microsoft reference material\)](#)

6.9 How to Manage Clinical Appeals for Eligibility (Pre/Post CCN)

PROCEDURES

General Considerations:

These steps outline the new clinical appeals process for appeals related to eligibility determination.

For general clinical appeals, please refer to the Directive (link TBD).

Role: Various

PROCEDURES	
STEP	ACTIVITY
1	<p>Veteran files appeal with Patient Advocate at facility regarding community care related decision</p> <p>Note: Simple administrative errors should be resolved outside of the formal appeals process.</p>
2	<p>Determine if appeal is related to address or clinical need</p> <p>If the appeal is related to an address, continue to step 3.</p> <p>If the appeal is related to a clinical need, continue to step 4.</p>
3	<p>Review for any appropriate changes</p> <p>Within 72 hours, designated admin staff should review for any appropriate changes</p>
4	<p>If eligibility appeal is related to clinical need (continued from step 2):</p> <p>Review appeal and finalize decision</p> <p>Within 72 hours, Chief of Staff or designee should review eligibility appeal and finalize decision. If the appeal is related to General Best Medical Interest (Hardship) and receiving care in the community for a one-year duration, the appeals process will take 25 days.</p>
5	<p>Send follow-up communication to Veteran</p> <p>Hold follow-up conversation and send appeal decision letter to the Veteran.</p>

6.10 PC3 Closeout Guidance

Healthcare Alliance (TriWest)

TriWest currently administers the PC3 network for all VA Regions who have not yet transitioned to CCN. It is important to note that the overall PC3 contract with TriWest

ends on 3/31/2021. VA staff will need to monitor community care referrals, and authorizations to ensure the total duration does not exceed the end date of the PC3 contract. Veteran's community care referrals associated with Standardized Episodes of Care (SEOCs) issued under a PC3 referral/authorization must end on the designated contract end date (3/31/2021).

Uniquely, as CCN is deployed in Regions 1, 2, and 3, there is a deployment schedule of when new authorizations will no longer be approved under PC3/TriWest. This deployment schedule is VAMC-specific and includes a CCN deployment date and a TriWest end date, which is 30 days post CCN deployment to allow for transition. The CCN deployment schedule can be found here:

<https://dvagov.sharepoint.com/sites/VHAOCCSEM/CIReports/Partial%20Scheduling/Fo rms/AllItems.aspx>

In Region 1, care cannot exceed 3/31/2021 per contract modifications. If you currently have care that exceeds 3/31/2021, facility community care staff will need to take steps to adjust those end dates. Please use the [Converting TW to CCN Region 1 Reference Guide](#) in order to help you review those referrals in order to take the appropriate actions and correct their end dates.

In Regions 2, 3 and 4, any referral submitted to TriWest with a referral expiration date past 3/31/2021 will automatically be adjusted by TriWest to end on 3/31/2021 in the TriWest portal. It is important to note, some staff within the facility community care offices may have the ability to adjust the referral expiration date within HSRM (VA Supervisor security group in HSRM), but for this transition this action will not be required as TriWest will be adjusting the referral expiration date automatically.

TriWest will provide a list of all referrals in Regions 2, 3, and 4 with an adjusted referral expiration date for appropriate follow up actions by the facility community care office. The report titled Referral Tracking- PC3 Closeout is available on the secure CI SharePoint site: <https://dvagov.sharepoint.com/sites/VHAOCCSEM/CIReports>. Facility community care offices will need to review each referral identified on the report and determine if the episode of care has been completed. If the episode of care has not been completed and care needs to continue, the VAMC should submit a new consult and referral to cover the remainder of the episode of care through CCN. Please use the [Converting TW to CCN Regions 2, 3, and 4 Reference Guide](#) in order to help you review those referrals in order to take the appropriate actions and correct their end dates.

In addition, for Region 4 it is important to note that the PC3 contract and CCN contract are two separate contracts with TriWest. Current Region 4 PC3 providers may, or may not, participate in both contracts so a new CCN authorization will have to be issued if care should be continued past 3/31/2021.

For those Veterans that need additional consults placed for continuation of PC3 care beyond 3/31/2021, you may schedule new referrals with a 4/1/21 appointment date. Since this is a continuation of care already started, starting care on 4/1/2021 will ensure there is no gap in coverage that would create billing issues.

If the PC3 consult has been closed, they can enter a note on the new CCN consult referencing that care has been rendered based on documentation from the PC3 consult and that this consult has been submitted for continuity of care during the PC3 close out transition period.

There are no changes to the consult closure process and the need for medical documentation retrieval for both pre 3/31/21 and post 3/31/21 consults.

6.11 How to Implement Site Improvement Initiatives



How to Evaluate Contractor Provided Data

In addition to data Veteran's Health Administration (VHA) data on network adequacy and utilization management from the Consult Toolbox (CTB), this section will provide instructions for accessing and interpreting data on the network adequacy and utilization management of Community Care Network (CCN) contractors.

Improvement Action Plans (IAPs) are meant to aid facilities in improving their community care program's performance. An Improvement Action Plan (IAP) will be developed by a Facility Community Care Office if they are unable to consistently meet their performance targets. The IAP is designed to address major deficiencies and areas of potential weakness. Improvement Action Plans should always be created and documented as a result of

internal audit findings to address ongoing reporting results.

The Facility Community Care Office will perform the following procedures to implement site improvement initiatives:

- How to implement Improvement Action Plans (IAPs) (8.2.1) – How to create and use and IAP to improve performance
- How to utilize the Community Care Support Center (CCSC) Consult Improvement Toolbox (8.2.2) – How to utilize various within the toolbox to improve community care performance.

How to evaluate contractor network using PPMS and current authorizations:

Sites are to utilize the report in VSSC titled "Community Care FBCS Authorization Entered After from Date" to determine the number of individual authorizations created. By utilizing this report sites will be able to determine the providers being utilized under individual authorizations and provider agreements to determine the top used providers for network outreach efforts.

https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/WorkloadFee/CommunityCare/Rpt_Auths_After_Treatment_Summary&rs:command=Render

Follow these steps:

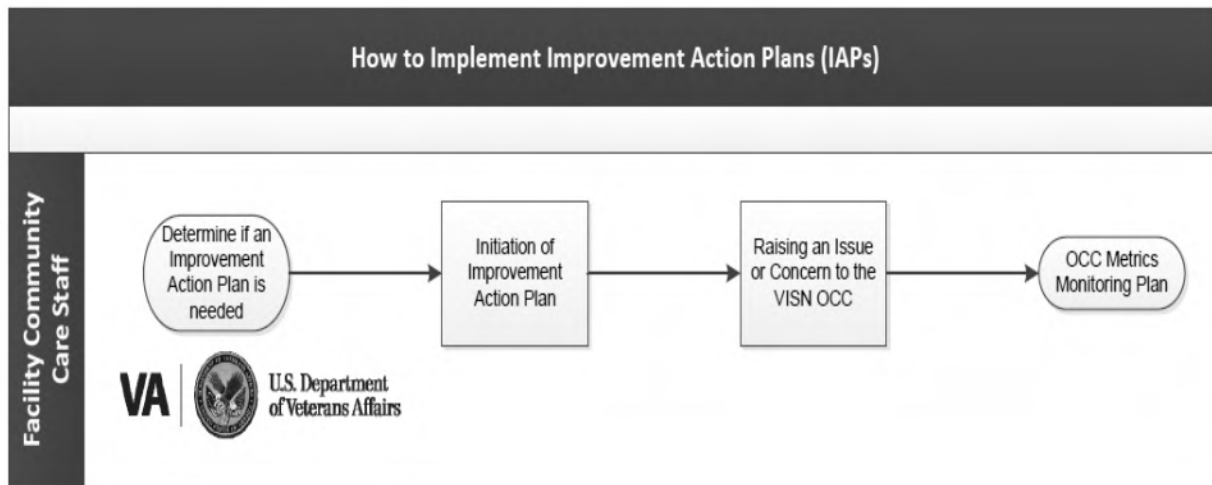
- Run the report with the following parameters, do not select parent facility level as this will make it harder to pull the raw data for all categories of care:

Summary Level	National	Fiscal Year	2019
Choose Site	National	Category of Care	ACUPUNCTURE,ADULT DAY HEALTHCARE
Detail of all Categories?	No		

- Click on your VISN to obtain the raw data for your station. You will need SSN level access in VSSC to obtain the raw data.
- Export report to excel and filter down to your facility to review the authorizations created for your site.
- In excel create a view to determine the number of individual authorizations by vendor/tax id.

  
Word
Excel
PowerPoint
PDF
TIFF file
MHTML (web archive)
CSV (comma delimited)
XML file with report data
Data Feed

6.12 How to Implement Improvement Action Plans (IAPS)



PROCEDURES

General Considerations:

- Facility Community Care Office that do not consistently meet performance targets will be responsible for developing an Improvement Action Plan (IAP)
- The purpose of the Improvement Action Plan is to address/correct any instances of errors, internal control weaknesses, and non-compliance with VA regulations, or other irregularities

STEP	ACTIVITY
1	Determine if an Improvement Action Plan is needed: Trend data weekly. If site targets are not met for four consecutive weeks, develop an IAP
2	Initiation of Improvement Action Plan: Develop an Improvement Action Plan (IAP), identifying areas of improvement and outlining recommendations and supporting policy, guidelines, or processes. SEE Improvement Action Plan Template

PROCEDURES	
	Schedule weekly conference calls and Lync meetings, including local Medical Center, VISN Leadership, and Community Care Oversight Committee; the purpose of these calls is to discuss the IAP, including progress made, timelines, and next steps
3	<p>Raising an Issue or Concern to the VISN Office of Community Care:</p> <p>If an IAP cannot be executed because of a lack of facility resources, raise an issue or concern to VISN Office of Community Care</p> <p>If an IAP cannot be executed because of a need in Tri-West general network development (not urgent care):</p> <p>This can be accomplished through the VISN BIM contacting the TriWest Region Director.</p> <p>West Region Directors (bottom right https://dvagov.sharepoint.com/sites/vacovha/DUSHCC/DC/DO/CI/S/default.aspx)</p> <p>Use the established issue brief template within internal Standard Operating Procedure (SOP) to write an issue brief</p> <p>Provide background of the issue or concern, and document recommendations and next steps</p> <p>Provide issue brief to VISN Office of Community Care leadership for guidance and assistance as necessary</p>
4	<p>Office of Community Care Metrics Monitoring Plan:</p> <p>Review and discuss ongoing metrics on a weekly basis with local facility Oversight Council and if necessary VISN Office of Community Care</p> <p>Update the IAP as necessary on process improvement measures</p>

Reference Documents

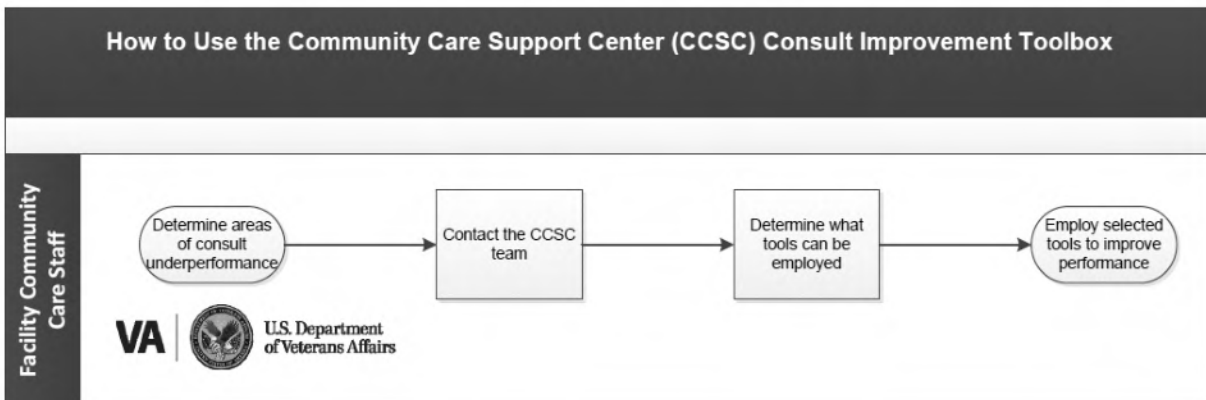
Improvement Action Plan Template

6.13 How to Use the Community Care Support Center (CCSC) Consult Improvement Toolbox

CCSC Consult Improvement Toolbox Overview

The Consult Improvement Toolbox is a collection of tools or suggestions that VISN staff may use at their discretion with the assistance of the CCSC team to improve consult underperformance in the VISN. The tools that are available within the toolbox are:

- Improvement Action Plans (IAPs) (please see section 8.2.1 for more information)
- Staffing increases
- Stand downs
- CCSC 'Go Team
- Designated Workgroups



PROCEDURES

General Considerations:

- Tools and suggestions should be implemented under the guidance of the CCSC team

STEP	ACTIVITY
------	----------

PROCEDURES	
1	Determine areas of consult underperformance: <ul style="list-style-type: none"> • Trend data weekly • If there are certain areas of the consult process that could be improved. Move to 'Step 2'
2	Contact the CCSC team: <ul style="list-style-type: none"> • Email (b)(6) @va.gov • Include clear information about the underperforming consult process areas
3	Determine what tools can be employed: <ul style="list-style-type: none"> • Work with a determined representative of the CCSC team to assess what tools can be implemented to improve the affected area's performance
4	Employ selected tools to improve performance: <ul style="list-style-type: none"> • Work with designated CSSC representative to employ various tools

Operating Model and Performance Metrics

Note: That as the Operating Model is implemented, it will be important to assess the impact of the individual foundational elements of the Operating Model on the metrics presented within this chapter. Please see below for information on the alignment of the evaluation reports presented below with the foundational elements of the Operating Model.

Clear Roles and Responsibilities

- Claims: Understanding the effects of other process changes on the roles and responsibilities for claims within the Facility Community Care Office will reduce claims without authorizations and claims batch backlogs
- Referral management: Understanding who is responsible within the Facility Community Care Office for each task reduces duplication and increases communication and more streamlined processes therefore reducing referral timeliness

Active Partnerships

- Claims: Timely payment to community care partners will ensure their continued role in providing care to our Veterans

Consistent Processes

- Claims: ensuring all processes are consistent will reduce claims received without an authorization, as this will be part of the standardized process and consistent for **every** referral
- Referral management: ensuring consistent referral processes will reduce the timeline for scheduling and ensure that referrals are managed timely and consistently

Standardized Care Coordination

- Referral management: Standardized care coordination will reduce the instances of Veterans receiving untimely care, therefore reducing referral timeliness and consult timeliness

Response Customer Service

- Referral management: ensuring that Veterans receiver timely to care and resolution to issues is integral to mission of VHA Office Community Care
- Claims: responsive Customer service that includes timely payment and invoice resolution will ensure our community care providers will continue to provide care to Veterans in the future

6.14 OCC Staffing Tool

The staffing tool is designed to enable each site with a method for quantifying resource needs necessary to successfully operate and execute the operating model.

The staffing tool is one part of the OCC operating model designed to provide sites with the right team, tools, training, and metrics to successfully implement and execute it.

The staffing tool incorporates the following:

- Average Task Time
- Workload Data
- Position Type (administrative and clinical)
- Recommended FTE levels based on calculated staffing needs for each site.
- Recommended levels are based on workload/process.

The Operating Model for Community Care is a standardized model for how resources (people, process, technology, and data) should be organized within local VA Community

Care departments to enable the future state vision. Each VA facility is responsible for implementing the administrative and clinical processes associated with the Operating Model. Part of this operating model is the VA Community Care Staffing Tool.

The VA Community Care Staffing Tool is designed to enable each site to quantify resource needs necessary to successfully operate and execute the new operating model. The tool utilizes average task times, workload data, type of role (administrative or clinical), other tasks (community care work that doesn't involve processing consults or coordinating care such as meetings, training, congressional research, etc.) and leave replacement factors to calculate resource needs. This effort is designed to assist with operation and staffing of the future state of community care.

For additional information on this process, please reference the Staffing Tool SOP.

Also, please see OCC Staffing Tool Training PowerPoint [OCC Field Guidebook - Staffing Tool Training - All Documents \(sharepoint.com\)](#)

VA Medical Centers are to update the Staffing Tool by accessing the [Staffing Tool SharePoint Site](#).

6.15 How to Report and Investigate Community Care-related Veteran Safety Events

The VHA Patient Safety Events in Community Care: Reporting, Investigation and Improvement Guidebook (Guidebook) and its processes were developed in a collaborative effort between VHA OCC, VA National Center for Patient Safety (NCPS), VAMC PSMs, VISN PSOs.

The Guidebook's purpose is to improve information sharing, reporting, and feedback to stakeholders for patient safety events (adverse events and close calls) that occur when Veterans are receiving care on behalf of VA in the community. The Guidebook is built on existing VHA patient safety reporting and investigation processes for VA-internal care. [VHA Handbook 1050.01](#) directs VA employees on the procedures that will help prevent unintentional harm to patients resulting from their medical care in VA.

The Guidebook provides the tools and processes to report, investigate, and improve patient safety for Veterans who receive community care, and supports VHA's goal of preventing unintentional harm to patients resulting from their medical care. The Guidebook and its associated processes increase communication and collaboration between VHA and its community partners. The most recent version of the Guidebook can be accessed on the [Patient Safety – Incident Reporting User Information Page](#). Any patient safety concerns, whether with TPA or Non-TPA community care providers, should be shared with your VISN PSO, VAMC PSM or VHA OCC at [CC-](#)

(b)(6)

@va.gov.

VHA Office of Community Care Patient Safety Guidebook

VHA Office of Community Care Patient Safety Event Reporting System Guidance

VHA Office of Community Care CCN Third-Party Administrator Quality and Patient Safety Representative Contact List

Requesting a Provider Hold

- FIRST: Consult the SOP found in the Patient Safety Events in Community Care Guidebook (attached).
- Always enter incident in JSPR. Reference attached document (Patient Safety Guidebook: *VHA OCC Patient Safety Event Reporting System Guidance_v1.1*)
- TPA involvement: Patient Safety Management level and field inquiries for follow up
- Reference attached document (TPA Quality/Safety Manager POC's: *VHA_CCN_TPA Q-PS Rep Contact List_20200519*)

Utilize [Request for Provider Hold SharePoint](#)

Instructions on how to enter a Request for Hold are on the Credentialing SharePoint listed below.

IMPORTANT SAFETY QUICK LINKS

Joint Patient Safety Reporting System (JPSR)	<u>Login Page</u>
VHA OCC Patient Safety	<u>Patient Safety Solutions Site</u>
VHA OCC Clinical Integration (CI)	<u>CI Solutions Site</u>
VHA OCC Network Management/Credentialing	<u>Credentialing SharePoint</u>
VHA OCC Field Request for Provider Holds	<u>Request for Provider Hold SharePoint</u>
Community Care Patient Safety and Quality Processes	<u>How VHA is Advocating for Change</u> <u>Community Care Critical Incident Tracking Notification SOP</u>

6.16 Facility Best Practices

This section of the Office of Community Care Field Guidebook will capture best practices within the community care process, identified by facility community care offices within VHA.

Veteran Self-Scheduling and Appointment Documentation:

Identified Need/Challenge	Process Implemented	Resources/References
Bedford VAMC facility community care office identified CC consults in a pending status for extended periods of time, due to delays in obtaining appointment information from community providers and Veterans.	Fax cover sheet/letter created to request that community provider send back sheet with the Veterans appointment date/time. The implementation of this process has resulted in an increase in obtaining community care appointment information in order to place the consult in a scheduled status.	<u>Appointment Request Fax Cover Sheet (Bedford VAMC)</u>

The CCN contracts were awarded to Optum Public Sector Solutions, Inc. (Optum) for Regions 1, 2, and 3 on December 28, 2018. On August 6, 2019, VA awarded the CCN contract for Region 4 to TriWest Healthcare Alliance (TriWest). The contract awards for Regions 5 and 6 are still pending. For additional information on CCN deployment please use the [CCN Deployment SharePoint Site](#).

HSRM Referral – Actions when a Community Provider is Deactivated in PPMS after an Appointment is scheduled and still Pending.

There is an auto task that is generated by HSRM. We do know field users have challenges with the task list at this point because of the large volume of task and the inability to sort and filter the list for an effective workflow. CI has been working with the HSRM team to remedy this issue and hope to have resolved with the 9.0 release in June 2020.

Task	Trigger	Receiver
EOC Complete – Follow Up for Medical Documentation	When a referral status is changed to EOC Complete .	VA Facility Community Care Staff

Follow Up with Provider	When two days have passed since the date of the Veteran's first appointment.	VA Facility Community Care Staff
Follow Up with Provider	When medical documentation has not been received from the community provider within 25 days of status change to Initial Care Given , or within 25 days of the earliest appointment.	VA Facility Community Care Staff
Follow Up with Veteran	When 5 days have passed since the date of the first appointment made for the Veteran.	VA Facility Community Care Staff
Inpatient Admission	When a referral is created or updated with the program authority Authorized/ Preauthorized VA Referral (not otherwise specified) – 1703.	Facility Revenue Technician
Invalid SEOC – Choose Valid SEOC in CTB	When a referral is generated from CTB with an invalid SEOC.	VA Facility Community Care Staff
New Appointment Scheduled	When an appointment is scheduled at a location that is different from that of the initial provider.	VA Facility Community Care Staff/Community Staff
Precertification	When a referral has a SEOC that requires precertification (meaning that the eligibility questionnaire is populated with OHI data and the referral is in the status of Sent or First Appointment Made).	Facility Revenue Group
Reassign Referral to Another Provider	When a provider has been made inactive (end-dated) and is also associated with a referral in the Sent, First Appointment Made, Initial Care Given, or Accepted status.	VA Facility Community Care Staff
Review Cancelled Referral	When a referral status is changed to Cancelled.	VA Facility Community Care Staff, TriWest

In the interim a supervisor or manager can run a daily-weekly report that shows when a veteran is scheduled in HSRM with a Community Provider who is no longer active in PPMS.

- Managers or supervisor should routinely run the HSRM Provider Exclusionary Management Report 1-2 times a week to validate that no Community Providers for which their VAMC has any future appointments scheduled in HSRM and that Community Provider have been recently deactivated in VA systems (PPMS).
- When there is a provider found that has been recently deactivated and there is a pending Veterans appointment - the MSA must take actions cancelling appointment in HSRM - notifying Veteran & vendor of the action and why.
- When notifying the Veteran, the MSA should obtain the veterans new appointing preference and follow the FGB Chapter 3.9 – 3.15 How to Schedule process.
- HSRM Report Name and Parameters:

Report: Provider Exclusionary Management Report

Definition: The Provider Exclusionary Management Report contains a list of referrals and past and/or future appointments scheduled with providers or community locations that have since been inactivated in HSRM or PPMS.

Primary Use: VA staff can use the Provider Exclusionary Management Report to identify when a Veteran was treated, or is scheduled to be seen by providers that are no longer active in VA systems. A provider or community location can be inactivated for a number of reasons, including be added to the LEIE list. This information provides report users with insights as to how often excluded providers have been seeing Veterans. The report can be used to review past appointments with providers that were later inactivated to identify Veterans that may need to be followed up with to discuss previous care provided. The report can also be used to identify appointments that need to be re-scheduled or referrals that need to be reassigned because the provider or location is no longer active.

Output: Excel

Report Parameters: Format

Provider Inactivated in Last N Days: Numerical Entry; used to return providers inactivated in a certain number of days in the past


Referral or Appointment Date From: Calendar Selection; this is used to return Veteran appointments within a date range with providers inactivated within a certain number of days

Referral Appointment Date To: Calendar Selection; this is used to return Veteran appointments within a date range with providers inactivated within a certain number of days

VA Facility: List Drop Down; used to only return referrals originating from the selected VA facility/s

6.17 Community Care Reports

Report Name and Link	Intended Use	Intended Users	Frequency of Review
Advanced Medical Cost Management Solution (AMCMS)	The Advanced Medical Cost Management Solution (AMCMS) is a tool that integrates financial management, medical management, utilization management, and data analytics to accurately monitor and forecast community care medical services costs and usage. This solution provides a functional and sustainable interactive model to calculate and account for outstanding liabilities for services/procedures that are authorized in the community.	Facility Leadership, Community Care Managers and Staff	As Needed
VSSC Access Team Power BI Report Links: <u>Summary Tab</u> <u>Usage Trend</u> <u>Usage by Provider</u> <u>Ordering</u> Overview Video: <u>Best Medical Interest (BMI) Usage Report Video</u>	Analysis and trend usage of BMI as an eligibility reason, track referral trends by provider etc.	Facility Leadership, Community Care Managers and Staff	As Needed
<u>Care Routing Tool</u>	Shows VISN and Station wait times by Stop Code	VA Community Care and Clinical staff	As Needed
<u>CTB Reports Landing Page</u> <u>PBI Reports -All</u>	Review standardized comments/actions captured on consults. Ideal for workload tracking and distribution. The following reports are available: - All Consults	Community Care Managers and Staff	Daily / As Needed

<u>Consult Management Reports and Information Page</u>	<ul style="list-style-type: none"> - Care Coordination Reports - Consult Toolbox Usage Report - Community Care Veteran Contact Attempts and Outcome Report - Community Care Consults Closed Without Medical Records - Consult Forward Reasons Detail - Consults by Order Date - Consults with COVID Priority - CTB Justifications for Community Care - High Risk Consults by Order Date - IFC Only - SARs - Screening Triage Tool Utilization - Self Scheduling Report - MSA Community Care Veterans Preference Capture Report to review utilization 		
CCN Optum Rejects Report  Reject Portal access instructions.doc	Review Referrals sent via HSRM that Optum was unable to process due to a specific error	Community Care Managers and Staff	Daily
<u>Community Care FMS Payments Cube</u>	Shows Office of Community Care (OCC) payments extracted from the Financial Management System (FMS). This does not include Cost Transfers or future scheduled payments. This cube differs from the NonVA Care Cube that uses Central Fee as its primary data source by using an extract from FMS as the primary data source. Unlike the NonVA Care Cube, detailed claim information is not in the FMS payment data and is not available in this cube.	Community Care Managers and Facility Leadership	As needed
<u>Community Care Referrals Cube</u>	Identify referrals by Category of Care, authorization pathway (PC3, CCN, etc.), select specific date ranges	Community Care Managers and Staff	Weekly
<u>Consult-HSRM Cycle Time Report</u>	Review the average cycle time for consult and HSRM referrals. The purpose of the report is to allow user to	Facility Leadership, Community	Weekly

	look at consult and referral processing timeliness by facility, for a specific timeframe or by SEOC.	Care Managers and Staff	
<u>Community Care Opt Out Report</u>	Captures the internal VA appointments with a community care opt out comments #COO#. This report is available in the appointment cube, All Appointments tabs- Community Opt Out tab.	Facility Leadership, RCI Leadership, Internal Scheduling Staff Leadership Community Care Managers and Staff	As Needed
<u>Consult Cube</u>	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.	Community Care Managers and Staff	Daily
<u>VHA FY21 National Unscheduled Consult, Return to Clinic and Recall Request Stand Down</u>	Monitor community care unscheduled consult workload, to include consults with no activity in 30 days.	Community Care Managers and Staff	As Needed
<u>HSRM SharePoint HSRM Training Resources</u>	Reports are available in HSRM. HSRM Reports Training takes place the second (2nd) Wednesday of each month from 1-2PM Eastern Time (ET), during which community care supervisors will receive an in-depth look into the HSRM reports available to VA Users.	Community Care Managers and Staff	As Needed

<u>Implementation Tracker</u>	Tracks CCN, eCAMS, HSRM go live dates at the facility community care level.	Community Care Managers	As Needed
<u>NonVA Care Cube</u>	NonVA Care Cube displays Fee Payment Files for Inpatient, Outpatient, Ancillary and Pharmacy. Useful in doing studies related to things like how much was spent on Non VA Care, where the Non VA Care Payments are going, what types of care we are purchasing with our Non VA Care dollars, what types of patients are using the Fee program, where these patients live, rurality and unauthorized claims.	Community Care Managers, Facility Leadership	As needed
<u>OCC IDA Reports</u> <u>Non-Restricted</u>	Reports available: Scheduling Preferences Consult Monitoring CCN Optional Task 1 Quality Assurance CCN Consults by Status Urgent Care Dashboard Emergency Referrals Report VA/DOD Metrics Referral Counts Paid Claims Beneficiary Travel Telehealth report	Community Care Managers	As Needed
<u>Performance Measure Reports</u>	Performance Metrics Report – Updated Monthly	Community Care Managers and Network Directors	Monthly or as needed
<u>Referral Coordination Initiative RCI Portal</u> <u>RCI & Specialty Care HOC</u>	This report portal supports management of access principles related to the Referral Coordination Initiative by provided a consolidated view of Internal and Community Care measures in the same trends/visuals.	Facility Leadership, RCT, Community Care Managers and Staff	As needed
<u>Referral Tracking PC3 Closeout</u>	Tracks number of referrals in HSRMS with a referral end date 4/1/2021 and after. Tracking only for PC3 contract	Community Care Managers	As needed

	closeout. When reviewing this report, facilities must also keep in mind their CCN transition date.		
<u>Transplant Workout Checklist</u>	Checklist to be used by VAMCs as needed for transplant patients.	Community Care Managers	As needed
<u>TPA Reports</u> <u>TriWest HealthCare Alliance</u> <u>Optum</u>	TPAs provide a variety of reports of use by the VAMCs.	Community Care Managers	As needed
<u>Urgent Care Dashboard</u>	Monitor community care urgent care utilization and expenditures	VISN BIMs	As needed
<u>Unscheduled No Activity GT 30 Days Trend by VISN / Site</u>	Monitor community care unscheduled consult workload, to include consults with no activity in 30 days.	Community Care Managers and Staff	As Needed
<u>VSSC COVID 19 Reports</u>	Review consults and appointments impacted with a COVID-19 comment captured. This includes consults where the COVID-19 tab in the Consult Toolbox was used.	Community Care Managers and Staff	Daily
<u>VSSC Top Metrics Report</u>	Review community care consult timeliness and metrics	Facility Leadership, Community Care Managers and Staff	Monthly
<u>VSSC Power BI</u> <u>VSSC Consult Reports</u> <u>VSSC Care in the Community Reports</u>	Contains reports and trends for Appointments, Clinic Utilization, COVID-19, Clinic Practice Management, Referral Coordination Initiative, Staff Activity, VA Online Scheduling, Scheduling Orders (Cerner), and Scheduling Resource Assessment	Facility Leadership, Community Care Managers and Staff	As Needed

<u>Workload Distribution and Oversight Report</u>	Review workload distribution and oversight in this report as it captures possible consult triggers and activity.	Community Care Managers and Staff	Weekly
--	--	-----------------------------------	--------

Monitoring Community Care eligibility reasons and 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 community care eligibility reasons and 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?
4. What are the eligibility reasons being used for referrals to community care?

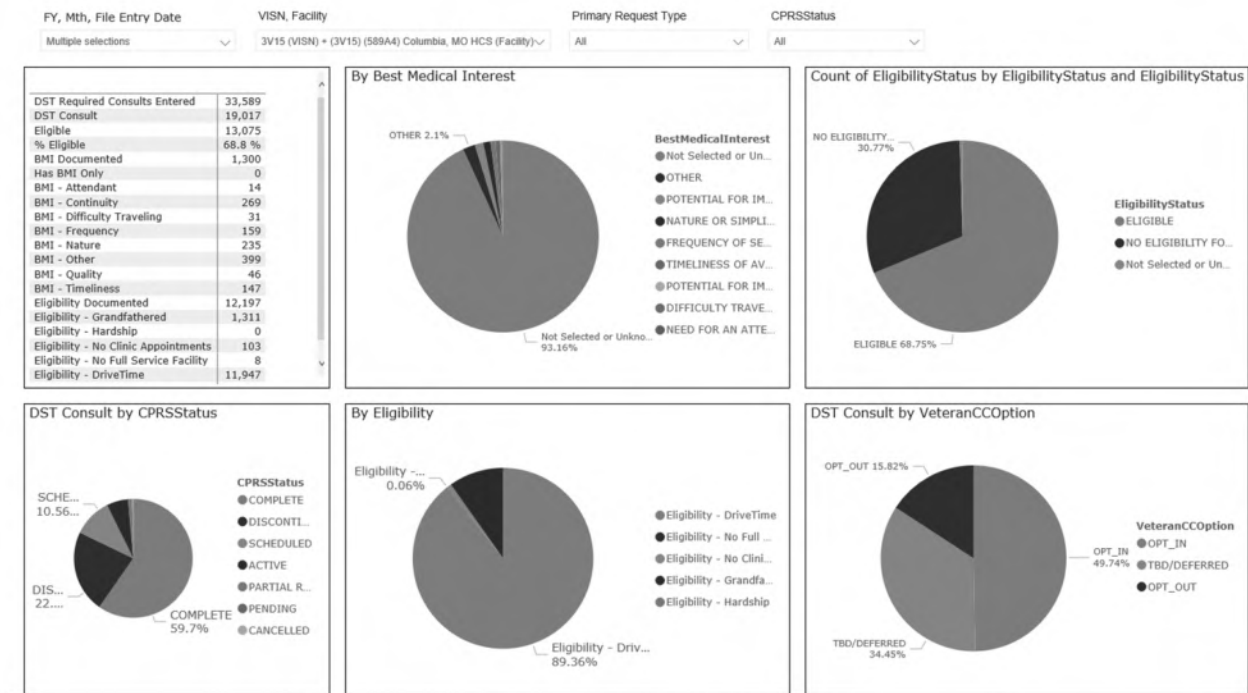
In order to answer these questions, in addition to other questions facilities should use the following reports:

DST Usage Report:

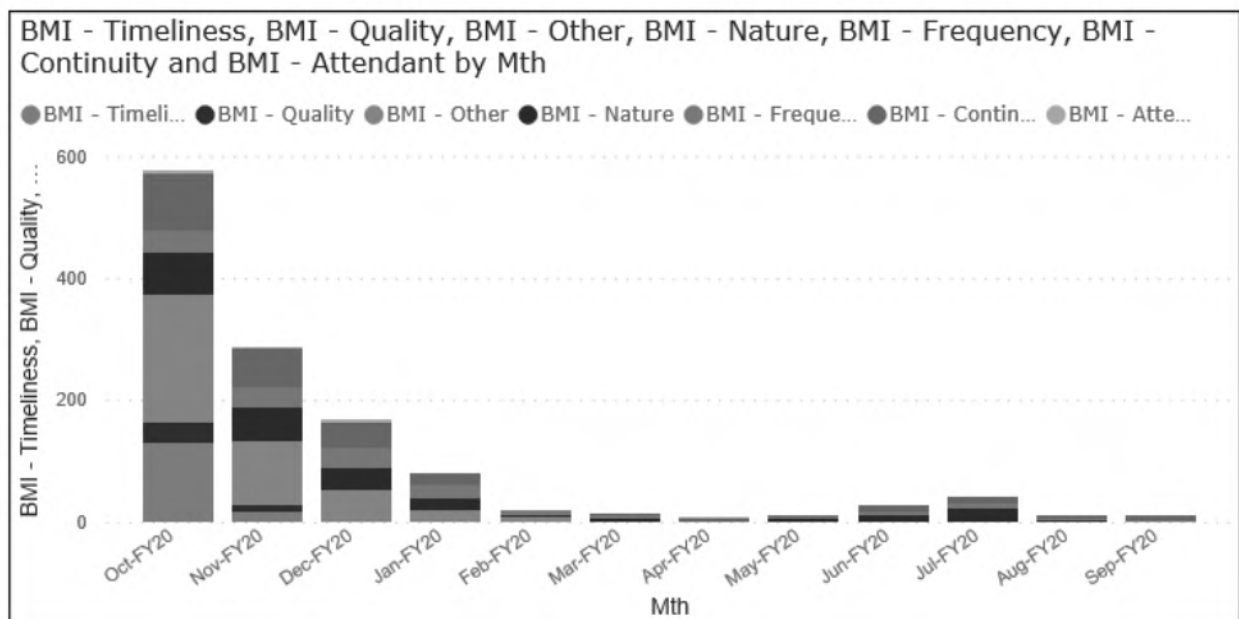
The DST Usage Report allows end users to review consults where the Decision Support Tool (DST) has been used to capture the community care eligibility reason. The report has many tabs to assist with analyzing community care referral patterns and DST usage patterns. There are a few specific tabs that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



- 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.

FY, Mth, File Entry Date	VISN, Facility	Primary Request Type										CPRSStatus					
Multiple selections	IV01	Multiple selections										All					
ConsultEnteredByStaffName		<input type="checkbox"/> Select all <input type="checkbox"/> Administrative <input type="checkbox"/> ClinicalConsult <input type="checkbox"/> ClinicalProcedure <input checked="" type="checkbox"/> CommunityCare <input type="checkbox"/> Prosthetics <input type="checkbox"/> Unknown															
		BHI - Quality	BHI - Timeliness	Eligibility - DriveTime	Eligibility - Grandfathered	Eligibility - Hardship	Eligibility - Appon										
		0	1	6	2	0	0										
		0	0	6	4	0	0										
		0	0	23	1	0	0										
		0	0	1	0	0	0										
		0	0	1	0	0	0										
		0	0	1	0	0	0										
		0	0	1	0	0	0										
		0	2	1	0	0	0										
		1	0	41	3	0	0										
		0	0	0	0	0	0										
		0	0	0	0	0	0										
		0	0	0	0	0	0										
		0	0	0	0	0	0										
		0	0	0	0	0	0										
		0	0	0	0	0	0										
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	0											
	0	0	0	0	0	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.



Consult Cube Dashboard

Product Last Updated 11/15/2020 at 8:23:00 AM CT

Open in Pyramid Analytics



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.

Client cancelled request 546b78ee-b5d0-4c95-af5e-24d376c3b06d

Receiving Facility Dist: [REDACTED]

Receiving Service Clia: [Multiple Selections]

Urgency Cat: All Urgency

CPRS Status: Open Consults

Open Consults, Open GT365 Days From Earliest Date, Open GT90 Days From Earliest Date, Unscheduled Consult, Unscheduled No Activity GT14 Days, Unscheduled No Activity GT30 Days, Stat Open GT48 Hours, Pending GT2 Business Days, Sched

Prim Clinic	Open Consults	Open GT365 Days From Earliest Date	Open GT90 Days From Earliest Date	Unscheduled Consult	Unscheduled No Activity GT14 Days	Unscheduled No Activity GT30 Days	Stat Open GT48 Hours	Pending GT2 Business Days	Scheduled Not Linked to Appt	Scheduled Linked to Post Appt	Partial Results GT 10 Days
All	21,954	1	5,272	12,791	5,319	2,329	0	58	483	7,451	131
(105) X-RAY	68	0	8	52	11				3	12	0
(109) NUCLEAR MEDICINE	2	0	0	2	1				0	0	0
(115) ULTRASOUND	25	0	2	19	9				0	4	0
(118) HOME TREATMENT SERVICES- (NON-HBPC, NON-HH, NO...	2,134	0	66	615	106				22	2	1,508
(142) WOUND TREATMENT & OSTORY CARE	6	0	1	2	2				0	4	0
(150) COMPUTERIZED TOMOGRAPHY (CT)	35	0	2	28	5				1	0	6
(153) MAGNETIC RESONANCE IMAGING/MRI	50	0	5	33	10				0	2	11
(180) DENTAL	769	0	242	503	336				0	0	241
(201) PHARM PHYSICIAN	188	0	50	103	45				0	0	0
(203) AUDIOLOGY	725	0	80	553	283				0	0	0
(204) SPEECH LANGUAGE PATHOLOGY	9	0	4	6	5				0	3	0
(205) PHYSICAL THERAPY	2,126	0	847	1,614	743				0	19	470
(206) OCCUPATIONAL THERAPY	163	0	57	141	33				0	0	20
(210) SPINAL CORD INJURY	28	0	9	21	11				0	2	5
(302) ALLERGY/IMMUNOLOGY	36	0	9	20	4				0	0	11
(304) DERMATOLOGY	802	0	308	556	242				0	60	140
(305) ENDOCRINOLOGY	55	0	18	40	20				0	4	9
(307) GASTROENTEROLOGY	335	1	119	263	138				0	0	49
(308) HEMATOLOGY	132	0	29	58	24				0	0	56
(312) PULMONARY/CHEST	545	0	137	389	195				2	1	131
(313) RENAL/NEPHROLOGY/EXCEPT DIALYSIS	41	0	3	24	2				0	0	6
(314) RHEUMATOLOGY/ARTHRITIS	91	0	42	39	38				0	9	20
(315) NEUROLOGY	357	0	64	172	62				1	7	107
(321) GI ENDOSCOPY	779	0	255	578	295				0	1	114
(322) Comprehensive Women's Primary Care Clinic	30	0	8	17	4				0	0	12
(323) PRIMARY CARE/MEDICINE	251	0	90	162	52				0	4	73
Z1961/0807782/US	37	0		37	2				0	1	37

Focus Data Point
Eliminate Data Point
Dice
Swap
Add
Member Selection
Actions
Build New Alert

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.

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.

Template: COMMUNITY CARE-OPTOMETRY ROUTIN

☒ Justification for Non VA Care:

* [REDACTED]

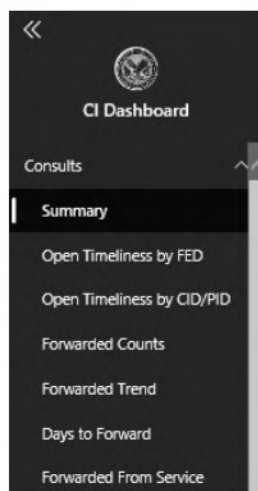
EMI-Hardship
EMI-per episode of care
No Full Service VA in State
Service Not Available
1703e Eligibility

Chief Complaint: *

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

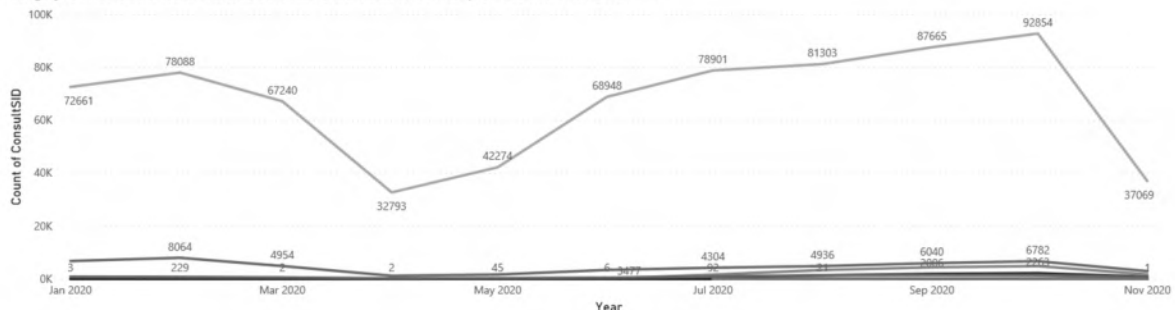


Consults Forwarded by Reason - Last Forwarded Date

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	17,069	3,019	41,463
Total	114	7,185	17,323	381	336	9,717	739,796	51,420	826,268

Consults Forwarded by Reason - Last Forwarded Date

Category ● 1703e ● Best Medical Interest ● Drive Time ● Grandfathered ● Hardship ● No Service ● Null ● Wait Time



Advanced Medical Cost Management Solution

The Advanced Medical Cost Management Solution (AMCMS) is a tool that integrates financial management, medical management, utilization management, and data analytics to accurately monitor and forecast community care medical services costs and usage. This solution provides a functional and sustainable interactive model to calculate and account for outstanding liabilities for services/procedures that are authorized in the community.

AMCMS is a dashboard that includes referral, claim, and budget data to provide a detailed view of historical utilization and cost. Users can access information about projected claim payments for outstanding referrals, budget management data, revenue collections, trends in volume of referrals and costs by category of care (CoC)/Standardized Episode of Care (SEOC), administrative cost estimates, and assessments of Community Care network adequacy. AMCMS provides decision makers with data and analytical tools necessary to:

1. Access, analyze, and understand community care cost drivers and utilization metrics.
2. Make more informed budgeting and financial management decisions
3. Improve cost controls to avoid future funding shortfalls and potential care coordination disruptions.

This tool and the reports therein help key stakeholders make informed decisions regarding Community Care utilization and medical service costs and provides a centralized resource for both clinical and financial management information. The following stakeholder groups should request access to the AMCMS tool.

- Veterans Integrated Service Network (VISN) Finance staff
- VA Medical Center (VAMC) Finance staff
- Office of Community Care (OCC) Staff:
 - Revenue Operations: Consolidated Patient Account Center (CPAC) management and individuals involved in budget and care management
 - Clinical and Network Management (C&NM) leadership and staff
 - Other OCC Stakeholders: Informatics and Data Analytics (IDA) and Business Office Administration (BOA) Finance staff
- VA medical facility leadership and clinical staff
- VISN Business Implementation Managers (BIMs)

Single Sign on Integration will allow users to access AMCMS with their VA-issued PIV cards. A process for requesting access is provided in detail on the [AMCMS SharePoint Solutions Page](#).

Please see additional resources below:

- [AMCMS SharePoint Solutions Page](#)
- [AMCMS Tool Access Overview](#)
- [AMCMS Access Control LEAF Site SOP](#)

- [AMCMS Finance Reference Guide](#)
- [AMCMS Leadership Presentation](#)
- [AMCMS Clinical and Utilization Reference Guide](#)
- [AMCMS TMS Training](#)
- Questions: VHAOCCAMCMSProjectManagers@va.gov

Referral Coordination Initiative (RCI) Reports

The Office of Community Care and the Access Office have collaborated with VSSC to create reports to assist with monitoring internal and community care measured related to the Referral Coordination Initiative.

- **RCI Data Portal:** Launching pad into RCI VSSC Dashboard and pre-existing related reports supporting management of referral coordination process
https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fAccess%2fConsults%2fConsult+-+RCI_Portal&rs:Command=Render
- **VSSC RCI Dashboard:** Provide a consolidated view of RCI key process indicators (KPIs) from both internal/direct and community care measures
<https://app.powerbigov.us/groups/me/apps/057a6693-7190-4fd4-9491-f8a038913689/reports/4a8c8345-a0a0-4d5c-a2a0-194304236571/ReportSection85644cc04246eefa74b4>

The results generated from these reports should be thoroughly analyzed to determine the effectiveness and efficiency of current operations and the reliability of reporting. Additional trend analysis should be performed to observe changes in reporting results over time and to determine the root causes behind inadequate performance.

These reports will evolve as new data measures are incorporated from various end users (i.e. RCI ELT, ND, VISN GPM, GPM, Admin/Clinical Leads).

The reports align with KPIs presented by ND's on weekly RCI HOC. The VSSC Consult Cube Dashboard must be used in order to obtain SSN level data of the reports captured on the RCI VSSC Dashboard. Reports will evolve as new data measures become available Metrics currently included in these reports are:

- Volume and percentage of internal/direct and community care Filter by VISN, Facility Specialty
- Complexity Consult Scheduling Timeliness Average days File Entry Date to First Scheduled Date by First Scheduled Month
- Average days File Entry Date to First Forwarded Date by First Forwarded Month

Additional description available in data supplement Filter by VISN, Facility, Specialty
Volume of Unscheduled Consults Metrics in development % of eligible Veterans that

opt out of Community Care % of consults with RCT engagement (based on #RCT# until CTB 2.0 is available) Scheduling Timeliness Metrics

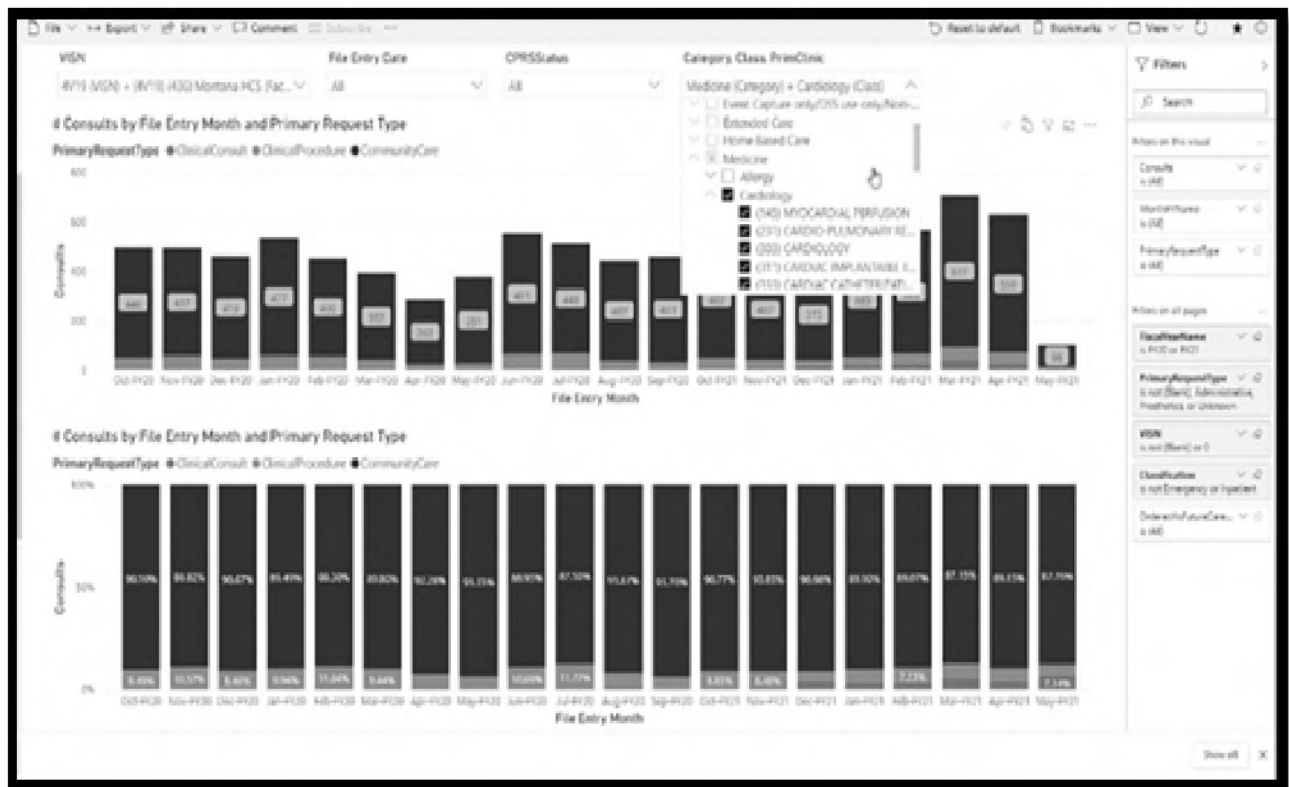
Additional Stop Codes for Community Care Consults

As per the guidance in the Specialty Program Section 1.3 facility community care offices are highly encouraged to assign an additional stop code to community care consults, in addition to the 669-stop code. This update to the community care consults will allow VAMCs to distinguish the type of care being rendered in the community. This adjustment to community care consults has been put in place in order to improve the data mining/capabilities for community care consults/referrals and allow for better comparison of care sent to the community vs. done within the VA.

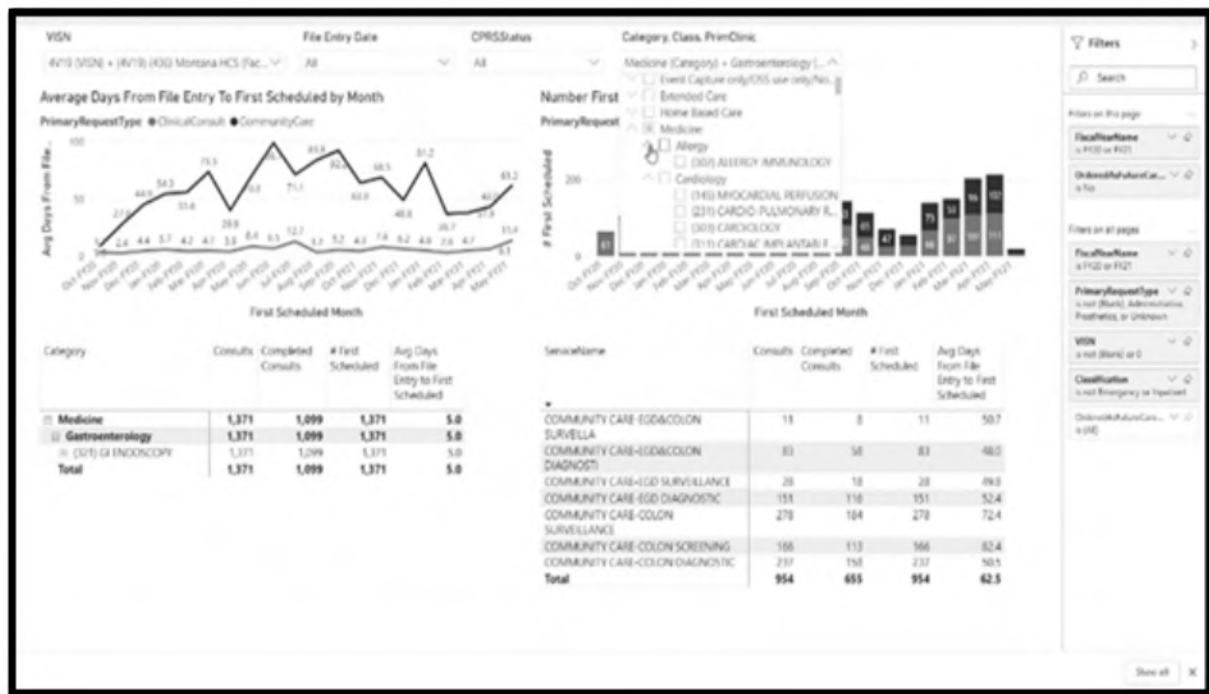
Once an additional stop code has been added to the community care consult set up, sites can use the RCI VSSC Dashboard in order to analyze consult volumes and timeliness at the stop code level both for internal and community care consults.

Below are a few of the reporting options available:

- View of internal and cc consults for cardiology service (volume and %):



- View of internal and cc consults for cardiology service (Trending by month):



- View of internal and cc consults for cardiology service (Trending by month):

Month/FYName	Oct-FY21	Nov-FY21	Dec-FY21
VSN	ClinicalConsult	ClinicalProcedure	CommunityCare
SV20	48,680	1,035	41,884
(SV20) (403) Anchorage, AK HCS	1,296	1,035	9,600
(SV20) (317) Boise, ID HCS	6,428	352	2,539
(SV20) (848) Portland, OR HCS	17,367	123	7,049
(SV20) (653) Roseburg, OR HCS	2,664	210	4,072
(SV20) (863) Puget Sound, WA HCS	11,040	333	9,891
(SV20) (848) Spokane, WA HCS	4,026	3,020	7,846
(SV20) (867) Walla Walla, WA HCS	1,021	17	3,436
(SV20) (892) White City, OR HCS	2,828	2,753	5,581
Total	48,680	1,035	41,884

6.18 OCC CACMI Process-Guidance

Office of Community Care Consult Cancelled Appointments and Consult Management Initiative (OCC CACMI) Review Process and Office of Community Care Unscheduled Consult Review Initiative

OCC CACMI Process

References:

Changes to Consult/Referral Management during COVID-19 – Memorandum Updates

The purpose of this document is to support activities at VHA Facilities in resolving both cancelled or discontinued consults in accordance with the VA Internal and Community Care Consult and Appointment Cancellation Management Initiatives Memorandum released on December 14, 2020.

Please Note:

- The OCC CACMI process will only focus on consult management and does not include community care appointments.
- The OCC CACMI review will focus on cancelled/discontinued community care consults designated as Priority 1, Priority 2, or No priority assigned for the following categories of care:
 - Cardiology
 - Oncology
 - Mental Health
 - Cardiology
 - Pulmonology
 - Gastroenterology

The benchmark will be to complete 100% of the Mental Health and Oncology, cancelled and discontinued consults by January 29, 2021. For Cardiology, Gastroenterology, and Pulmonology cancelled and discontinued consults, the benchmark to complete the remainder of the review is to have 50% of the review completed by February 19, 2021, 100% of the review by March 12, 2021. Each VISN will need to assign a primary POC and an alternate POC for OCC CACMI. Each VISN will send the names of the POCs and alternate POCs to the VHAOCCACMI mail group.

Updated 01/22/2021

January 29, 2021 deadline has been extended to February 19, 2021.

Clinical Service	Deadline	% Complete
Mental Health and Oncology	February 19, 2021, changed from January 29, 2021	100%

Cardiology, Gastroenterology and Pulmonology	February 19, 2021	50%
Cardiology, Gastroenterology and Pulmonology	March 12, 2021	100%

Upon receipt of the names these POCs will be granted access to the CACMI OCC Folder.

POCS may access the CI secure SharePoint site in order to:

- Retrieve the master spreadsheet.
- Distribute to their facility community care offices.
- Update the master spreadsheet in Column F with the outcome of the action taken using the designated reasons provided.

The VISN POCs will distribute to each medical center with instructions to enter the disposition action on the spreadsheet. It is also recommended that the facility community care clinical staff at each facility be assigned for the reviews.

Roles and responsibilities:

VISN BIMs

- Report progress updates to Office of Community Care, Clinical Integration.
- Oversee the timely submission of updates to the secure CI SharePoint site by the VISN POCs.
-

VISN POCs

- Retrieve the VISN information from the master spreadsheet.
- Distribute the spreadsheet to the facility community care offices.
- Distribute the instructions to the facility community care offices to enter the disposition action on the spreadsheet.
- Consolidate facility community care offices responses and update master spreadsheet in the appropriate VISN folder on the CI secure SharePoint site.
-

Facility Leadership

- Communicate messaging of importance of OCC CACMI.
- Support efforts as necessary.
- Confirm information for Attestation Memorandum.
- Coordinate and advise on clinical review process.

Facility Community Care Program Manager/Clinical Manager

- Develop facility plan and coordinate efforts.
- Coordinate data gather efforts.
- Confirm information for Attestation Memorandum.
- Report progress to assigned VISN BIM based on designated timeline.
- Ensure coordination with internal clinical services.
- Coordinate administrative efforts.
- Coordinate priorities of effort.
- Coordinate clinical reviews.

Consults

Consult Management process should continue as directed by VHA Consult Directive 1232. The purpose of the review is to ensure that all the above-mentioned community care consults cancelled or discontinued during the pandemic were cancelled or discontinued for appropriate non-COVID related reasons and do not require any additional follow-up. Initial national guidance stated that community care consults **should not** be cancelled or discontinued for COVID related reasons during the pandemic. Upon review, any community care consults that are found to have been cancelled or discontinued for COVID related reasons require follow-up which may include the following: clinical review, resubmission or entry of a new consult, patient contact, and scheduling activity.

The review should include the following steps:

1. VISN POC will pull the data from the CI secure SharePoint site, separate by facility, and distribute accordingly. The master spreadsheet will include community care consults with Priority 1, Priority 2, and No Priority designated for the above listed categories with a cancellation/discontinuation date between January 1, 2020 – July 21, 2020.
2. Facility community care offices will review cancelled and discontinued community care consults to determine what action, if any is needed:
 - a. For **cancelled** community care consults with **action needed**, disposition as appropriate, based on the review, utilizing the CTB reasons. Copy/Paste the comment: #CACMI-No further review required for this consult.
 - b. For **cancelled** community care consults where follow-up activity was appropriate and **no further action needed**, disposition the consult as appropriate, based on the review, utilizing the CTB reasons. Copy/Paste the comment: #CACMI-No further review required for this consult.
 - c. For **discontinued** community care consults with **action needed**, take appropriate action for care coordination following local

community care process. Copy/Paste the comment: #CACMI-No further review required for this consult.

- d. For **discontinued** community care consults where follow-up activity was appropriate and **no further action needed**, disposition the consult as appropriate, based on the review, utilizing the CTB reasons. Copy/Paste the comment: #CACMI-No further review required for this consult.
 - e. **Please Note:** The reason for the use of the comment “#CACMI-No further review required for this consult” to be entered on each reviewed community care consult is for data/tracking purposes.
3. Use master spreadsheet to track reasons for cancellation/discontinuation, need for follow-up and follow-up actions taken.
 4. Follow VISN process to submit reviews for the VISN to submit a consolidated update to OCC.

Review Process

Please Note: Due to system limitations with CTB, facility community care offices will use the standardized comments below from the CTB rather than launching the CTB to capture these updates.

Scenario	Standardized Comment Examples	Actions/Next Steps
Cancelled community care consults with action needed.	<ul style="list-style-type: none"> • NVA-The care will be provided through a Community Care Consult. • CCA-A Community Care appointment has been scheduled. • NVN-Community Care not needed; care provided by VA appointment. 	<ul style="list-style-type: none"> • Schedule community care appointment. • Edit and resubmit the consult to the ordering provider/RCT for internal VA appointment scheduling. • Request a new consult (as appropriate). • Copy/Paste the comment: #CACMI-No further review required for this consult.
Cancelled community care consults with no action needed.	<ul style="list-style-type: none"> • NAE-Not Administratively eligible. • NXC-Not eligible for community care. 	<ul style="list-style-type: none"> • Copy/Paste the comment: #CACMI-No further review required for this consult.

	<ul style="list-style-type: none"> • REF-Veteran refuses community care appointment. • NVD-Community care disapproved. • NVN-Community care is not needed, care provided by VA. 	
Discontinued community care consults with action needed.	<ul style="list-style-type: none"> • NVA-The care will be provided through a Community Care Consult. • CCA-A Community Care appointment scheduled. • NVN-Community Care not needed; care provided by VA appointment. 	<ul style="list-style-type: none"> • Request a new consult using the significant finding alert process to the ordering provider. • Copy/Paste the comment: #CACMI- No further review required for this consult.
Discontinued community care consults with no action needed.	<ul style="list-style-type: none"> • NAE-Not Administratively eligible. • NXC-Not eligible for community care. • REF-Veteran refuses community care appointment. • NVD-Community care disapproved. • NVN-Community care is not needed, care provided by VA. 	<ul style="list-style-type: none"> • Copy/Paste the comment: #CACMI- No further review required for this consult.

Please Note: If a discontinued consult was discontinued correctly using the CTB options, and no further action is required, enter the comment “#CACMI-No further review required for this consult” is the only action necessary to complete this review.

Please Note: Not all situations match the above examples and all discontinuation reasons in the CTB may be used as appropriate. If a consult was not discontinued correctly utilizing the consult toolbox, please utilize the most appropriate CTB when reviewing, followed by the comment: “#CACMI-No further review required for this consult.”

Consult Toolbox Discontinuation Reasons:

DUP-Duplicate Request.

REF-Veteran declined/refused-does not want appointment. Please submit new consult if Veteran agrees to care.

NN-Care is no longer needed.

NEL-Veteran does not meet eligibility requirements.

EXP-Veteran has expired.

FSE-Failed mandated scheduling effort (multiple missed/cancelled appts. or Veteran did not respond to mandated scheduling effort). Consult discontinued, per VA consult management policy. Please submit a new request if care is still desired and Veteran agrees to receiving care.

EDC-Established patient, follow-up appointment has been scheduled.

ERR-Entered/Requested in error.

ODC-Other discontinuation reason:

NVA-The care will be provided through a Community Care Consult.

NAE-Not administratively eligible.

NXC-Not eligible for Community Care.

CCA-A community care appt has been scheduled.

CCD-Community Care Appointment Date: (appointment date)

CCP-Community Care Provider: (Community appointment provider)

REF-Veteran refuses Community Care appointment.

NVD-Community Care disapproved.

NVN-Community care not needed; care provided by VA appointment.

Pre-Recorded Training Slides

Please reference the OCC CACMI Process Guide.

Facilities will be required to submit an Attestation Memorandum; careful coordination of the clinical reviews is essential.

Questions may be sent to the VHA OCC CACMI email group: (b)(6) @va.gov

OCC Unscheduled Consult Review Initiative

Sites are no longer required to keep unscheduled consults in an Active status indefinitely due to the COVID-19 pandemic and should work to safely disposition and deliver care to Veterans. The Office of Community Care Stand Down will **begin upon release of the DUSHOM Memo** and will be continuous to ensure 100% completion for all open/unscheduled community care consults. This initiative will focus on reviewing, scheduling and dispositioning community care consults, that are unresolved beginning with the oldest first based on:

Roles and responsibilities:

VISN BIMs or POCs

- Report progress updates to Office of Community Care, Clinical Integration Field Support.

Facility Leadership

- Communicate messaging of importance of OCC Unscheduled Consult Initiative.
- Support efforts as necessary.

Facility Community Care Program Manager/Clinical Manager

- Develop local plan and coordinate efforts.
- Coordinate data gather efforts.
- Report progress to assigned VISN BIM based on weekly meeting schedule.
- Ensure coordination with internal clinical services.
- Coordinate administrative efforts.
- Coordinate priorities of effort.
- Coordinate clinical reviews.

Consults

Community Care consults in an Active status that have file entry date of 90 days or greater in the past should be prioritized from oldest to newest and action taken to schedule, complete, or cancel as appropriate per local process. The consults that will be reviewed for this effort are all open/unscheduled community care consults. These Active community care consults should be scheduled, completed, cancelled.

Unscheduled Consult Initiative Process Guide

Please Note: If after clinical review of the consult the care is no longer needed, the consult should be cancelled. Use of the CTB is highly encouraged. Use of the CTB when cancelling or discontinuing consults can prevent future reviews of this kind.

The review should include the following steps:

1. Facility community care offices will review, schedule and/or take appropriate action on high-risk unscheduled community care consults in subsequent order beginning with the oldest first: Consult > 365 Days; Consults > 180 Days; and Consults > 90 Days to move the status from Active to Scheduled status using the VSSC Consult Cube – Open Consults Tab
 - a. Prioritize high volume/high risk services and Priority 1 & 2 consults
 - b. Unscheduled Consults (Pending and Active)

Scenario	Process Steps	Action Taken
Active Consult: Care still needed.	<ul style="list-style-type: none"> Clinically review the consult to ensure care has not already occurred through different means. Clinically review the consult to ensure it is not a duplicate request. 	<ul style="list-style-type: none"> Schedule the appointment. Forward the community care consult to the local specialty service if the Veteran chooses to keep care within the VA.
Active Consult: Care Occurred.	<ul style="list-style-type: none"> During the clinical review if it is discovered the care already occurred for this consult, follow local process to obtain records and complete the consult. During the clinical review if it is discovered the care already occurred on a different consult, cancel the consult. 	<ul style="list-style-type: none"> Complete the consult upon receipt of records. Cancel the consult using the CTB and send a significant finding alert to the ordering provider.
Active Consult: Care no longer needed.	<ul style="list-style-type: none"> During the clinical review if it is discovered that the care is no longer needed, the consult should be cancelled. 	<ul style="list-style-type: none"> Cancel the consult and document the reason by adding a comment to the consult (the reason for cancelling the consult should be one of the reasons listed above). Send a significant finding alert to the ordering provider.

<p>Active Consult: Unable to coordinate care.</p>	<ul style="list-style-type: none"> During the clinical review if it is discovered the care is still needed, and the appointment is unable to be scheduled due to circumstances outside of the community care office control the consult must remain in Active status and be followed up on per local process. 	<ul style="list-style-type: none"> For these unscheduled consults where care is still needed, and the facility community care office is unable to coordinate the care at this time, use the Appt. Tracking tab and expand Network Issues section under the Returned from Community Care Provider Section by clicking the + sign. Select appropriate option based on the specific scheduling challenge experienced. The step by step guidance for capturing scheduling challenges can be found in the <u>Office of Community Care Field Guidebook</u>, Chapter 6, Section 6A.
---	--	--

Pre-Recorded Training Slides

Questions may be sent to the VHA OCC CACMI email group: (b)(6)@va.gov

The recorded training for these processes will be available soon.

6.19 Published 2021 VA Fee Schedule

Beginning January 1, 2021, the U.S. Department of Veterans Affairs (VA) will phase in a new approach for its community care fee schedule payment rate calculations that better aligns VA to industry best practices. Instead of rates being calculated based on the location of the referring VA medical center, **rates will now be calculated based on the location of where the care is provided (i.e. rendering locality)**. This means that beginning January 1, 2021, payment rates under the VA fee schedule may be different from 2020.

Impact of Rate Changes on Providers

VA generally reimburses hospital care, medical services and extended services at the applicable Medicare rate published by the Centers for Medicare and Medicaid Services (CMS). When no CMS rate is available, VA and Third-Party Administrators reimburse at the lesser amount of (1) billed charges or (2) the VA fee schedule rate*. The VA fee schedule rate is the amount published for the designated date of service time period.

The rate changes only apply to services being reimbursed under the VA fee schedule, which is mainly used for Geriatrics and Extended Care services, along with a small number of health care services not covered by the CMS schedule.

With the 2021 VA fee schedule rates based on where the care is provided, community providers can expect better consistency with industry standard practices and alignment with the CMS schedule. In addition, please note the following:

- VA Fee schedule rates for 2021 are calculated to limit decreases in provider reimbursement as much as possible. However, VA could not eliminate every instance of a rate decrease.
- Rates for home care services were increased to cover the average cost of personal protective equipment per visit, in accordance with the CARES Act.
- VA's dental schedule is not publicly available due to the terms of VA's contract for compiling a dental services fee schedule.
- Reimbursement rates are subject to change annually and more often if required.
- *Alaska VA fee schedule and methodology is an exception and will be released at a later date.

Click [here](#) to access the 2021 VA Fee Schedule and the updated VA Fee Schedule webpage.

Note: For questions or concerns, please contact VA Customer Service at 877-881-7618.

6.20 Veterans Integrated Service Network (VISN) Referral Coordination Initiative (RCI) Standards and Expectations for Fiscal Year (FY) 21

RCI remains a high priority to improve timeliness and Veteran satisfaction. RCI will ensure Veterans understand their full range of care options for direct care in VA and in the community as they make the best decisions about their healthcare needs. To achieve this, VA is implementing Referral Coordination Teams (RCT) at each VAMC, VISN, or partnering VAMC to streamline and standardize the referral process while educating Veterans about their care options.

The Veterans Integrated Service Network (VISN) Referral Coordination Initiative (RCI) Standards and Expectations for Fiscal Year (FY) 21 Memorandum provides guidance to Veterans Affairs (VA) VISN and VA Medical Center (VAMC) leadership regarding the RCI standards and expectations for FY21. VA will continue to prioritize COVID-19 pandemic efforts but must continue to work on operational initiatives

RCI Implementation Requirements:

- Ensure your facilities are meeting the RCI timeline, goals and key performance expectations listed in [RCI Guidebook – Data and Measuring Success](#).
- Apply the [RCI Guiding principles](#).
- Ensure the 6 core processes and strategies for RCI are in place locally, referenced further in the [VHA Senior Leader Quick Guide for RCI Implementation](#).
- Utilize the [RCI Implementation Checklist](#), a step-by-step guide to putting RCI in place at your facility. The RCI Implementation Checklist was created to assist VAMCs with effectively implementing RCTs in a standardized manner, while still allowing for VAMCs to adjust as needed based on their unique needs.
 -
 - VAMC designee(s) are required to update their RCI Implementation Checklist bi-weekly via the [RCI Implementation Checklist Tracker SharePoint](#) by updating their progress on the checklist and populating the number of completed tasks. **The first submission will be due on April 2, 2021.**
 - ii. VHA leadership will regularly review and monitor VAMC checklist submissions to assess VAMC RCI Implementation progress and follow up with facility and VISN champions and sponsors as necessary.

- iii. Training on the RCI Implementation Checklist is available: RCI Implementation Checklist Training Recording. Training will also take place on upcoming RCI Office Hours Calls.
 - Network Directors or their delegates will regularly report RCI implementation progress and outcome data on the Healthcare Operations Calls (Thursdays 3:30 pm Eastern Time) as requested.
- RCI goals, timelines, milestones, updated guidebook, educational materials, and communication materials are available here:
- RCI SharePoint Site: Implementation resource center including updated guidebook, communication toolkits, promising practices, recorded educational materials and information regarding weekly calls.
- RCI Data Portal: Intended for VISNs and facilities to track RCI Key Performance Indicators. Includes RCI Dashboard and additional access related data reports supporting management of referral coordination processes
 - The RCI Dashboard: Provides a consolidated view of both internal/direct and community care measures such as consult volumes and scheduling timeliness.
- TMS trainings for RCI are now available for your staff,
- The clinical or administrative member of the RCT will add a **#RCT#** comment to indicate that the referral was addressed by a clinical member of the RCT
- The preferred process is for the clinical member of the RCT to capture the **#RCT#** comment, but in the circumstances where the clinical member has reviewed the consult and the comment was not added, the administrative member of the RCT can document the **#RCT#** comment.
- A report to track utilization of this comment will be added to the RCI Dashboard.
- Refer to RCI Guidebook Section 7.2.7 for additional instructions.
- Further developments of a Consult Toolbox (CTB) RCT tab are forthcoming. Guidance on this process can be found in the RCI Guidebook -RCT Operations Section.

Additional Training



TMS	Community Care Hub
<ul style="list-style-type: none"> • TMS- VA 4533180 PPMS Field User Training • TMS VA 38474 Provider Exclusionary Management (PEM) • TMS VA 39022 Evolving Role of Facility Community Care Nurses (June 13, 2019) • TMS VA 4540164 Delegation of Authority and Clinical Review • VA TMS 4533298 Admin Key for CPRS • TMS- 4491496 Optimizing Patient Safety • TMS VA 4491498 Patient Safety Managers Training- Investigate a Patient Safety Event • TMS VA 4443818 Building a New OCC Organizational Structure • TMS VA 4448115 How to Implement a New OCC Organizational Structure • TMS VA 4442912 How to Establish an Oversight Council in VAMC • TMS VA 4448116 How to Use the Operating Model SharePoint Site • TMS VA 4444271 Operating Module Implementation: Module 1- Overview • TMS VA 4411360 Operating Module Implementation: Module 3- Operating Model Tools and Resources 	<ul style="list-style-type: none"> • <u>Webinar: Capturing Community Care Scheduling Challenges and Addressing Network Adequacy</u> This webinar will explain the importance of tracking scheduling challenges in the Consult Toolbox (CTB) in support of monitoring the impact of COVID-19 on appointment availability, identify common errors and troubleshooting tips when searching for providers in PPMS, and explain the purpose and functionality of the Network Adequacy SharePoint site. <i>(recorded December 2020)</i>

- **TMS VA 4434814**
How to Improve your VAMC with Co-located Integrated Teams
- **TMS VA 4557774**
Webinar: Consult Toolbox and the Use of COVID-19 Tab
- **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

LEGISLATION



- [Clinical Integration SharePoint CI Memo Documents](#)
Contains VHA OCC & 10N announcements, memorandums, and other published documents

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>

Veteran Health Administration (VHA) Office of Community Care (OCC) Field Guidebook

Chapter 7: Community Care Clinical Coordination Contact Center (C6)

Introduction	7.0	<u>Introduction to the C6 Program</u>
C6 Criteria	7.1	<u>C6 Eligibility Criteria</u>
C6 Entry Points	7.2	<u>Ways a Veteran Can Receive C6 Services</u>
PCMM Panel	7.3	<u>How to Assign a C6 Veteran to A C6 Primary Care Patient Centered Management Module (PCMM) Panel</u>
Phone System	7.4	<u>Phone System</u>
Consult Management	7.6.1	<u>How to Enter a C6 Community Care Consult in the Computerized Patient Record System (CPRS)</u>
	7.6.2	<u>How to Create/Enter a C6 Consult in Cerner Millennium</u>
	7.7	<u>How to Transfer a Veteran's Community Care Back to an Internal Veterans Affairs (VA) Clinic</u>
	7.8	<u>C6 Referral Coordination Team (RCT) Process</u>
VAOS	7.9.1	<u>C6 VA Online Scheduling (VAOS) Overview</u>
	7.9.2	<u>Receiving a C6 VAOS Request in Cerner Millennium</u>
Request for Service	7.10	<u>Request for Service (RFS) Process in Cerner Millennium</u>
Patient Safety Incidents	7.11	<u>How to Process Community Care Related Patient Safety Events</u>
Transplant, IVR and ART	7.12	<u>Process for Handling Transplant, In Vitro Fertilization (IVF) and Assisted Reproductive Technology (ART) Services for C6 Veterans by the Facility</u>

Customer Service	7.13	<u>How to Handle a Crisis Call</u>
-------------------------	-------------	---

7.0 Introduction to the C6 Program

Community Care Clinical Coordination Center (C6) is a new department within the Office of Community Care (OCC)/Clinical Integration and Field Operations (CIFO). The purpose of C6 is to give Veterans access to administrative and clinical staff who will manage their care when the Veteran selects to receive care in the community. C6 will offer a service to eligible Veterans, which will coordinate their community care in a central location, support facility community care offices, and provide an overall better customer experience. Local Veteran Affairs Medical Center (VAMC) staff can focus their efforts on managing the care of Veterans who have elected to receive their care inside Veterans Affairs (VA). A benefit to the local VAMC will be that C6 will reduce clinical and administrative burden at the facility level. C6 will also serve as a “Learning Laboratory” for Clinical Integration Field Operations to test new processes, procedures, policies, tools, and technology to improve coordination and efficiency at local VAMCs.

C6 is physically located in Denver, Colorado. C6 will operate during normal business hours (8 AM-4:30 PM) Monday through Friday based on the Veteran’s local Veterans Affairs medical center’s time zone (except federal holidays).

C6 will be staffed by an integrated team following the recommendations from the CC Operating Model, who will assist the Veteran with their care coordination needs. Administrative functions will be handled by Advanced Medical Support Assistants (AMSAs) and clinical functions will be handled by Registered Nurses (RNs).

The C6 staff will:

- Assist with care coordination services that include case management and disease management services if applicable.
- Assist you with making appointments, follow up on provided VA and community care services, and handle subsequent referrals from community providers.
- Help coordinate the transfer of your health records between community providers and other similar services.
- Assist with requests for durable medical equipment and prescriptions.

The guidance in this chapter is specific to the OCC C6 staff and for VAMCs that fully opt-in for C6 support and services based on their facility needs. Care coordination for eligible Veterans at facilities that opt-in will be transitioned to the C6 team.

7.1 C6 Eligibility Criteria

A Veteran is eligible for C6 if:

1. Veteran meets hardship/grandfathered eligibility or resides in a state or territory with no full-service VA **and**
 - a. Choose to receive primary care (PC) in the community

Or

2. Veteran is drive time eligible for specialty care by residing greater than 60 minutes from a Veteran Affairs Medical Center (VAMC) offering specialty care and 30 minutes from primary care **and**
 - a. Choose to receive PC in the community

Note: Veterans with an active assignment to a VAMC Patient Aligned Care Team (PACT) team will not be eligible for C6 support.

7.2 Ways a Veteran Can Receive C6 Services

The following are the ways that a Veteran can receive C6 services:

1. Established Veterans with a VA PC who elects to be seen in the community with a 12-month primary care Standardized Episode of Care (SEOC) in the community. These Veterans will be reassigned to a C6 PCMM Panel.
2. New Veterans - Requires consult/referral from the facility community care office and a 12-month primary care SEOC in the community.
 - CPRS sites: The facility community care office will initiate the Community Care C6 PC consult.
 - Cerner Millennium sites: The facility community care office will initiate the Ambulatory Referral – VA (Community Care Request).
3. Established Veterans in the community meeting C6 criteria.
4. Veteran's eligibility/ineligibility status changes.

7.3 How to Assign a C6 Veteran to the C6 Patient Centered Management Module (PCMM) Panel

The Patient Centered Management Module (PCMM) Web application assists VA facilities in implementing and monitoring patient and staff assignments in both primary care and non-primary care teams. C6 staff will have administrative rights in PCMM to create teams, build/assign panels, and assign Veterans. C6 staff will be responsible for assigning Non-VA providers and aligning C6 Veterans to the C6 panel in PCMM. Please refer to the [How C6 PCMM Panel Standard Operating Procedure \(SOP\)](#) for guidance.

To view please see [PCMM PACT Assignments](#).

7.4 Phone System

Veterans can access C6 services by calling 877-881-7618 and pressing 6 when prompted, from 8 a.m. to 4:30 p.m. Monday through Friday based on the Veteran's local Veterans Affairs medical center's time zone (except federal holidays).

7.5 Customer Relationship Management (CRM) – See Chapter 5, Section 5.9

7.6.1 How to Enter a C6 Community Care Consult in the Computerized Patient Record System (CPRS)

When the consult is a new request or transfer of care to the C6 PCMM Panel:

- Forward the CC PC consult to COMMUNITY CARE-ADMIN C6 FOR PRIMARY CARE.
- This process is only to request or transfer the CC PC consult to a C6 PCMM Panel.

When the consult is a result of a RFS or direct scheduling:

- A C6 consult will be uniquely identified as C6 to appear in the appropriate task queue in HSRM.

- C6 staff will manually input “#C6#” in the order note in CPRS to establish each consult as belonging to C6.
- This comment will be used as an identifying factor in HSRM.

7.6.2 How to Create/Enter a C6 Referral in Cerner Millennium

Please note the guidance below is ONLY for sites that are using Cerner Millennium.

The C6 referral management processes will occur after the initial seed of Veterans is transferred to C6 at each initial deployment site. It was determined that there is a need for C6 referrals to be uniquely identified as C6 to appear in the appropriate task queue in HSRM. C6 staff will manually input “#C6#” in the referral order comments section in Cerner Millennium to establish each referral as belonging to C6. This comment will be used as an identifying factor in HSRM. In HSRM effective August 2, 2021 C6 users will have their own referral list and task list to work from that will include C6 referrals only. Although C6 referrals will only show on the C6 referral list, referring facilities have the ability to search for a C6 referral by using unique identifiers (i.e., UCID, referral ID, etc.)

Process of Uniquely Identifying C6 Referrals

Step 1: C6 will utilize the Ambulatory Referral – VA (Community Care Request) order to transfer care from the facility to C6. Should a Veteran request to return to a VAMC for primary care, C6 staff will create a referral and update the location to the Veteran’s home facility.

Step 2: C6 referrals will be assigned to C6 by updating the “Refer To” location as “C6”. This will allow for identification of C6 referrals.

Step 3: C6 staff will manually input “#C6#” in the referral order comments section to establish each referral as belonging to C6. This comment will be used as an identifying factor in HSRM. HSRM will also include a box checked stating, “assigned workgroup C6 referral.”

Referral Processing Information	
Referral Number	VA000001171
* Status	Sent
Referral Return Reason	
Unique Consult ID	500_3490
* Network	Not Allocated
Optional Task(s)	Audit Trail
Source of Referral	Interfaced from VA
Comments	
Assigned User	
Date Added	05/21/2019
Update Date	06/13/2019
Update Time	13:40
Update User	Training FCC
Update Facility	Canandaigua VA Medical Center
Ordering Officer	Training FCC
Assigned Workgroup	<input checked="" type="checkbox"/> C6 Referral

Note: In the case that a Veteran’s appointment (primary care or specialty care) has not yet taken place, C6 can close the consult in CPRS and initiate a referral case denoting the it has been placed in Cerner to the C6 location for care to be followed by C6.

Sites where C6 will be deployed will be responsible for the activities below:

- Sites will be responsible for closing any existing episodes of care or open consults in CPRS for C6 Veterans by the agreed upon C6 go-live date. Sites are responsible for creating the referral case in Cerner PowerForm. This will ensure that C6 staff can function in Cerner Millennium entirely.
- Primary care consults can be closed in CPRS once it is verified that the Veteran has attended their appointment and there has been least at least one request for medical documentation. Referral case will be initiated in Cerner to follow episode of care.

- Specialty care consults can be closed once it is verified that the Veteran has attended their appointment and there have been least at least three requests for medical documentation. Referral case will be initiated in Cerner to follow episode of care.

7.7 How to Transfer a Veteran's Community Care Back to an Internal Veteran Affairs (VA) Clinic

There are two ways to transfer a Veteran's Community Care back to the Internal VA Clinic:

1. Using a Primary Care (PC) Consult in CPRS

C6 staff will transfer care back to the facility using the facility's internal consults in CPRS. If a primary care consult is not available, C6 staff will contact the site Point of Contact (POC) to coordinate appropriately. It is recommended that the site build a PC consult.

In Cerner Millennium, C6 staff will change the "Refer To" location of the referral from "C6" back to the facility community care office.

The process to transfer a Veteran's care back to the VA is documented below.

PROCEDURE	
STEP	ACTIVITY
1	In conversation with a C6 staff member, the Veteran states they want to opt out of C6.
2	In CPRS, a C6 staff member will enter an internal consult and send consult back to the facility. In Cerner Millennium, a C6 staff member will change the "Refer To" location from "C6" to the facility.
3	C6 staff member contacts Veteran and notifies the Veteran's community provider that services will be provided annually.
4	Care is provided internally in the VA and C6 documentation is retrieved by the VA staff.

2. Using another method

7.8 C6 Referral Coordination Team (RCT) Process

C6 will develop a hybrid approach where C6 staff will act as the Referral Coordination Team (RCT) for the C6 identified Veterans, working collaboratively with the VAMC's RCT(s). The Executive Director of Clinical Integration & Field Operations will act as the C6 Chief of Staff and support C6 staff and their Non-Physician Provider. C6 clinical and administrative staff will be identified on the C6 Delegation of Authority Medical Services (DOAMS) list. Sites will use the [C6 RCI template](#) to share information on site's practices for referring various categories of care. Each site must populate the RCI template and upload to the [C6 SharePoint Site](#). Sites should update and upload this document to the C6 SharePoint site annually and as needed due to changes within the local facility, unless there is a RCI tool/template that is distributed nationally.

If a C6 Veteran elects to choose care at the VA in discussions with a C6 staff member then the C6 staff member will transfer the Veteran back to the appropriate VA facility following the process outlined in section 7.7. A VA MSA will contact the Veteran to schedule an appointment at the VA.

7.9.1 VA Online Scheduling (VAOS) Overview

VAOS is a mobile scheduling application that will allow Veterans who meet certain types of Maintaining Internal Systems and Strengthening Integrated Outside Networks (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.

Eligible Veterans can use VAOS to request the following types of community care appointments:

- Audiology – hearing aid support
- Audiology – routine exam
- Nutrition
- Optometry – routine exam
- Podiatry – routine exam
- Primary care – routine appointment

C6 will not be accepting VAOS requests at initial go-live but has plans to accept VAOS requests in January 2021.

7.9.2 Receiving a VA Online Scheduling (VAOS) Request in Cerner Millennium

C6 staff will be responsible for monitoring VAOS appointment requests for C6 Veterans in Scheduling Manager, using the C6 Veteran population report, beginning in January 2021. An encounter will be created in PowerChart to initiate scheduling. Sites should verify that VAOS requests are for non-C6 Veterans.

7.10 Request for Service (RFS) in Cerner Millennium

C6 will follow the national Request for Service (RFS) process. However, there are certain steps C6 staff will need to follow to in Cerner Millennium.

How to View RFS Details for a Provider in Cerner Millennium:

PROCEDURE	
STEP	ACTIVITY
1	C6 staff member will open PowerForm in Cerner and select "Order Profile".
2	Right click on the order and select 'Modify'.
3	Enter physician name and click 'Okay'. This action will search for providers in Cerner and Provider Profile Management System (PPMS).
4	Select 'Order Information', which will show order details such if the order was signed and by whom. This information can also be viewed by selecting 'Order History.'

To View the RFS:

PROCEDURE

STEP	ACTIVITY
1	C6 staff member will select patient in PowerForm.
2	Select 'View Images.'
3	An alternate method is to select 'Menu' and then 'Documentation.'

7.11 How to Process Community Care Related Patient Safety Events

Procedures associated with reporting, investigation, and improvement for community care-related patient safety events can be found in the [VHA Safety Events in Community Care Guidebook \(version 5.0\)](#). Utilization of the Joint Patient Safety Reporting System (JPSR) within this process is paramount to ensuring that patient safety events are properly captured and investigated. C6 staff will follow the national process to report safety events. For guidance on how to report incidents for C6, please refer to the C6 JPSR Reporter Training and C6 JPSR Reporter Quick User Guide available on the [OCC C6 SharePoint Site](#)

7.12 Process for Handling Transplant, In Vitro Fertilization (IVF), and Assisted Reproductive Technology (ART) Services for C6 Veterans by the Facility

C6 staff will assist with all paperwork and appointment scheduling for C6 Veterans seeking Transplant, IVF and ART services. However, management of this Veteran population will remain the responsibility of the facility for all clinical coordination of these services.

7.13 How to Handle a Crisis Call

When dealing with a crisis call, C6 staff will follow the [standardized process](#). The C6 staff member will also complete a Report of Contact (ROC) and Joint Patient Safety Report (JPSR) for the incident.

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Create a Community Care Consult	1.1	2.13
Scenarios When a New Community Care Consult is Required	1.1.1	2.14
How to Forward an Existing In-House Consult to Community Care	1.2	2.18
Enhancement to Expediate Community Care Appointing Process	1.2.2	2.19

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Determine Eligibility for Community Care	2	2.9
Types of Consults in DST	2.1.1	2.10
Navigating the DST	2.1.2	2.11
Guidance on Decision Support Tool Contingency Operations	2.1.3	2.17
Role Based Responsibilities Overview: Eligibility and Requests for Care	2.2	2.1
Guidance on Forwarding in-house Consults (and Interfacility Consults for Sites with an Integrated VistA) to Community Care	2.3	2.18
How to Determine Eligibility for an Established Veteran	2.4	2.1
How to Determine Eligibility for a New Clinic Veteran	2.5	2.2
How to Make a General Eligibility Inquiry	2.6	2.12
How to Determine Eligibility for a New Enrollee Appointment Request	2.7	2.3
Special Notes for Former Distance-Eligible Veterans (Grandfathered Veterans)	2.8	2.7
How to Determine and Manage Best Medical Interest (Hardship)	2.9	2.4
How to Manage Clinical Appeals for Eligibility	3	5.2

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
Leveraging the Delegation of Authority for Routing Community Care Consults	3.1	2.22
Best Medical Interest vs. Delegation of Authority	3.1.2	2.5
How to Perform Clinical Review for Services Requested	3.2	2.23
How to Determine Clinical Service Availability Within VAMC or at a Sister Facility	3.2.1	2.26
How to Assess Clinical Appropriateness	3.2.2	2.24
How to Assess Which Services to Buy	3.2.3	2.27
Changing the SEOC after the Consult is sent to HSRM	3.2.4	Tools Tile
Infertility Services	3.2.5	Speciality Programs (Coming Soon)

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Assess which Services to Buy	4.1	2.27
How to Determine and Document Veteran's Care Coordination Needs	4.1.1	2.25
How to Review Available Community Care Options	4.2	3.7
How to Review Community Care Programs and Determining Community Care Purchasing Authorities	4.2.1	3.6
How to Review Community Care Funding	4.2.2	3.6
How to Determine Clinical Service Availability within VAMC or Sister Facility	4.2.3	2.26

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
In-itiating Community Care Under Selected Option	5	3.11
Contact Veteran and Fulfill Minimum Contact Requirements	5.1	3.13
How to Continue Care Initiation Using the Selected Community Care Option	5.1.1	3.12
How to Schedule Using Patient-Centered Community Care (PC3) contract	5.1.2	3.14
How to Schedule Using Individual Authorizations (IA)	5.1.3	No longer an option
VA/DOD Sharing Agreement Referral Process	5.1.4	3.4
How to Schedule Using Indian Health Service and Tribal Health Program (IHS/THP)	5.1.5	Specality Programs (Coming Soon)
How to Schedule Using Veteran Care Agreements (VCA)	5.1.6	Specality Programs
Transitioning to the Community Care Network (CCN)	5.1.7	Legislation Tile
How to Vendorize a Veteran Care Agreement (VCA) in VistA	5.1.8	Specality Programs
How to Schedule Care Under CCN	5.2	3.15
How to Schedule Under CCN When VA is Scheduling	5.2.1	3.16
How to Schedule Under CCN When Veteran Elects to Self-Schedule	5.2.2	3.17
How to Schedule Under CCN When Veteran Requests Appointments via VA Online Scheduling (VAOS)	5.2.3	2.21

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
Optional Task #1 - Appointment Scheduling and Comprehensive Care Coordination under CCN	5.2.5	3.2
How to Add Non-Participating Providers to Community Care Options	5.2.6	Tools Tile
How to Notify CCN Contractor if Requested Provider is Not in-Network	5.2.7	Tools Tile
Provider Profile Management (PPMS)	5.3	Tools Tile, Job Aid& Artifacts Tile, and the Special Programs Section - 1.10
Trouble Shooting Steps to Follow when Unable to Find Specific Providers within HSRM	5.3.1	Tools Tile
Gap Analysis Tool	5.3.2	Tools Tile
Distance Eligible Veteran (DEV) Requesting an Appointment	5.4	3.11
How to use the Decision Support Tool (DST)	5.5	2.10
How to use the Types of Consults in DST	5.5.1	2.10
How to Navigate in DST	5.5.2	2.10
Guidance on Decision Support Tool Contingency Operations	5.5.3	2.18

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Perform Care Coordination	6.1	3.2
How to Coordinate Pre-Authorized Care	6.1.1	3.4 - 3.8
Understanding Pharmacy Benefits, Durable Medical Equipment (DME) and Medical Devices	6.1.2	3.5
Managing Care Coordination for Veterans through Community Care Emergency Treatment Process	6.1.3	3.6
Urgent Care Benefit	6.1.4	3.7
Transplantation Care Process	6.1.5	3.8
Request for Service (RFS)	6.2	3.42
Oversight of SARs/RFS in the TriWest VA Staff Portal	6.2.2	3.43
Management of Community Provider Request for Services	6.2.3	3.44
Community Provider Orders	6.3	3.46

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Manage Clinical Documentation From Community Providers	7.1	3.22
How to Verify the Veteran Attended the Appointment	7.1.1	3.23
How to Search for Clinical Documents	7.1.2	3.24
How to Save Documents to the Shared Folder Location	7.1.3	3.25
Roles and Responsibilities for Importing Clinical Documentation	7.1.4	3.26
Release of Information (ROI) and Accounting of Disclosure	7.1.5	3.27
How to Use Available Clinical Document Exchange Tools	7.2	3.28
Requesting Clinical Documentation From the TPAs or Community Providers	7.2.1	3.29
Receiving Documents via TriWest Portal (TPA)	7.2.2	3.3
Receiving Documents via Azure RMS	7.2.3	3.31
Receiving Documents via VHIE Direct Secure Messaging (DSM)	7.2.4	3.32
Receiving Documents via Joint Legacy Viewer (JLV)	7.2.6	3.33
Receiving Documents via eFax (StreamFax/RightFax)	7.2.7	3.34
Receiving Documents via Traditional Fax	7.2.8	3.35
Receiving Documents via US Mail	7.2.9	3.36
How to Use FBCS to Receive and Upload Clinical Documentation	7.2.10	3.37
Receiving Documents via HSRM	7.2.11	3.38

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Perform Quality Assurance and Upload Clinical Documentation	7.3	3.39
Performing Quality Assurance on Clinical Documentation Received From TPAs or Community Providers	7.3.1	3.40
Saving Clinical Documentation to a Shared Location	7.3.2	3.41
Recording the Documentation Exchange Method	7.3.3	3.42
How to Coordinate Veteran Follow Up Needs	7.4	3.42
How to Perform Clinical Review of Documentation and Coordinate Follow Up Care	7.4.1	3.21
How to Coordinate Veteran Appointment	7.4.2	3.42
How to Close Community Care Consults	7.5	4
Uploading and Indexing Clinical Documentation Into VistA Imaging Capture	7.5.1	4.1
Update to Current Procedure: Administratively Closing the Community Care Consult	7.5.2	4.2
How to Run the Administrative Closure Report	7.5.3	4.3
How to set up the Community Care Urgent Care Record Note	7.5.4	4.4

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Evaluate Site Performance Reports	8.1	6.2
How to Evaluate Referral Management Community Care Consults	8.1.1	6.3
How to Evaluate Referral Management Timeliness	8.1.2	6.4
How to Evaluate Secondary Authorizations Requests (SARs) /Notifications for TriWest	8.1.3	6.5
How to Evaluate Claims Without Authorization	8.1.4	Specality Programs (Coming Soon)
How to Evaluate Claims Batch Backlog	8.1.5	Specality Programs (Coming Soon)
How to Evaluate Facility Third-Party Administrator (TPA) Funds (FTFT)	8.1.6	4.8
How to Evaluate Health Share Referral Manager (HSRM) Measures	8.1.7	6.6
How to Use the Office of Community Care Top Metrics Report	8.1.8	6.7
Contractor Provided Data	8.2	6.8
How to Evaluate and Interpret Data for Network Adequacy	8.2.1	Specality Programs (Coming Soon)
How to Evaluate Utilization Management for Scheduling Opportunities	8.2.2	Specality Programs (Coming Soon)
How to Report and Investigate Community Care-related Veteran Safety Events	8.3	6.12
Review of Community Provider Opioids Prescribing Practices	8.4	4.9

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
How to Receive and Document Inquiries	9.1	5
Customer Service Escalation	9.2.1	5.1
Veteran Complaint and Grievance Customer Service	9.2.2	5.2
Congressional and VA Inquiry Response	9.2.3	5.3
How to Perform Rapid Inquiry Resolution	9.3	5.4
How to Communicate Resolution and Conduct Follow Up with Veterans or Community Providers	9.4	5.5

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
Managers and Leads References	10	6
Decision Support Tool (DST) Usage Report - Review and Disposition	10.1	6.13
Dispositioning Individual Authorizations and Provider Agreement Authorizations	10.2	N/A
VACAA Closeout Actions & Reminders	10.3	
Oversight of SARs/RFS in the TriWest VA Staff Portal	10.3.1	3.44
TPA Partial Scheduling Guidance	10.4	Specality Programs (Coming Soon)
TPA SP Reporting Tool	10.4.1	Specality Programs (Coming Soon)
Guidance for Clinical Application Coordinator	10.5	Specality Programs (Coming Soon)
Preparation Required for Health Share Referral Manager (HSRM) Deployment	10.5.1	Specality Programs (Coming Soon)
Obligation at Payment Model Standard Operating Procedure	10.6	Specality Programs (Coming Soon)
Claims Suspended Pending Authorization Process	10.7	5.6
Facility Best Practices	10.8	6.14
OCC Staffing Tool	10.8.1	6.11

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
The Role of Community Care	11.1	1
Medical Center Staff Interactions with Community Care Transformation Changes	11.2	2.1
Eligibility	11.3	2
New Community Care Wait Time Standards	11.3.1	2.1
Wait Time Scenario Calculation Table	11.3.2	2.1
Checking Eligibility through CPRS and DST	11.3.2	2.3
The Decision Support Tool	11.4	2.4
Types of Consults in DST	11.3.1	2.10
Navigating the DST	11.3.2	2.11
Guidance on Decision Support Tool Contingency Operations	11.3.3	2.17
Consult Management Processes	11.4	6.3
Ordering a Consult	11.4.1	2.17
Forwarding a Consult	11.4.2	2.19
Guidance on Forwarding in-house Consults (and Interfacility Consults for Sites with an Integrated VistA) to Community Care	11.4.3	2.18
Veterans Community Care Program Eligibility (VCCPE) Consult Management Guidance	11.4.4	2.10
Referrals and Authorizations (R&A)	11.5	6.4
CPRS	11.5.1	Tools tiles
HSRM	11.5.2	Tools tiles
Care Coordination Model	11.6.1	3.00
SEOC	11.6.2	3.3
Scheduler Only Communication 1.0.1 SEOC	11.6.3	3.3
Customer Experience (CX)	11.7	5
Roles and Responsibilities	11.8	6.1

FGB 2.0 Conversion Chart		
Title	FGB 1.0 Sub-Chapter	FGB 2.0 Sub-Chapter
MSA	11.8.1	Chapters 2 & 3- Depending on process
Radiology and Nuclear Medicine MSA	11.8.2	2.9
Contact Center Administrative Staff and Other Administrative Staff	11.8.3	5
Providers	11.8.4	Chapter 2
Patient Alignment Care Team (PACT) or Specialty Clinic Staff	11.8.5	2.3
C3 Staff	11.8.6	5
Trainings	11.9	Trainings Tile

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

Specialty Programs

Last Updated on: Tuesday, August 3, 2021

1.0	<u>Dental</u>
1.1	<u>Dialysis</u>
1.2	<u>GEC</u>
1.3	<u>Guidance for Clinical Application Coordinator (CAC)</u>
1.4	<u>VA – Indian Health Service (IHS) and Tribal Health Programs (THP) Reimbursement Agreements Field Guidebook</u>
1.5	<u>IVF Overview / Maternity/Newborn Referrals Process</u>
1.6	<u>Radiology</u>
1.7	<u>VCA</u>
1.8	<u>Residential Treatment and Rehabilitations Programs</u>
1.9	<u>Complementary and Integrative Health (CIH) Services</u>
1.10	<u>Mayo Destination Medical Center (DMC)</u>
1.11	<u>Transgender and Intersex Veterans</u>
1.12	<u>Traveling Veterans Guidance</u>

1.0 Dental

Introduction

The Department of Veterans Affairs (VA) provides oral health services to eligible Veterans specified under 38 U.S.C. §§1710(c) and 1712. VA implements its statutory authority through regulations that establish the Dental Program, such as Title 38 CFR §§17.160 – 17.166. Dental care may be provided through community providers when VA cannot provide the care needed. Specific statutory and regulatory requirements define Veteran access to dental care through a community provider. These requirements include available VA care, and the needs and circumstances of Veterans eligible for dental care.

Under the MISSION Act, there are two methods by which VA may purchase dental care in the community for Veterans: either through the Community Care Network (CCN) or a Veterans Care Agreement (VCA).

For VA Medical Centers (VAMCs) where a CCN has been operationalized, dental care must be purchased through the CCN by working with the Third-Party Administrator (TPA) (e.g. through Optum) assigned to their region.

For VAMCs where a CCN has not yet been operationalized, a VCA may be established with dental care providers. To establish a VCA for dental care, VAMCs must follow the procedures established by the VHA Office of Community Care.

The Veteran's eligibility must be verified, and the community care dental treatment must be approved by the VA Dental Chief or designee prior to the treatment being provided to be reimbursed by VA.

The VAMC Dental Service Chief or designee is responsible for reviewing and determining if a proposed treatment plan is appropriate.

- [VHA Directive 1130 Veterans Health Administration Dental Program March 6, 2020](#)
- [VHA HANDBOOK 1130.01\(1\) VHA Dental Program Amended March 10, 2020](#)
- [Veteran Community Care Dental Care Reference Sheet](#)
- [VA's Dental Standardized Episodes of Care \(SEOC\) Frequently Asked Questions \(FAQ\)](#)

Determining Veteran Eligibility for Community Care Dental Treatment

The VA MISSION Act does not change dental care eligibility. Dental care is only available to eligible Veterans. To receive dental care from a community provider, Veterans must be eligible for dental care and eligible for community care.

Eligibility criteria for outpatient dental care are not the same as other Community Care programs and are based on Veteran classes. These classes are described in Veteran Classes for Community Care Dental Care Program.

Apart from Veteran classes III and VI, determining Community Care dental eligibility and verifying Veteran dental classes is performed under the following VA resources:

- **First resource:**

VA Health Care Facility (HCF) Business Office is the first resource for administrative determination of dental eligibility. This office determines a Veteran's eligibility for all dental patient classifications

- **Second and final resource:**

VA's Health Eligibility Center (HEC) has final responsibility for verification of all administrative aspects of a Veteran's eligibility for dental care

Important! The above do not make eligibility determinations for Class III and Class VI Veterans.

Determining Eligibility for Veteran Classes III and VI

VA Dental Service Chiefs or designees are responsible for making all Class III and Class VI eligibility-determinations these determinations are based on review of the Veteran's medical history.

Authorizing Dental Care

The process begins when the Veteran presents to the VA Medical Center requesting dental care.

1. The Veteran's Dental Class rating and eligibility for VA Dental care are reviewed and verified with assistance from the Enrollment and Eligibility Department if necessary, and with concurrence from the Dental Service.
2. Community Care Consult requesting Dental services is placed by the VA Dental Provider, or a Dental note is entered by the VA staff dentist.
 - a. Consult should include specific ADA codes for the care being approved.
 - i. If under the CCN -do not include pricing as this is established by the TPA
 - ii. If under VCA - VA will continue to reimburse using the Fair Health data. VA is working with Fair Health to make this data available to providers.
3. The VA Community Care (VACC) staff will alert the Dental Service Chief, or designee who will review the consult to determine:
 - Is the care is clinically indicated?
 - Can the care be provided within the VA?
 - If care can be provided within the VA, the consult will be returned to the Dental Clinic for scheduling with a comment that services are available in-house.
 - Does the request meet the criteria for community referral?
 - If the referral does NOT meet the criteria for community referral, the consult is cancelled by the reviewer. The reviewer must include an explanation for cancelling the consult and alert the referring provider.
 - If the consult DOES meet criteria for community referral, the reviewing clinician (Dental Service Chief or designee) will "Authorize the Treatment".
 - The VACC staff has the medical reviewer approve the consult.
 - If predefined care options DO exist, the VACC staff will contact the Veteran and inform them that the services will be scheduled with a specific facility.
 - If predefined care options DO NOT exist, the VACC staff will review VCA options.

NOTE: For more specific instructions on consult actions and Standard Episodes of Care (SEOC), please refer to [Chapter 3: section 3.4 How to Perform Care Coordination](#), [Chapter 3: section 3.3 Standardized Episodes of Care \(SEOC\)](#) and the Dental SEOC Training Deck, and [the OCC Dental Standardized Episodes of Care Training](#)

4. Once the care option is established and accepted, coordinate a scheduled appointment for the Veteran with the contract provider or through VCA processes.

NOTE: For more information on scheduling appointments, please refer to Chapter 3: How to Schedule

Levels of care for eligible Veterans

1. Comprehensive

Veterans eligible for outpatient comprehensive dental care include Classes I, II(a), II(c), IV. These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs. A recall program must be established for those Veterans who are eligible for comprehensive and repeat dental care. The goal of care is to attain and sustain oral health and function, including prosthetic rehabilitation, as indicated.

2. Focused or Limited

Intended to resolve a specific dental condition consistent with the patient classification. Goal - specific improvement of the oral conditions that:

- Directly impact the medical condition (Class III & VI)
- Assist in Vocational Rehab (Class V)
- Are appropriate to the extended care status of the patient; and
- May include relief of pain, elimination of infection or improvement of speech or esthetics

3. Emergency

Emergent/Urgent dental care is provided as a humanitarian service to individuals who do not have established dental eligibility.

- No entitlement to follow-up care
- Complete VAF 10-2570g, Dental Outpatient
- Emergency/Referral and Treatment Record
- Bill for care provided

Authorizing Dental Care Exceeding \$1,000

Per 38 U.S.C. 1712, DENTAL CARE; DRUGS AND MEDICINES FOR CERTAIN DISABLED VETERANS; VACCINES, requires that confirmation of the appropriateness of a proposed treatment plan and associated fees be made by a VA dentist in all cases where the total Community Care program dental treatment plan exceeds \$1,000.

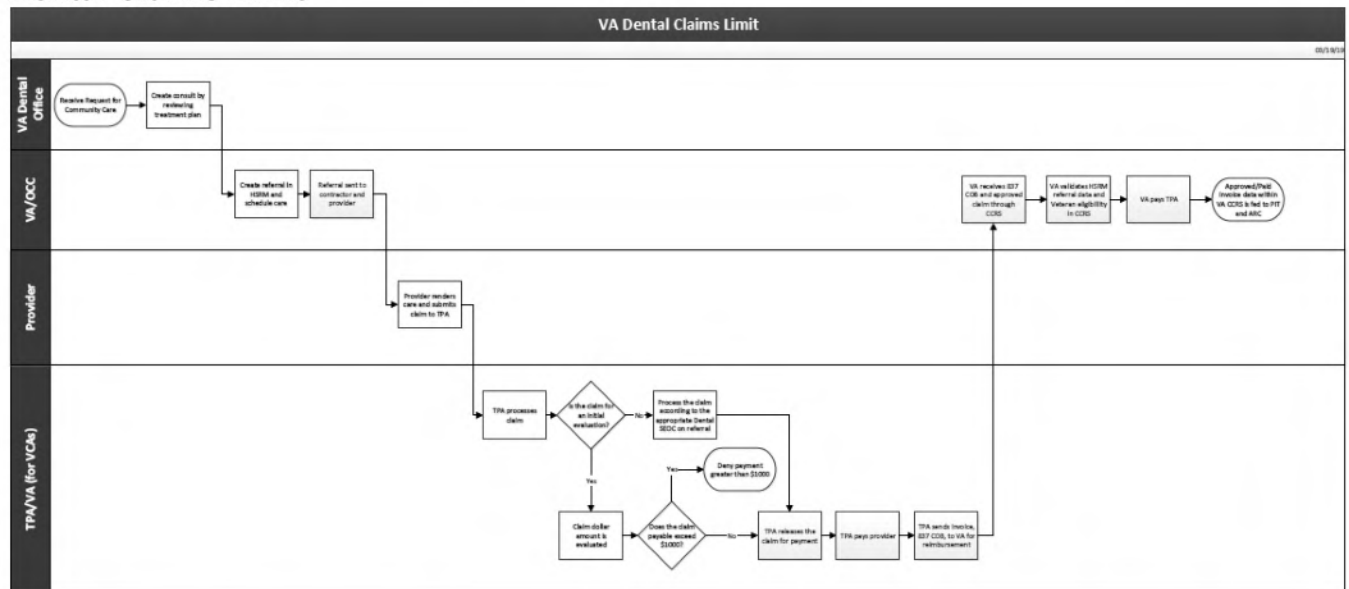
In any rolling calendar year, the VA may not pay more than \$1000.00, total, for care that was not approved prior to treatment. This confirmation may be received by:

1. An examination by a VA dentist to determine needs prior to Community Care dental care authorization.
2. A second opinion examination by a VA dentist after submission of Community Care dentist's treatment plan and associated fees.
 - A second opinion examination may be completed by a, designated, authorized, outside provider when no VA dentist is available.

3. A review of the clinical record, applicable images and supporting documentation by a VA dentist after submission of a Community Care dentist's treatment plan and associated fees. This review does not necessarily require the Veteran to be present.

Note: Veterans who refuse to participate in a requested confirmation examination or refuses to accept a treatment plan determined by VA to be satisfactory, must have their case closed and be so informed.

Dental Claims Limit



Note: Per contract community dental providers are prohibited from charging Veterans for personal protective Equipment (PPE) / cleaning fees and are not separately reimbursable.

Veteran Classes for Community Care Dental Care

Class	Veteran's Eligibility Criteria	Eligible for these Services	Purpose of Visit Codes
Class I	Those having a service-connected, compensable (10% or more) dental disability or condition rated under the 9900 series of the Schedule for Rating Disabilities. These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs.	<ul style="list-style-type: none"> Entitled to dental care for any dental condition (outpatient comprehensive) Includes repeat care 	15
Class II	Recently discharged veterans with a service-connected non-compensable dental condition or disability who served on active duty 90 days or more and who apply for VA dental care within 180 days from separation from active duty	<ul style="list-style-type: none"> Discharge rules apply Verification of DD-214, line 17 if dental treatment was completed prior to discharge 	16

Class	Veteran's Eligibility Criteria	Eligible for these Services	Purpose of Visit Codes
	Note: Public Law 83 enacted June 16, 1955, amended Veterans' eligibility for outpatient dental services. As a result, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be non-compensable are no longer eligible for Class II outpatient dental treatment.	<ul style="list-style-type: none"> One-time completion of care 	
Class IIA	Those having a service-connected non-compensable dental condition or disability resulting from combat wounds or service trauma. Veterans eligible for outpatient comprehensive dental care include Class II(A). These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs	<ul style="list-style-type: none"> Care only for the service-connected condition(s) Includes repeat care 	17
Class IIB	Certain veterans enrolled in a VA Homeless Program for 60 consecutive days or more may receive certain medically necessary outpatient dental services Note: Note: On October 1st, 2010, Veterans receiving dental care under the provisions of VHA Directive 2007-039 Eligibility Guidelines for a One-Time Course of Dental Care for Certain Homeless and Other Enrolled Veteran were categorized under Dental Classification IIB.	One-time course of dental care	18 (as of 10/1/10)
Class IIC	These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs. This Class includes Veterans who were Prisoners of War (POWs) for any period of time	<ul style="list-style-type: none"> Eligible for any needed dental care Eligible for outpatient comprehensive dental care Includes repeat care 	19
Class III	Veterans with a dental condition professionally determined by VA to be aggravating or complicating the management of a service-connected medical condition under active treatment.	Provide focused care to treat only the oral conditions that directly impact the management of the service-connected medical condition.	21
Class IV	These Veterans receive any dental treatment that is reasonably necessary and clinically determined by the treating dentist to meet the Veteran's dental needs. This includes Veterans whose service-connected disabilities have been rated at 100 percent (total) or who are receiving the	<ul style="list-style-type: none"> Eligible for outpatient comprehensive dental care; These Veterans are eligible for any needed dental care. Includes repeat care. 	22

Class	Veteran's Eligibility Criteria	Eligible for these Services	Purpose of Visit Codes
	100 percent rate by reason of individual unemployability.	Note: Veterans awarded a temporary total disability are not eligible.	
Class V	A veteran who is participating in a VA vocational rehabilitation program under 38 U.S.C. Chapter 31	<ul style="list-style-type: none"> Entitled to any necessary dental treatment to promote a successful completion of a VOC Rehab veteran's training program The VA Form 28-8861 must accompany requests for dental care. Dental care should not be provided beyond the anticipated rehabilitation date as specified on the form. 	23
Class VI	Any veteran scheduled for admission or receiving care if the dental condition is clinically determined to be complicating a medical condition under VA treatment.	Provide focused care to treat only the oral conditions that directly impact the management of the non-service-connected medical condition.	24

1.1 Dialysis

PURPOSE

The purpose of this guidance is to provide Facility dialysis coordinators (or other dialysis points of contacts) and facility community care offices with guidance on the various community care referral pathways and processes for Dialysis Services under: Community Care Network (CCN) & National Dialysis Services Contract (NDSC) for End Stage Renal Disease (ESRD) dialysis facility; Community Care Network (CCN) for Nephrology oversight; and CCN / NDSC for Acute Kidney Injury (AKI); and CCN / NDSC Transient (Travel) Veteran ESRD dialysis facility with CCN Nephrology oversight for AKI and Transient (Travel) services.

Community Care Network (CCN) transition for Dialysis services began in Fiscal Year (FY) 2021 and utilizing CCN ESRD Dialysis Facilities is priority over the NDSC ESRD Dialysis Facility pathways. For FY 21, nine, (9) NDSC Contractors were approved for another Option Year. Nine (9) other NDSC Contractors transitioned over to CCN for FY 21 and beyond for ESRD Dialysis Facility services.

Dialysis Coordinators and Facility community care staff will be required to collaborate and establish communication to coordinate their Veteran population requiring Dialysis services and transition community care network dialysis services that were previously authorized under the National Dialysis Services Contract (NDSC) into the Community Care Network (CCN) for all new Dialysis service requests. For NDSC Renewal timeframes for each FY, reviewing the Veteran's current address and current situation during the Renewal period would help determine if the Veteran would like to move to a different ESRD Dialysis Facility provider closer to their residence. Nephrology oversight under CCN would also be required for all Dialysis ESRD Dialysis Facility services. Utilizing CCN ESRD dialysis facilities is the preferred referral pathway for FY 21 and beyond. However, until all End Stage Renal Disease (ESRD) Dialysis Facilities can be transitioned to CCN, the current NDSC ESRD Facilities will be maintained for an additional year. It is not yet determined what will occur for FY 22.

ROLES AND RESPONSIBILITIES

VAMC Dialysis Coordinator or other Dialysis POC:

- Determine Veteran's eligibility for VHA Benefits for all Dialysis Service requests and Renewals for each Fiscal Year.
- Determine if there is availability at a VA Dialysis Unit as applicable.
- For Annual Renewals, determine if Veteran has moved within the past year to impact where they receive current Hemodialysis services (MISSION Act criteria) and locate new ESRD Dialysis Facility and Nephrology oversight services under CCN.
- For all new Dialysis service requests, determine availability of Community Care Network (CCN) ESRD dialysis centers first.

- Must utilize Community Provider Locator (CPL) Tool to locate CCN ESRD Dialysis and Nephrology Oversight Providers (No NDSC Facilities are in CPL or PPMS).
- Must use RAS to locate all ESRD Dialysis Facilities under NDSC.
- Collaborate with local facility community care administrative staff for oversight and processing of Consults/SEOCs/Authorizations.
- Utilize NDSC contract only when CCN ESRD Dialysis Facility not available; or not willing to sign up to CCN with VCA bridge to CCN.
- All ESRD Dialysis Facility requests under Renewal, New, AKI or Transient will require a CCN Nephrology oversight consult.

VA Provider:

- Determine continued clinical eligibility for Annual Renewal ESRD Dialysis Facility and Nephrology Oversight consults for New ESRD Dialysis Facility and Nephrology Oversight services requests; and AKI; and Transient (Travel) requests.
- Use the Decision Support Tool (DST) to capture Best Medical Interest (BMI) community care eligibility considerations for all VAMC with in-center Dialysis units.
 - BMI should be utilized for Veterans who live 60 minutes' drive time from their residence to VAMC due to traveling 2 hours per treatment day, 3 times/week.
 - Use of BMI to obtain a closer ESRD Dialysis Facility and Nephrology Oversight services would be indicated to reduce their drive time impact for 3x/weekly treatments.
- DST should not be used for NDSC NON-VA CARE HCPS HEMODIALYSIS/ NON VA CARE HCPS PERITONEAL DIALYSIS consults
- Enter the appropriate community care consults, Community Care-Hemodialysis / Peritoneal Dialysis and Community Care-Nephrology consult or NDSC: NON VA CARE HCPS HEMODIALYSIS/ NON VA CARE HCPS PERITONEAL DIALYSIS consult and Travel Veteran Coordinator consults for Transient (Travel) per local policy.

Facility Community Care Staff:

- Confirm community care eligibility.
- Will assist Dialysis Coordinators or other Dialysis POCs for help identifying CCN ESRD Dialysis Facility or Nephrology Oversight providers in PPMS.
 - Dialysis Coordinators or other Dialysis POC's have access to CPL which mirrors PPMS CCN / VCA providers.
 - Dialysis Coordinators or other Dialysis POC's must use RAS to locate all ESRD Dialysis Facilities under NDSC.
- Per local guidance process community care referral in HealthShare Referral Management (HSRM) when referring the care under a CCN or

VCA provider (both for Facility and nephrology provider) and apply the appropriate Standard Episode of Care (SEOC).

- If NDSC AKI services approved, the ESRD Dialysis Facility must be entered into a Community Care-Hemodialysis consult and the NDSC Facility vendorized in local VistA and manually entered Provider Profile Management System (PPMS).
 - These process steps allow approved NDSC AKI ESRD Dialysis Facility to be paid by eCAMs under NDSC Fee Schedule.
 - A Community Care-Nephrology consult must be placed with the AKI services and appropriate SEOCs.

CONTRACT PATHWAYS: The following contract vehicles must be utilized in this order to approve community care for ESRD Dialysis Facility and Nephrology Oversight services for FY 21 and beyond:

- Community Care Network (CCN), if not available then
- NDSC, if CCN and NDSC are not available, then
- VCA (utilize only as a bridge while signing on to CCN)

Note: All Nephrology Oversight services for ESRD Dialysis Facility services are only approved under CCN or VCA (VCA used only as a bridge to sign up to CCN)

- Dialysis coordinators and facility community care staff must determine if there are available ESRD Dialysis Facilities under each of these contract vehicles, following the order provided above.
- Facility community care staff have access to Provider Profile Management System (PPMS) to locate CCN/VCA Providers. PPMS does not locate NDSC ESRD Dialysis Facilities.
- Dialysis Coordinators may use the [Community Provider Locator \(CPL\) Tool](#). Go to FGB Chapter 2, Section 2.19 & Tools Section under "Options"

Note: Community Provider Locator (CPL) Tool will not identify NDSC ESRD Dialysis Facilities, only CCN, VCA (or PC3 until March 31, 2021 in applicable regions). VA Facility Dialysis Coordinators or other Dialysis POC's must review RAS for NDSC providers **only if** no CCN, or VCA, ESRD Dialysis Facilities are available.

- Search in CPL to locate ESRD Dialysis Facility:
 - Registered Nurse- Hemodialysis
 - Registered Nurse- Dialysis Peritoneal
 - Tech, Other Renal Dialysis
 - Clinic/Center ESRD
- Search in CPL to locate Nephrology Oversight Providers:
 - Internal Medicine-Nephrology
 - Registered Nurse-Nephrology
 - Specialist/Technologist, Other- Nephrology

Note: Facility community care staff will use PPMS to assist the Dialysis Coordinators as required

CONSULT REQUIREMENTS:

PROCEDURE

1. Community Care ESRD Dialysis Facility and Nephrology Oversight Renewal

Assumptions:

- Process addresses Hemodialysis/Peritoneal Dialysis and Nephrology Oversight services to include:
 - Home
 - In-Center
- VAMC Dialysis Coordinator will determine:
 - If there is availability at the VA Facility Dialysis Unit
 - If Veteran has moved within the past year
 - If there are any closer Community Care ESRD dialysis services (if located, sign up under CCN and use a VCA as bridge while pending CCN sign on).
- VAMC Dialysis Coordinator will work with facility community care staff to determine what Contract Pathway (CCN, NDSC, VCA) the Dialysis Facility and Nephrology fall under
- Dialysis Coordinators may use the [Community Provider Locator \(CPL\) Tool](#) for locating CCN & VCA contracted Facilities and Nephrology Oversight providers. Go to FGB Chapter 2, Section 2.19
- **PROCESS FLOW – Annual Renewal**
 Link: [Office of Community Care Field GuideBook](#) Specialty Programs Chapter / Dialysis Section 1.1

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
1	<p>Review Dialysis Authorization List in RAS and Nephrology Authorizations in CPRS – Enter into Facility Spreadsheet</p> <p>VAMC Dialysis coordinator will:</p> <ul style="list-style-type: none"> • Use local VAMC Facility spreadsheet or National Dialysis Transition Team Sample Spreadsheet to track ESRD Dialysis authorizations from RAS for FY under review (Annual Renewal for NDSC begins, each July) <p>Sample Spreadsheet</p> <ul style="list-style-type: none"> • Going forward for FY 21 and beyond, capture list of ESRD Dialysis Facilities from both CCN and RAS annually beginning in July

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<ul style="list-style-type: none"> • Reviews spreadsheet and verify if ESRD Dialysis Facility is under NDSC or CCN • Link on how to generate RAS listings: Generate Listing of FY20 Authorization • Determine Nephrology Oversight provider is identified on separate tab in spreadsheet and they are under a CCN contract VCA pending sign on to CCN <ul style="list-style-type: none"> ▪ You must have two separate consults for ESRD Dialysis Facility AND Nephrology Oversight. <p>Note: National Dialysis Services Contract (NDSC) must ALWAYS be renewed Fiscal Year to Fiscal Year. Authorizations for NDSC cannot cross Fiscal Years and must always end September 30th of that Fiscal Year.</p> <p>Note: The list generates all authorizations, will need to filter out transient or deceased Veterans. Transient (Travel) Veterans can be filtered out as well.</p> <p>Note: Community Care Network (CCN) ESRD Dialysis Facility and Nephrology Oversight standardized episode of care (SEOC) timeframe is 365 days. Nephrology Oversight can only be approved under CCN or VCA as a bridge to CCN. Annually, it is advised to review and renew both services concurrently to maintain a consistent timetable for the Veteran since both services require separate consults and authorizations.</p>
2	<p>Perform Annual VHA Eligibility Review</p> <ol style="list-style-type: none"> 1. Annual renewal eligibility must be completed prior to the end of each fiscal year for NDSC and at the end of each EOC for Community Care expiration date for VHA Eligibility Review. This ensures the Veteran is still actively enrolled in VHA Healthcare and is eligible for services. 2. Clinical Review by Dialysis Coordinator or other Dialysis POC and VA Provider is required to ensure ongoing chronic ESRD Dialysis Facility and Nephrology oversight services are still required. <p>Note: Clinical review should follow Delegation of Authority (DOA) as designated by the COS if VA Provider is not part of the local VAMC Clinical review process.</p> 3. If Dialysis Coordinators or other Dialysis POC finds a change in Veteran status, they must notify the Veteran, VAMC Eligibility Office/VAMC Enrollment Office; and VA Provider to assist with eligibility verification or develop an alternate plan of care.

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<p data-bbox="370 338 1446 443">4. Community care eligibility for ESRD dialysis Facility and nephrology oversight care should be based on the MISSION Act eligibility criteria, as outlined in:</p> <p data-bbox="418 453 1382 527" style="padding-left: 40px;">Chapter 2 section 2.0 of the Office of Community Care Field Guidebook</p> <p data-bbox="516 537 1122 569" style="padding-left: 80px;"><u>Office of Community Care Field GuideBook</u></p> <ul style="list-style-type: none"> <li data-bbox="370 579 1503 684">▪ The eligibility determination should be made by using the DST if the care is available within the VA. The same eligibility determination should be applied to both the dialysis and nephrology oversight consults when appropriate. <li data-bbox="370 695 1487 768">▪ For example, if the Veteran is eligible for community care due to drive time, then this eligibility reason would be applied to both associated consults. <li data-bbox="370 779 1511 1052">▪ In the scenario where the consult is set to not launch DST, the end user will need to determine if the care is available within the VA. If the care is available within the VA, then an internal consult can be entered directly. The internal service will use the Consult Toolbox to forward the consult to community care, if necessary, and capture the community care eligibility reason at that time. The same eligibility reason should be applied to both the dialysis and nephrology oversight consults. <ul style="list-style-type: none"> <li data-bbox="521 1062 1503 1430">○ For example, If the Veteran lives 45 – 60 minutes from VAMC in-center Dialysis unit, due to the 3 times per week treatment requirement, it would be beneficial to look for an ESRD Dialysis Facility closer to the Veterans home. This would be especially significant if the Veteran lived in a region where seasonal weather would make the commute even more difficult or longer. The risk/benefit would be taken into consideration and the VA Provider could place a Best Medical Interest (BMI) eligibility. See BMI information below. <li data-bbox="370 1440 1511 1598">▪ If the service is not available within the VA, then the ordering provider should enter the consult directly to community care and use the appropriate consult justification reason. The same consult justification reason should be used for the dialysis and nephrology oversight consults. <li data-bbox="370 1608 1503 1766">▪ If the provider is referring the Veteran for community care due to Best Medical Interest, in the FGB guidance Chapter 2, <u>2.4 How to Determine and Manage Best Medical Interest (Hardship)</u> of the Office of Community Care Field Guidebook should be followed. <p data-bbox="326 1808 724 1839">Link to <u>DST SharePoint Site</u></p>

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<ul style="list-style-type: none"> ▪ NON VA CARE HCPS consults for National Dialysis Contract Services (NDSC) will not trigger the DST. They should not be used with the DST, only Community Care consults. ▪ NON VA CARE HCPS consults cannot be forwarded to Community Care via the Consult Toolbox. NDSC consults for ESRD Dialysis Facility are only processed thru Referral Authorization System (RAS). Do NOT force the NON VA CARE HCPS consult thru HSRM, it will result in an improper payment for the ESRD Facility and they will not be paid for their claims. ▪ A separate Community Care-Nephrology consult MUST be entered for Nephrology oversight. <p><u>Change in Status:</u></p> <p>For NDSC NON VA CARE HCPS Hemodialysis/Peritoneal and Community Care Nephrology consults:</p> <ul style="list-style-type: none"> ▪ If the Veteran has expired, regained kidney function, discontinued dialysis, transferred care to another VAMC or has received a kidney transplant, add comment to NDSC NON VA CARE HCPS Hemodialysis/Peritoneal consult, and end the authorization in RAS. Add a comment to Community Care-Nephrology consult and cancel in HSRM. <p>For Community Care-Hemodialysis/Peritoneal and Community Care-Nephrology Consults:</p> <ul style="list-style-type: none"> ▪ If the Veteran has expired, regained kidney function, discontinued dialysis, transferred care to another VAMC or has received a kidney transplant, add comments to <i>both consults</i> and cancel in HSRM. <p>If a Veteran is Ineligible:</p> <ul style="list-style-type: none"> ▪ Advise ESRD Dialysis Facility that Veteran has been notified of ineligibility and steps needed to re-establish VA care if applicable. ▪ ESRD Dialysis Facility will be notified once Veteran is eligible for VA authorization. ▪ Notify ESRD Dialysis Facility that Veteran is currently ineligible for VHA health care and will need to utilize alternate health care for dialysis coverage. ▪ Notify VA provider if care is not re-established and need for alternate plan of care.

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
3	<p>Perform Clinical Review</p> <p>As noted in Step 2., Dialysis Coordinator will first determine the Veteran is still eligible for VHA benefits for the annual review and then Clinical Review by VA Provider, Delegation of Authority (DOA) or Chief of Staff (COS). Annual renewal eligibility must be completed prior to the end of each fiscal year for NDSC and at the end of each EOC for Community Care expiration date for VHA Eligibility Review. This ensures the Veteran is still actively enrolled in VHA Healthcare and is eligible for services.</p> <p>How to perform a clinical review, refer to Chapter 3.20</p> <p>Clinical Review is completed by the Delegation of Authority (DOA) designated by the COS in the local facility.</p> <p>If Clinically appropriate, proceed to Step 4 If not clinically appropriate, the DOA may suggest an alternate plan of care.</p>
4	<p>Determine if Dialysis Services are located within VAMCs</p> <p>Must determine if dialysis services are available within the VAMC. Link to Dialysis Locator Tool (All VA In-Center Dialysis Units)</p> <p>If not, proceed to Step 5</p> <p>Note: A VAMC may provide services but no access is available and would require community care Justification as: "Wait Time"</p> <p>If there are no VAMC Dialysis ESRD Dialysis unit, then Justification for Community Care is: "<i>Services not available</i>"</p>
5	<p>Determine Contract Vehicle</p> <p>Locate ESRD Dialysis Facility contract vehicles for Renewal or New requests in this order:</p> <ul style="list-style-type: none"> ○ CCN, if not available then ○ NDSC, if CCN and NDSC are not available, then ○ VCA (utilize only as a bridge while signing on to CCN) <p>Note: While Community Care Network (CCN) Third Party Administrators are currently building their dialysis/nephrology network please note that all Veterans must be contacted to discuss a change in their dialysis facility.</p> <p>Note: In addition, all Renewal Reviews must determine if Veteran has changed location/residence and a closer ESRD Dialysis Facility may be closer. The ESRD Dialysis Facility must be contacted to sign up with CCN. Use a VCA as a bridge to CCN as it can take up to 3 – 4 months to complete CCN sign on.</p>

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<p>As of FY 21, nine (9) prior NDSC Contract ESRD Dialysis Facility Contractors have transitioned to CCN for FY 21.</p> <ol style="list-style-type: none"> 1. AVERA HEALTH 2. COMMUNITY DIALYSIS CENTER 3. HAPEVILLE DIALYSIS CENTER 4. INDEPENDENT DIALYSIS FOUNDATION, INC. 5. PHYSICIANS CHOICE MANAGEMENT, LLC 6. PHYSICIANS DIALYSIS MANAGEMENT, LLC 7. SATELLITE HEALTHCARE, INC. 8. SOUTH FULTON DIALYSIS CENTER, LLC. 9. TRINITY DIALYSIS CLINIC, INC. <p>Locate ESRD Dialysis Facilities (CCN & VCA only) Dialysis Coordinator and other Dialysis POC's will use: Community Provider Locator (CPL) Tool Attempt to first locate a CCN (or VCA) ESRD Dialysis Facility using the Community Provider Locator (CPL) Tool.</p> <p>Community Provider Locator (CPL) Tool <u>will not identify</u> NDSC ESRD Dialysis Facilities. CPL will only identify CCN, VCA providers (or Nephrology Providers under PC3 until March 31, 2021 in applicable regions).</p> <p>Note: Use RAS to locate NDSC ESRD Dialysis Facilities as secondary if no CCN ESRD Dialysis Facility will not sign up with CCN.</p> <p>Dialysis Coordinators may use the <u>Community Provider Locator (CPL) Tool</u>. Go to FGB Chapter 2, Section 2.19 & Tools Section under "Options"</p> <p>Search in CPL to locate ESRD Dialysis Facility:</p> <ul style="list-style-type: none"> ○ Registered Nurse- Hemodialysis ○ Registered Nurse- Dialysis Peritoneal ○ Tech, Other Renal Dialysis ○ Clinic/Center ESRD <p>Note: Facility community care staff will use PPMS to assist the Dialysis Coordinators in locating CCN (VCA providers) as required:</p> <ul style="list-style-type: none"> ○ For more information on how to look up a CCN provider in PPMS, go to FGB Chapter 2, section 2.19 and reference <u>PPMS</u>.

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<ul style="list-style-type: none"> ○ For more information on how to look up an NDSC provider, go to RAS. ○ For more information on how to complete a VCA, consult local community care office. <p>Stations who need to procure a VCA for these nephrology oversight services should notify the VCA Team at: (b)(6) @va.gov their network gap for tracking, this information should include the provider name, NPI, and approximate number of Veterans that will be serviced by the provider.</p> <p>LINK VCA: VCA Guidebook</p> <p>Locate Nephrology Oversight Provider (CCN & VCA only)</p> <p>Locate Nephrology Oversight contract vehicles for Renewal or New requests in this order:</p> <ul style="list-style-type: none"> ▪ CCN, if not available then, ▪ VCA (utilize only as a bridge while signing on to CCN) <p>Please utilize CPL Tool. Community Provider Locator (CPL) Tool.</p> <p>Note: Nephrology Oversight is only approved under CCN or VCA and is NOT approved under NDSC and requires a separate consult from ESRD Dialysis Facility services, only CCN, VCA (or PC3 until March 31, 2021 in applicable regions).</p> <p>Search in CPL to locate Nephrology Oversight Providers:</p> <ul style="list-style-type: none"> ○ Internal Medicine-Nephrology ○ Registered Nurse-Nephrology ○ Specialist/Technologist, Other- Nephrology <ul style="list-style-type: none"> • Ask Nephrologist to join CCN and provide them the contact information for CCN Contractor to sign up (Optum or TW): CCN Provider Network Information - Join CCN • If they will NOT join CCN, identify other Nephrologist already with the Dialysis Facility willing to join CCN; or Nephrologists already in CCN (CPL Tool or PPMS) <p><u>Script for Nephrology Provider to Join CCN</u></p> <p><i>We understand you are not currently under the Community Care Network <u>or</u></i></p>

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<p><i>We are aware you may be interested to provide Chronic ESRD Dialysis services (OR Nephrology Oversight Service) to our Veterans.</i></p> <p><i>VA remains committed to ensuring our Veterans receive timely and quality care through our community partners. VA also understands the potential concerns when evaluating contracting options for VA Community Care.</i></p> <p><i>VA would like to connect your organization with (Optum or TriWest) on the path forward in our mission to serve Veterans' needs for dialysis care.</i></p> <p><i>VA greatly appreciates your consideration of this request and we would like to set up a teleconference with you and our TPA representative.</i></p> <p>PROVIDE THEM WITH THE TPA CONTACT INFORMATION TO SIGN UP WITH CCN</p> <p>Link: CCN Provider Network Information - Join CCN</p> <p>Note: Use a VCA as a bridge to CCN as it can take 3 – 4 months to complete credentialing and sign on to CCN. You cannot use VCA as a permanent contract vehicle, it is a temporary bridge to CCN only.</p>
6	<p>Create ESRD Dialysis Facility (CCN / NDSC) AND Nephrology Oversight Consults (CCN/VCA)</p> <ul style="list-style-type: none"> • For ESRD Dialysis Facility services provided through CCN or VCA, utilize the Community Care-Hemodialysis or Community Care-Peritoneal Dialysis consult. • Two (2) separate consults are required for ESRD Dialysis Facility and Nephrology Oversight services: <ul style="list-style-type: none"> ○ For ESRD Dialysis Facility services provided through NDSC, utilize NON VA CARE HCPS HEMODIALYSIS or NON VA CARE HCPS PERITONEAL DIALYSIS Consult ○ Enter ESRD Dialysis Facility consult and a separate Community Care-Nephrology consult. ○ Select appropriate Standard Episode of Care (SEOC) for both ESRD Dialysis Facility and Nephrology Oversight services. ○ Dialysis-specific SEOC table ○ NON VA CARE HCPS HEMODIALYSIS AND PERITONEAL DIALYSIS consults are processed thru Referral Authorization System (RAS) <p>See Entering Community Care-Hemodialysis Consult PPT in FGB Office of Community Care (OCC) Field Guidebook Home Page Specialty Programs Chapter Section: 1.1 Dialysis</p>

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<p>Link: Office of Community Care Field GuideBook</p> <p>For guidance on community care consult management refer to FGB Chapter 2.13 for Community Care consult management processes</p> <p>Community Care – Consult Names / Clinic Services</p> <p>VA Medical Center (VAMC) Clinical Applications Coordinators (CACs) will build the following consult services (<i>if not already available</i>) and attach to the templates as below:</p> <p><u>CONSULT SERVICE TEMPLATE</u></p> <p>COMMUNITY CARE-HEMODIALYSIS CC V10.1 HEMODIALYSIS COMMUNITY CARE-PERITONEAL DIALYSIS CC V10.1 PERITONEAL DIALYSIS COMMUNITY CARE-NEPHROLOGY (local build) NON VA CARE GENERIC V6.2</p> <p>Note: Additionally, a corresponding community care clinic must be established as below:</p> <p><u>CONSULT CLINIC</u></p> <p>Community Care-Hemodialysis Com Care-Hemodialysis Community Care-Peritoneal Dialysis Com Care-Peritoneal Dialysis</p> <p>IMPORTANT:</p> <p>The following 2 (two) consult services must remain with the NON VA CARE naming convention and remain linked to the templates as below. This is required so that the consult will transmit correctly to the HCPS (Health Claims Processing System) system.</p> <p>Note: All AKI services must be processed thru HSRM and can be approved thru NDSC ESRD Dialysis Facility and CCN. However, AKI Services may NOT be processed thru NON VA CARE HCPS consult templates (RAS). All approved AKI ESRD Dialysis Facility services must be entered thru a Community Care-Hemodialysis consult with the appropriate SEOC and separate Community Care-Nephrology consult and appropriate SEOC.</p> <p><u>CONSULT SERVICE TEMPLATE</u></p> <p>NON VA CARE HCPS HEMODIALYSIS NON VA CARE HEMODIALYSIS V62</p>

Community Care ESRD Dialysis Facility and Nephrology Oversight Fiscal Year (FY) Renewal

Step	Activity
	<p>NON VA CARE HCPS PERITONEAL DIALYSIS NON VA CARE PERITONEAL DIALYSIS V62</p> <p>You can locate the COMMUNITY CARE HEMO-PERITONEAL DIALYSIS CONSULT Folder on the SharePoint that contains: Technical Guide, two (2) Templates and NON VA CARE GENERIC v6.2 to create your local Community Care-Nephrology consult.</p> <p>Link to locate: Community Care Dialysis Technical Setup Information</p> <p>CCN and VCA community care consults will be forwarded to the Office of Community Care, when applicable.</p> <p>Note: NON VA CARE HCPS HEMODIALYSIS or NON VA CARE HCPS PERITONEAL DIALYSIS consults must not be forwarded to Community Care via consult toolbox (CTB)</p> <p>Medical Records Return Guidance for CCN / NDSC/ VCA:</p> <ul style="list-style-type: none"> • Community Care (CCN) and Veteran Care Agreement (VCA): The referring VAMC is responsible for ensuring medical records are received for continuity of care. In cases where clinical documents are not returned, Facility Community Care Office staff should contact the community provider to request the clinical documents. If this outreach fails, the staff should alert the appropriate facility VCA contact or the CCN Regional representative. Additional guidance is located in FGB Chapter 4.0. • NDSC: NDSC providers are not required to submit medical records or documentation. However, records must be submitted upon request. If a NDSC provider does not comply with a request for medical records, the VA should notify the contract team at: <div style="border: 1px solid black; display: inline-block; padding: 2px;">(b)(6)</div> @va.gov <ul style="list-style-type: none"> ○ A Contactor Officer Representative (COR) would be assigned to assist obtaining Medical Records. <p>Note: Medical documentation may need to be requested from the ESRD Dialysis Facility and the Nephrologist Oversight Provider as both are separate and VA Provider would guide what specific medical records would be required to obtain from both or separately.</p>

2. Community Care ESRD Dialysis Facility and Nephrology Oversight - New Services Requests

Please see Procedure 1. Community Care ESRD Dialysis Facility and Nephrology Oversight Renewal

for authorization process.

Follow the steps for Renewal except for the following key requirements related to **new ESRD Dialysis Facility and Nephrology Oversight authorization**.

- **PROCESS FLOW – New Service Requests**

Link: [Office of Community Care Field GuideBook](#) Specialty Programs Chapter / Dialysis Section 1.1

Community Care ESRD Dialysis Facility and Nephrology Oversight - New Service Request	
Step	Activity
1	Receive and Review New ESRD Dialysis Facility Request (Will also require a Community Care-Nephrology consult)
2	Perform VHA Eligibility Review (Dialysis Coordinator or Other VAMC Dialysis POC) – See Procedure 1.
3	Perform Clinical Review – See Procedure 1.
4	Determine if Dialysis Services are available in VAMCs – See Procedure 1.
5	Determine Contract Vehicle – See Procedure 1. Note: Always check for a CCN provider before moving to other vehicles (NDSC for ESRD Dialysis Facility, or VCA as a bridge to CCN). Nephrology Oversight is only approved under CCN, or VCA as a bridge to CCN. Note: Just because you do not find a CCN ESRD Dialysis Facility, you must determine where the Veteran resides and research ESRD Dialysis Facilities around them and ask the Facility to join CCN. We are transitioning to CCN and our TPA's and the VA must work to build the network.
6	VAMC Dialysis Coordinator (or other VAMC Dialysis POC) adds new Veteran and ESRD Dialysis Facility and Nephrology Oversight provider request VAMC Dialysis Coordinator or other Dialysis POC will: <ul style="list-style-type: none"> • Create or use local VAMC Facility spreadsheet or National Dialysis Transition Team Sample Spreadsheet to track new ESRD Dialysis Facility and Nephrology Oversight authorizations. • Review spreadsheet and verify provider is under NDSC or CCN • Work collaboratively with Facility Community Care staff to manage Dialysis population

Community Care ESRD Dialysis Facility and Nephrology Oversight - New Service Request

Step	Activity
7	Create ESRD Dialysis Facility AND Nephrology Oversight consult – Refer to Procedure 1.

3. Community Care Acute Kidney Injury (AKI) and Nephrology Oversight Provider

Assumptions:

- Requests for AKI may come from VA or Community Providers
- AKI can be approved through CCN **and** NDSC for ESRD Dialysis Facility services
- **All AKI must be processed through HSRM to include NDSC ESRD Facility.**
- All AKI NDSC ESRD Dialysis Facility services must be entered via Community Care-Hemodialysis consult and processed in HSRM.
- AKI NDSC ESRD Dialysis Facility services must NOT be processed in RAS.
- All NDSC AKI ESRD Dialysis Facilities must be vendorized in **local** VistA
- Once in **local** VistA, must be entered manually in PPMS by selecting: “**Local Contract**” AND “**Clinic/Center-End Stage Renal Disease (ESRD) Treatment**” to be processed correctly thru HSRM and Electronic Claims Adjudication Management System (eCAMS)
- All AKI requests require separate Community Care-Nephrology oversight consult
- Nephrology services can only be obtained through CCN or VCA (as a bridge to CCN)
- AKI SEOC is 90 days in length and Nephrology Oversight SEOC is 90 days
- All NDSC AKI authorizations crossing FY will require a new authorization

PROCESS FLOW – New Service Requests

Link: [Office of Community Care Field GuideBook](#) Specialty Chapter / Dialysis Section 1.1

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
1	<p>VAMC Dialysis Coordinator (or other VAMC Dialysis POC) Receives AKI request</p> <p>Add AKI Request to Facility spreadsheet and identify if CCN or NDSC ESRD Dialysis Facility</p> <p>Add Current Nephrology Oversight provider (Facility Spreadsheet) or New Nephrology Oversight provider if required</p>

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
2	Perform VHA Eligibility Review (Dialysis Coordinator or Other VAMC Dialysis POC) – See Procedure 1.
3	Perform Clinical Review – Refer to Procedure 1.
4	<p>Determine Contract Vehicle ESRD Dialysis Facility (CCN, NDSC, VCA) Nephrology Oversight (CCN, VCA)</p> <p>For all CCN AKI Providers, follow current process to enter Community Care-Hemodialysis consult and Community Care-Nephrology consult and associated AKI SEOC's</p> <p>SEOC Database Link, Dialysis-specific SEOC table</p> <p>For NDSC AKI ESRD Dialysis Facility – must follow below to process thru HSRM:</p> <p><u>VENDORIZE NDSC AKI ESRD FACILITY in LOCAL VISTA</u></p> <ul style="list-style-type: none"> • NDSC Contractors can provide AKI services as part of a contract modification in October 2019. • For most AKI NDSC approved services, local VAMC stakeholder will not be required to perform full Vendorizing process as the NDSC Dialysis Facility is already in the Financial Management System (FMS). • Since they are already in FMS, it is not necessary to place the Financial Service Center (FSC) Vendor File Request VA-10091 Form (Austin). However, if they wish to utilize Electronic payments, then use of the form would be required. <p>NOTE: Only Contracted NDSC ESRD Dialysis Facility will be approved for AKI Services. You will not be able to authorize any AKI services without the NDSC ESRD Dialysis Facility approved under the contract.</p> <p>Note: In rare instances if they are new providers to NDSC for AKI, they need to follow the normal vendorization process with FSC.</p> <p>See Appendix 1. For list of NDSC ESRD Dialysis Facilities</p> <p><u>Local Facility VistA Entry Requirements of AKI NDSC Dialysis Facility</u></p> <ul style="list-style-type: none"> • Prior to manually entering the NDSC AKI ESRD Facility in PPMS, NDSC and VCA providers must also be vendorized in the local facility VistA system which requires the FBAASUPERVISOR security key. <ul style="list-style-type: none"> ○ For the step by step process on how to vendorize a provider/practice, reference Specialty Programs, 1.7 of the Field Guidebook.

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
ESRD	<ul style="list-style-type: none"> For NDSC AKI ESRD Dialysis Facilities, user will enter the national contract number found in the table provided in Appendix 1 into local facility VistA when vendorizing. This will allow the contract to be selected in the payment modules. <p>Note: These steps are the same as how sites vendorize VCA Dialysis Facilities in local facility VistA except with AKI, you will utilize the NDSC contract number See Appendix 1.</p> <p><u>For VCA ESRD Dialysis Facilities Vendorization in local facility VistA</u></p> <ul style="list-style-type: none"> Upon entering and establishing the Contract ID (number) in PPMS, the Contract ID is entered into local facility VistA as a Contract ID which then makes the contract ID number selectable in the payment modules. The assigned Contract ID should be entered into local facility VistA exactly as it appears in PPMS; if the number isn't completely and accurately entered into the Contract ID prompt in local facility VistA; the Contract ID will not be available to select in the payment modules. <p>Example of NDSC AKI ESRD Dialysis Facility Local Facility Vendorization Process</p> <p>To begin Vendorization process:</p> <ol style="list-style-type: none"> 1. Launch local facility VistA and access the Medical Fee Main Menu: Supervisor Main Menu 2. Enter Contract File Enter/Edit <p>Start Screen to Create NDSC AKI Vendor in Local Facility VistA</p>

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step
Activity

Select Medical Fee Main Menu Option: Supervisor Main Menu

```

Clerk Look-Up For An Authorization
Contract File Enter/Edit
Delete Reject Flag
Edit Pharmacy Invoice Status
Enter/Edit Suspension Letters
Fee Basis 1358 Segregation of Duty Report
Fee Schedule Main Menu ...
Finalize a Batch
FPPS Update & Transmit Menu ...
List Batches Pending Release
MRA Main Menu ...|
Update FMS Vendor File in Austin [FBAA FMS UPDATE]
Delete Vendor MRA [FBAA MRA DELETE VENDOR]
Reinstate Vendor MRA [FBAA MRA VENDOR REINSTATE]
Pricer Batch Release
Print Rejected Payment Items
Queue Data for Transmission
Re-initiate Rejected Payment Items
Release a Batch
Reprocess Overdue Batch [FBAA REPROCESS BATCH]
Resend Completed Batch [FBAA RESEND VOUCHER MSG]
Site Parameter Enter/Edit
Unauthorized Claims File Menu ...
Void Payment Main Menu ...
  
```

3. Select Fee Basis Contract Number: Enter NDSC AKI Contract ID number located in PPMS within the provider's profile under the section labeled "Agreements."

4. Prompted to Confirm: "Are you adding LC123456789 as a new FEE BASIS CONTRACT? No/" Enter Y for YES

Adding NDSC AKI Contract ID Number to Local Facility Vista

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step

Activity

```
LTC Outpatient Ending Authorization Report
Outputs Main Menu ...
Payment menu ...
Registration Menu ...
Supervisor Main Menu ...
Terminate ID Card
Unauthorized Claim Main Menu ...
Vendor Menu ...
```

```
You have PENDING ALERTS
Enter "VA to jump to VIEW ALERTS option
```

```
Select Medical Fee Main Menu Option: ^contrac
```

```
1 Contract Expiration List [FBCNH EXPIRATION REPORT]
2 Contract File Enter/Edit [FBAA CONTRACT FILE]
```

```
Type '^' to stop, or choose a number from 1 to 2 :2 Contract File Enter/Edit
Select FEE BASIS CONTRACT NUMBER: LC123456789
Are you adding 'LC123456789' as a new FEE BASIS CONTRACT (the 890TH)? No//
(No) ??
```

```
Select FEE BASIS CONTRACT NUMBER:
```

Note: By placing prefix **“LC”** in front of the Contract ID, you are identifying the ESRD Dialysis Facility provider for AKI approved services.

5. Hit Enter

6. Status: Enter "A" for ACTIVE

7. Select VENDOR: Enter Vendor Tax ID. If a list populates, choose the correct number for the applicable vendor

8. Enter "Y" for Yes when prompted if adding APPLICABLE VENDORS

9. Select VENDOR: Hit Enter Key (no entry)

Assigning NDSC AKI Contract ID to Appropriate AKI NDSC Dialysis Facility

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step	Activity
------	----------

Select VENDOR: 123456789

- | | | | |
|---|---------------------------|--------------|-----------------|
| 1 | 123456789 VCA VENDOR | 123456789 | HOME HEALTH SER |
| | P O BOX 999 | | |
| | DENVER, CO 99999-9999 | TEL. # | (999) 999-9999 |
| | | | |
| 2 | 123456789 VCA VENDOR2 | 123456789999 | HOME HEALTH SER |
| | 111 E 1 st ST. | | |
| | DENVER, CO 99999-9999 | TEL. # | (999) 999-1111 |

CHOOSE 1-2: 1 VCA VENDOR 123456789 HOME HEALTH SER
 P O BOX 999
 DENVER, CO 99999-9999

Are you adding "VCA Vendor" as
 A new APPLICABLE VENDORS (the 1st for this FEE BASIS CONTRACT)? No// y (YES)

Select VENDOR:
 CHOICE INDICATOR:
 CHOICE PROVIDER AGREEMENT:

10. Enter NDSC ESRD Dialysis Facility Tax ID

11. CHOICE INDICATOR: Hit Enter Key (no entry)

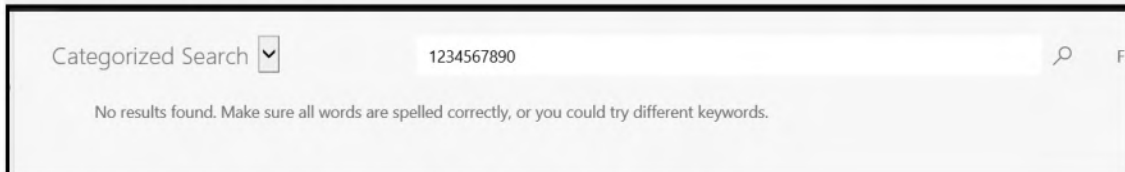
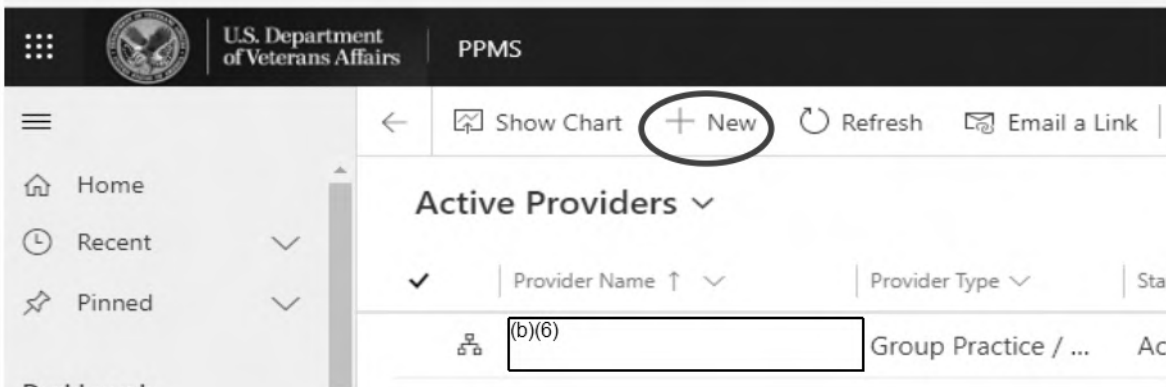
12. CHOICE PROVIDER AGREEMENT: Hit Enter Key (no entry)

Information on how to vendorize in VISTA is located in the FGB, Specialty Programs, Chapter 1.7

NOTE: Use this same process for VCA and just enter the VCA Contract ID number where applicable in the steps for local facility VistA vendorizing. Example:
VCA1234567890

PLACING NDSC AKI ESRD FACILITIES IN PPMS

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
	<p>All NDSC AKI ESRD Dialysis Facilities must be active in Provider Profile Management System (PPMS) before they can be processed in HSRM utilizing the payment system - Electronic Claims Adjudication Management System (eCAMS). NDSC AKI must not be processed thru RAS (FSC).</p> <ul style="list-style-type: none"> • NDSC AKI ESRD Dialysis Facility requests must be entered into a Community Care-Hemodialysis consult to be processed through HSRM. NDSC consults must not be processed through RAS (FSC) • NDSC AKI ESRD Dialysis Facility must first be vendorized in local facility VistA before placing in PPMS • NDSC providers must be manually loaded into PPMS by Facility Community Care staff and assigned to labels: • “Local Contract” <u>AND</u> • “Clinic/Center-End Stage Renal Disease (ESRD) Treatment” • All CCN AKI ESRD Dialysis Facilities will already be loaded and available in PPMS • CCN providers are entered into PPMS automatically by the contractors (Optum and TriWest). • NDSC ESRD Dialysis Facilities are NOT available in PPMS. They can be found in RAS. See Appendix 1. – List of Current NDSC ESRD Dialysis Facilities <p>NOTE: VCAs will be loaded into PPMS following the standard VCA process</p> <p>Note: User should follow the standard process and select “local contract” when entering a NDSC AKI ESRD Dialysis Facility and “Clinic/Center-End Stage Renal Disease (ESRD) Treatment” labels.</p>
Example of NDSC AKI ESRD Dialysis Facility Manual Entry into PPMS	

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
	<p>1. Initial Search will not yield NDSC AKI ESRD Facility but begins Manual Process to enter NDSC AKI Facility into PPMS.</p> <p>Facility in PPMS using NPI – Initial Screen (will not locate them) Must Start Manual Entry Process</p> <div data-bbox="267 474 1385 644">  </div> <p>2. Manual Entry Process of NDSC AKI ESRD Facility</p> <p>Select “New”</p> <div data-bbox="267 766 1435 1150">  </div> <p>3. Manual Entry of NDSC AKI ESRD Facility Demographics entered PPMS</p> <p>Manually Entered: Facility NPI, Address, Phone #, Fax #, then “Save and Close”</p>

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step

Activity

New Provider
 Provider · Information ▾

(b)(6)
Owner

Provider Summary Identifiers / DEA / License Contact / Activities

Provider Information

Status	* Active
Provider Type	* Group Practice / Agency
Provider Name	*(b)(6)
Provider Identifier	*(b)(6)
Provider Identifier Type	* NPI
Status Reason	Pending Review
Quality Ranking Total Score	---
Quality Ranking Last Updated	12/29/2020
Main Phone	---

Preferred Means for Receiving Referral

HSRM	<input checked="" type="checkbox"/>	Direct Messaging (VHIE)	<input type="checkbox"/>
Secured Email	<input type="checkbox"/>	Fax	<input checked="" type="checkbox"/>
Mail	<input type="checkbox"/>		

Individual

Is Accepting New Patients	No
Primary Care Provider Accepting VA	No
Gender	Not Specified

4. Search for NDSC AKI ESRD Facility again in PPMS using NPI to enter local Contract ID

Must Re-Search by NPI in PPMS for NDSC AKI ESRD Facility

nt
airs

PPMS

Categorized Search ▾

(b)(6)

Providers

(b)(6)
FS Active
Active

Provider Identifiers

(b)(6)
1 NPI

5. Create a New Service Entry for NDSC AKI ESRD Facility

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step

Activity

Save Save & Close + New Email a Link Refresh Check Access Share Follow Word Templates Run

Home Recent Pinned Dashboards Dashboards Provider

0 (b)(6) Provider - Information Contracted Owner

Provider Summary Identifiers / DEA / License Contact / Activities Related

Provider Information

Status * Active

Provider Type * Group Practice / Agency

Provider Service (Provider)

+ New Provider Sen

Network Name St... Provider Provider Identifier R... Sp

CCN Region 3 Active (b)(6) Un... M

6. Select “Local Contract” from drop down, this assign “Local Contract” label in PPMS

Drop Down to Select “Local Contract” Assignment for NDSC AKI ESRD Dialysis Facility

Save Save & Close + New

New Provider Service

General Administration

Provider * (b)(6) Subservice Rollup ---

Provider Network * Look for Network VA Provider Networks Recent records High Perf Provider Unknown

Specialty * Local Contract Local Contract Telehealth Available No

Caresite * Veteran Care Agreement Veteran Care Agreement Provider Specialty ---

Organization / Group Change View

Provider Relationship * ---

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight

Step

Activity

7. At Caresite Option – Enter Name of NDSC AKI ESRD Dialysis Facility from drop down, this assigns the Caresite to the Facility in PPMS

You MUST Select: “Clinic/Center – End Stage Renal Disease (ESRD) Treatment Clinic/Center”

The screenshot shows the 'New Provider Service' form in the PPMS system. The form is divided into 'General' and 'Administration' tabs. The 'General' tab is active. The form fields include: Provider (with a redacted value (b)(6)), Provider Network (set to Local Contract), Specialty (with a dropdown menu open), Caresite, and Organization / Group. The Specialty dropdown menu is open, showing a search bar with 'clinic/center' and a list of options. The option 'Clinic/Center - End-Stage Renal Disease (ESRD) Treatment Clinic/Center' is highlighted with a red oval. Other options include 'Clinic/Center - Endoscopy Clinic/Center' and 'Clinic/Center - Family Planning, Non-Surgical Clinic/Center'. The left sidebar shows navigation options like Home, Recent, Pinned, Dashboards, Provider, and Locations.

NOTE: By Selecting Local Contract and Clinic/Center – End-Stage Renal Disease (ESRD) Treatment Clinic/Center, this will properly identify the NDSC AKI ESRD Dialysis Facility thru the HSRM and Claims payment (eCAMS) process

For additional information on adding a provider in PPMS reference Section 2.5 of the User Functionality Guide located on the [PPMS SharePoint](#).

Information on how to add the vendor in PPMS as a local contract is available on this link:

[PPMS Local Contract ID Entry - Provider in FMS \(Follow VCA Process for NDSC AKI Local Vendorizing\)](#)

Community Care Acute Kidney Injury (AKI) and Nephrology Oversight	
Step	Activity
5	<p>Create ESRD Dialysis AND Nephrology Oversight consult – Refer to Procedure 1.</p> <ul style="list-style-type: none"> For CCN AKI provider, place Community Care-Hemodialysis consult If there is no CCN provider and utilizing NDSC, must place Community Care-Hemodialysis consult to be processed through HSRM. <ul style="list-style-type: none"> You can no longer use NON VA CARE HCPS HEMODIALYSIS consult NDSC AKI provider must be vendorized in local facility VistA and ESRD Dialysis Facility manually placed in PPMS. Must enter separate and required Community Care-Nephrology consult Use appropriate AKI Diagnosis Codes: Appendix 2 Select appropriate Standard Episode of Care (SEOC) for both ESRD Dialysis Facility and Nephrology Oversight services. <p>SEOC Database Link Dialysis-specific SEOC table See Appendix 3</p> <p>Note: Use “Acute Outpatient Center Based Assisted Hemodialysis” SEOC. Use “Nephrology Medical Oversight services” SEOC. Both SEOCs are approved for 90 days only.</p>
6	<p>Process ESRD Dialysis Facility and Nephrology Oversight consults – See Procedure 1.</p>

4. Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight Provider with Travel Veteran Coordinator (TVC) Process

PROCESS FLOW – Transient (Travel) and TVC Process Flows

Link: [Office of Community Care Field GuideBook](#) Specialty Programs Chapter / Dialysis Section 1.1

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight	
Step	Activity
1	<p>VAMC Dialysis Coordinator (or other VAMC Dialysis POC) Receives request for Transient services – See Procedure 2.</p> <p>Key Requirements:</p> <p>Internal VA Dialysis Centers:</p> <ul style="list-style-type: none"> • Check if there is an internal VA dialysis center available in the area the Veteran is traveling. • Link to locate VAMC Dialysis Centers <ul style="list-style-type: none"> ○ VHA Dialysis Facilities List: https://www.va.gov/health/services/renal/dialysis.asp • Manage steps in establishing transient care with the VAMC Dialysis Coordinator at the VAMC receiving Veteran to identify if there is internal capacity. If there is an opening, and the location is convenient for the Veteran schedule the ESRD Dialysis treatments. • If an internal VA Dialysis Center is unavailable, then identify available ESRD Dialysis Facilities and Nephrology Oversight following normal process looking for CCN providers initially. • When Best Medical Interest (BMI) is Active for Community Care, notify VA Provider to determine what specific ESRD Dialysis services and Nephrology oversight provider is required during the Veteran's Transient Travel. • Remember to review for contract vehicles for Transient Travel: <ul style="list-style-type: none"> ○ CCN / NDSC / VCA (as bridge to CCN) Note: Do not start with CCN if their NDSC ESRD Dialysis Facility is available where the Veteran is traveling (Receiving VAMC). Example: Veteran already receiving ESRD Dialysis services with NDSC Contractor, Fresenius at home location and Fresenius is also available at their traveling location (Receiving VAMC). • If care is not available under CCN or NDSC, follow normal VCA process to cover Dialysis services for the period of Veteran' Transient Travel.

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
	<p>Differences Between CCN and NDSC Timeframes and Fiscal Year Renewal Requirements:</p> <ul style="list-style-type: none"> • CCN Authorizations follow the 365-day Episode of Care (EOC) of a calendar year and can cross the Fiscal Year without new Consults / Authorizations (CCN Hemodialysis / Peritoneal AND Nephrology Oversight). • All NDSC Authorizations including Transient Services must end each FY (October 1st – September 30th). • NDSC Authorizations crossing the FY will require placement of a new consult and authorization for continuation for Transient (Travel) EOC. • Dialysis Coordinators / Facility Community Care staff must maintain and track both authorizations for Dialysis services (ESRD & Nephrology oversight), especially if ESRD Dialysis Facility is under NDSC for expiration requirements at the end of a FY. <p>Example NDSC: If Veteran is traveling from Labor Day to Halloween, two (2) sets of NDSC Consults/Authorizations will be required as the services cross the end of Fiscal Year.</p> <p>Note: Dialysis services on cruise ships and/or international travel are not covered under the National Dialysis Services Contract (NDSC). It may, however, be reimbursed under the Foreign Medical Program depending on where the Veteran is traveling.</p> <p>Link: Foreign Medical Program</p> <p>Phone Number: USA/Canada: 877-345-8179</p> <p><u>Referral Authorization System (RAS):</u></p> <ul style="list-style-type: none"> • All RAS Authorizations are valid for one (1) Fiscal Year and will require new consults/authorizations that cross end of Fiscal Year for Transient (Travel) • As of April 1st, 2019, the NDSC contract was modified to allow 60-days of Travel • RAS Authorizations will still need to be created in 30-day increments up to a maximum total of 60-days due to RAS software constraints <p>Example: 45-day Travel will require one (1) 30-day Authorization; and (1) 15-day Authorization</p> <p>Community Care Network (CCN) and Patient Centered Community Care (PC3) Nephrology Oversight Consults:</p>

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
	<ul style="list-style-type: none"> • Nephrology oversight can be approved under CCN or VCA (never under NDSC) and requires a separate consult from ESRD Dialysis Facility Services • Use HSRM for All Nephrology Oversight: Close out of PC3 Contract on March 31st, 2021 for all VHA Enterprise <ul style="list-style-type: none"> ○ All Consult/Authorization for PC3 Nephrology will be entered in HSRM <ul style="list-style-type: none"> ▪ Do not enter in VA/TW Portal ▪ Region 5 & Region 6 are currently using PC3 Nephrology Consults only. All other Regions - the TW Portal is closed <p>Returning Transient (Travel) Veteran – Same NDSC Provider at Receiving VAMC Facility</p> <ul style="list-style-type: none"> • NDSC Contractor to NDSC Contractor: <ul style="list-style-type: none"> ○ For continuity of care, if Veteran is currently under NDSC services and returning to previous Transient location; and <i>there is the same NDSC contractor</i> for ESRD Dialysis Facility services at the Receiving location, do not search for CCN ESRD Dialysis Facility and maintain the Veteran with that NDSC ESRD Dialysis Facility. <ul style="list-style-type: none"> ▪ They may be returning yearly for winter travel (snowbirds) back to prior VAMC and same NDSC ESRD Dialysis Facility or new travel where their current NDSC provider is also located. ○ Sending NDSC ESRD Dialysis Facility Contractor will provide sending VAMC Dialysis Coordinators (or other VA Dialysis POC) with Receiving NDSC Contractor information <p>Example: Fresenius to Fresenius Facility (under NDSC) and transfer is seamless and is maintained under NDSC.</p> <ul style="list-style-type: none"> ○ If unable to transfer to same NDSC contractor or not available, attempt to locate a CCN ESRD Dialysis Facility provider; and if not available (or if they are not willing to sign up under VCA short-term for the Veteran travel; or for CCN long term), then look for other NDSC Dialysis Facilities in RAS <p>Note: RAS Authorizations are not Contractor Dependent and can alternate between NDSC Contractors as needed for Transient services</p> <p>Note: If Travel over 60-days, the Receiving VAMC will use the Center-Based Hemodialysis dropdown vs. Transient Modality in RAS. RAS Process Guide Link: Referral Authorization System (RAS) - Process Guide V 5.6</p>

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
	<p>New Transient (Travel) Requests – Locating CCN ESRD / Nephrology Oversight Providers</p> <ul style="list-style-type: none"> Additional research may be required to locate other ESRD Dialysis Facilities and Nephrology Oversight Providers that <i>are not under CCN or NDSC</i>. This is based on a new location where Veteran will be residing while on Travel. <p>*REMINDER: all Nephrology Oversight is only approved under CCN/VCA.</p> <ul style="list-style-type: none"> The Veteran's Transient (Travel) location is based on need to receive ESRD Hemodialysis three (3) times per week (or less based on travel timeframe, i.e., wedding, funeral, family reunions, etc.). Must determine if there are any <i>CURRENT CCN</i> ESRD Dialysis Facilities first, and then look for NDSC Dialysis Facilities geographically appropriate for the Veteran that would not result in long commute times or weather considerations based on the seasons. If challenges exist for the Veteran, must search for a closer Dialysis provider and establish a VCA. <p>To locate area ESRD Providers and Nephrology Oversight use:</p> <p>Dialysis Finder Link per CMS: <i>Medicare.Gov Find and Compare Section</i></p> <ul style="list-style-type: none"> A CCN or VCA may only be required for short-term travel coverage in some instances. Locating new CCN providers will also assist in building the Community Care Network (CCN) and will offer another ESRD Dialysis facility location for that Receiving VA facility in the future.
2	<p>Traveling and Permanent Relocating Veteran Program – Key Requirements</p> <ul style="list-style-type: none"> Definition: Veteran leaving a VA facility and requesting continuation of Hemodialysis (HD) or Peritoneal Dialysis (PD) care for travel or permanent relocation. NEW Requirement: Traveling/Relocating Veteran Consult process is required for ALL timeframes of travel or permanent relocation for HD or PD care. <i>The Sending Facility will be required to utilize the Traveling Veteran Consult process for those Transient/Travel Veterans that plan to travel or permanently relocate regardless of the planned timeframe for travel.</i>

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight	
Step	Activity
	<ul style="list-style-type: none"> Traveling/Permanent Veteran Consult process is required for ALL TIMEFRAMES of Travel or Permanent Relocation for Hemodialysis or Peritoneal Dialysis services. <p>Note: The Sending VA facility must utilize the Traveling/Relocating Veteran Consult Process for all timeframes of travel (<i>travel under and over 60 days</i>) to ensure Registration at receiving VA and Dialysis Coordinator/other Dialysis POC awareness.</p> <ul style="list-style-type: none"> This ensures safe transition of Dialysis and Nephrology oversight authorizations, especially in times when travel extends past 60 days unexpectedly (e.g., medical emergency, travel bans, etc.). If Veteran is traveling less than 60 days, the Traveling/Relocating Veteran Consult Process will be utilized for awareness to Receiving facility Dialysis Coordinator/other Dialysis POC of Veteran's travel to Receiving VA catchment area only.
2	VAMC Dialysis Coordinator (or other VAMC Dialysis POC) adds New Veteran and ESRD Dialysis Facility and Nephrology Oversight Provider Request – See Procedure 2 or per local policy
3	<p>Traveling/Relocating Veteran Consult Process– Required for ALL Transient (Travel) for Dialysis Services: Sending & Receiving VAMC Responsibilities</p> <p><u>Traveling/Relocating Veteran Consult Process– Sending VAMC:</u></p> <ul style="list-style-type: none"> The Sending VA Dialysis Coordinator ensures the Transient Veteran is already listed on the VA Facility Spreadsheet. The Sending VA Dialysis Coordinator ensures the Traveling/Relocating Veteran Consult is entered at the Sending VA. The Traveling Veteran Coordinator (TVC) at the Sending VA will forward the Traveling/Relocating Veteran Consult to the Receiving VA via the Traveling/Relocating Veteran Inter-Facility Consult (T/RV IFC). TVC at the Receiving VA will alert Receiving Dialysis Coordinator. The Receiving VA Dialysis Coordinator ensures the Transient Veteran is entered into their VA Facility Spreadsheet. Registration: If the Veteran is NOT already registered at the Receiving VA, the Traveling/Relocating Veteran Inter-facility Consult will prompt the Receiving VA to register the Veteran with their Enrollment/Eligibility Office (TVCs do NOT perform the registration directly). <ul style="list-style-type: none"> Many enrollment/eligibility processes occur with the Traveling/Relocating Veteran Inter-Facility Consult to complete the Registration process or confirmation before the T/RV IFC can be transmitted to the Receiving VA TVC in the electronic health record (EHR).

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
4	<ul style="list-style-type: none"> ○ Dialysis Coordinators can also verify if the Veteran is already Registered at the Receiving Facility in JLV <ul style="list-style-type: none"> ▪ VistA Users: Can be verified by clicking the blue highlighted button at the top right-hand corner of the Veteran's chart titled: Remote Data. ▪ ▪ ○ For Permanently Relocating Veterans, the Receiving VA Traveling Veteran Coordinator (TVC) will care coordinate the new Primary Care appointment and assignment using the Traveling/Relocating Veteran Consult process. <p>Traveling and Permanent Veteran Program: Directive 1101.11(3). PACT Assignment Guidance</p> <ul style="list-style-type: none"> • Veterans DO NOT require PACT assignment to receive care or care coordination at the Receiving VA. <ul style="list-style-type: none"> ○ Directive: VHA Handbook VHA Handbook 1101.11(3): <u>VHA Handbook 1101.11(3). - Coordinated Care for Traveling Veterans</u> Location: Page 6 (d) in Handbook 1101.11(3). not the Toolbar page counter. <p>Note: Assignment of traveling or permanently relocating Veterans to a local PACT at the receiving VA facility is not a prerequisite for receiving primary or specialty care at the VA receiving facility, including Dialysis and Nephrology services.</p> <p>Reference: <i>VHA Handbook Page 6 (d): "Patients who are traveling and do not require multi-PACT assignments should primarily be managed by their preferred facility PACT using non-face-to-face care modalities as much as possible. Assignment of traveling Veterans to a local PACT at the alternate facility is not a prerequisite for receiving primary or specialty care at the alternate facility."</i></p> <p>Link for National Travel Veteran Coordinator National Team: <u>All Coordinators - PCMM v2.0 (va.gov)</u></p> <ul style="list-style-type: none"> • Dialysis services can be ordered without PACT assignment. <p>Note: All services can be ordered without PACT, not just Dialysis services.</p>

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
5	<ul style="list-style-type: none"> • Local policy determines who will order the required Dialysis services consults within their VAMC as PACT assignment is not required for all services. • The Traveling/Relocating Veteran Consult Process is key for oversight and care coordination between the Sending and Receiving VA Dialysis Coordinators/POCs. • The Traveling Veteran Coordinators (TVCs) own the process for these consults and are alerted, but DO NOT act as a Dialysis Coordinator/POC at either site. <p><u>Traveling/Relocating Veteran Consult Process – Receiving VAMC:</u></p> <ul style="list-style-type: none"> • The Receiving VA Traveling Veteran Coordinator (TVC) will alert the Receiving Dialysis Coordinator/other Dialysis POC for awareness in the EHR of Veteran traveling to Receiving VA catchment area and need for HD/PD takeover (if traveling for >60 days). <p>NOTE: Follow local policy on communicating between TVC and Dialysis Coordinator/other</p> <p>Dialysis POC, i.e., Traveling/Relocating Veteran Inter-facility consult, etc.</p> <ul style="list-style-type: none"> • Receiving Dialysis Coordinator/other Dialysis POC to ensure orders and consults are placed at the Receiving VA as indicated on the Traveling/Relocating Veteran Inter-Facility Consult from Sending VA, notifying Receiving TVC. <p>NOTE: When Veteran is returning home at the end of travel, the same process is followed but in reverse.</p> <ul style="list-style-type: none"> • ESRD Dialysis Facility and Nephrology Oversight Consult/Authorization Entry Responsibility is Determined by a Veteran's Planned Travel Timeframe (EOC) and Determines What VA Facility Will Place the Required Consults/Authorization, including Travel/Relocating Veteran Consult. <p><u>Transient (Travel) Veteran – Timeframes / Consult Entries</u></p> <ul style="list-style-type: none"> • For Transient (Traveling) Veterans requesting an extension of their travel during their authorized Dialysis Services while on Travel: Under 60-days and Over 60-days <ul style="list-style-type: none"> ○ <u>Under 60-days:</u> <p>Q: What happens if travel is 60 days or less?</p> <p>A: The sending VA facility will be responsible for extending the authorizations for the additional timeframe up to 60 days max.</p>

725

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step

Activity

6

Note: In addition, the Traveling/Relocating Veteran Consult must be placed for ALL Travel requests despite Travel timeframe

Transient (Travel) Veteran Scenarios – Crossing Third Party Administrator

7

Veteran Crossing Contractor Regions – TriWest to Optum & Vice Versa

Treating Specialty: Clinic/Center - End-Stage Renal Disease (ESRD) Tree

PPMS Provider Search

Community:

Provider / Facility:

Provider Location:

Provider Name:

Affiliation:

Allocated Date:

Appointment Date:

Provider Details:

Description	Code
CCN1	CCN1
CCN2	CCN2
CCN3	CCN3
CCN4	CCN4
Department of Defense (DoD)	DoD
Indian Health Services (IHS)	IHS
Local Contract	LC
Tribal Health Program	THP
TriWest - Choice	TriWest Choice
TriWest - PC3	TriWest PC3
Veteran's Care Agreement (VCA)	VCA

Page 1

Screenshot of PPMS – You can select where the Veteran will be traveling to another Region even if they are in a different TPA Region.

- Depending on where the Veteran is traveling, Facility Office of Community Care Staff would select that Region – access PPMS for available Region Network providers in line with the Veterans preferences.
- All VAMCs can enter CCN Consult/Authorizations via HSRM even if changing TPA's or crossing Regions
- Stakeholder will select the Region the Veteran is traveling to in HSRM if different from their home VAMC and Region

Create ESRD Dialysis Facility AND Nephrology Oversight (CCN/VCA) consults

See Procedure 1 section

- For dialysis provided through CCN or VCA, utilize the Community Care-Hemodialysis or Community Care-Peritoneal Dialysis consult.

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
	<ul style="list-style-type: none"> For dialysis provided through NDSC, utilize the NON VA CARE HCPS HEMODIALYSIS or NON VA CARE HCPS PERITONEAL DIALYSIS consult. <p>Note: Choose the Center-based Hemodialysis modality in the dropdown menu in RAS.</p> <p>Note: For all transient consults, indicate in the consult that the request is for “Transient” care. For consult templates, refer to FGB Chapter 2.13 for Community Care consult management processes</p> <p>Transient (Travel) Veteran Consult and SEOC Requirements</p> <p>Key Requirements:</p> <ul style="list-style-type: none"> Standard Episodes of Care (SEOC) are required for Community Care consults <ul style="list-style-type: none"> Community Care-Hemodialysis consult <ul style="list-style-type: none"> Use the associated SEOC – DIA Transient Center-Based Assisted Hemodialysis Community Care-Nephrology consult <ul style="list-style-type: none"> Use the associated SEOC – MSC Nephrology Medical Dialysis Oversight Services <p>Standard Episode of Care (SEOC) Details for DIA / MSC: SEOC Database</p> <p>Standard Episode of Care SEOC for Dialysis Care Table: SEOC Table</p> <p>Note: NDSC NON VA CARE HCPS Hemodialysis & Peritoneal consults use same SEOCs but are selected in the Consult Toolbox (CTB) in CPRS when completing the consult and processed in RAS</p>
	<p>Transient VCA</p> <p>Key Requirements:</p> <ul style="list-style-type: none"> ESRD Dialysis Facility and Nephrology Oversight consults can only be authorized through HSRM Please follow normal procedures for VCAs. VCAs may be requested for ESRD Dialysis Facility and Nephrology Oversight services. Please give as much advance notice as possible, so the VCA Department may create the agreement in time for the veteran’s travel period. <p><u>Veteran Care Agreement (VCA):</u></p> <p>Note: While best medical interest (BMI) may be a deciding factor in care coordination for Veterans receiving End Stage Renal Disease dialysis, there would be limited circumstances that would qualify a transient dialysis Veteran for best medical interest in the use of non-participating CCN or NDSC providers. A</p>

Community Care Transient (Travel) ESRD Dialysis Facility and Nephrology Oversight

Step	Activity
	VCA for the travel time only may be needed. The Provider(s) may wish to still join CCN
	<p>Transient (Travel) Reminders</p> <ul style="list-style-type: none"> For AKI, please follow guidance located in Procedure 3 For international and cruise travel, please refer to the Foreign Medical Program. See link and phone number below: <ul style="list-style-type: none"> Foreign Medical Program Office: 877-345-8179 https://www.va.gov/COMMUNITYCARE/programs/veterans/fmp/index.asp <p>The travel expense is not covered by the VA.</p>

5. Dialysis Procedures

Key Requirements:

- Veterans may require procedures that address placement of Catheters / Ports / AV Fistulas / Occluded Grafts / Removals and Revisions
- Determine if your local VAMC has services that can be completed onsite or will require Community Care
- Each VAMC will determine what VA Provider places the required consults per your Chief of Staff (COS) and Delegation of Authority (DOA)
- Follow your Local Policy for specific Community Care consult name to send Veterans for Dialysis Procedures, i.e., Community Care-Dialysis Access, Community Care-Vascular or Community Care-ESRD Interventional Radiology
- Standard Episodes of Care (SEOC) are required for Community Care consults as above based on local policy
 - Use the associated SEOC – MSC Kidney Dialysis Access Creation, Revision, or Optimization
- Standard Episode of Care (SEOC) Details for DIA / MSC: [SEOC Database](#)

Standard Episode of Care SEOC for Community Dialysis Care Table: [SEOC Table](#)

Note: NDSC Contract is not approved for use for Dialysis Procedures, CCN/VCA ONLY

ACRONYMS

- Acute Kidney Injury (AKI)
- Best Medical Interest (BMI)
- Community Care Network (CCN)
- Community Nursing Home (CNH)
- Community Provider Locator Tool (CPL)
- Consult Toolbox (CTB)
- Contractor Officer Representative (COR)
- Decision Support Tool (DST)
- Episode of Care (EOC)
- End Stage Renal Disease (ESRD)
- Field Guidebook (FGB)
- HealthShare Referral Management (HSRM)
- Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act
- National Dialysis Services Contract (NDSC) contract
- Office of Community Care (OCC)
- Provider Profile Management System (PPMS)
- Patient-Centered Community Care (PC3) contract
- Referral Authorization System (RAS)
- Standardized Episode of Care (SEOC)
- Travel Veteran Coordinator (TVC)
- Veteran Care Agreement (VCA)
- Veterans Health Administration (VHA)

APPENDIX

1. Contract Provider List for NDSC and NDSC AKI

Contract Number	Contract Name	NDSC FY21 Contract Renewed
36C79119D0013	AMERICAN RENAL ASSOCIATES, LLC	Y
36C79119D0014	ATLANTIS HEALTHCARE GROUP (PR), INC.	Y
36C79119D0016	CENTRAL FLORIDA KIDNEY CTRS	Y
36C79119D0018	DAVITA	Y
36C79119D0019	DIALYSIS CLINIC INC.	Y
36C79119D0020	DIALYSIS NEWCO INC.	Y
36C79119D0021	FRESENIUS MEDICAL CARE HOLDINGS, INC.	Y
36C79119D0026	RSA - GUAM, LLC	Y
36C79119D0030	US RENAL CARE, INC.	Y

2. AKI Diagnosis Codes

The following are the associated AKI diagnosis codes:

N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.2	Acute kidney failure with medullary necrosis
N17.8	Other acute kidney failure
N17.9	Acute kidney failure, unspecified
T79.5XXA	Traumatic anuria, initial encounter
T79.5XXD	Traumatic anuria, subsequent encounter
T79.5XXS	Traumatic anuria, sequela
N99.0	Post-procedural (acute)(chronic) renal failure

Billing Notes: HCPCS Code for this care is G0491 and Condition Code is 84. Line should be indicated as covered. Lines billed with modifier AY should not receive separate payment.

3. SEOC Database

Link: [Dialysis-specific SEOC table](#)

Guidance for Entering Multiple Dialysis Service Requests for both National Dialysis Contract (NDSC) in Referral Authorization System (RAS) and Community Care Network (CCN) Scenarios

Guidance will assist Facility Dialysis Coordinators (or other Dialysis points of contact) and Facility Community Care staff when there are requests for different dialysis treatment modalities that may be required for the same episode of care or overlapping of services.

Scenario 1: Peritoneal Dialysis with Additional Hemodialysis In-Center Treatment One (1) time per week

Veteran requires Chronic Peritoneal Dialysis (PD) for daily home PD treatments. In addition, the Nephrologist has ordered outpatient in-center Hemodialysis as a supplemental one (1) day/week due to fluid gains, clearances, and reoccurring calciphylaxis. Veteran refuses to commit to complete In-Center Hemodialysis as he prefers home Peritoneal Dialysis and Nephrologist plan is to re-evaluate every 6 months

to determine if Veteran will continue to remain on this additional alternate Hemodialysis treatment.

Guidance:

- In addition to the **NON-VA CARE HCPS-Peritoneal Dialysis consult**, one (1) additional consult created in CPRS will be required to cover the additional HD service – 1 day / week.
- When a NDSC NON-VA CARE HCPS consult is entered in CPRS, it will write over to RAS. Any updates made in RAS will be communicated back to CPRS.
- NDSC Hemodialysis / Peritoneal authorizations are managed in RAS and processed by Financial Service Center (FSC).
- HealthShare Referral Management (HSRM) & CCRS processes Community Care Network (CCN) contracted services.

Key Requirements:

National Dialysis Service Contract (NDSC):

Dialysis Coordinator or other Dialysis Point of Contact:

- *Veteran already has **NON-VA CARE HCPS - Peritoneal Dialysis consult** (NDSC) placed for Chronic Care and **Community Care-Nephrology Oversight consult** (CCN) placed with appropriate Standard Episode of Care (SEOC)*
 - *Reminder that Nephrology Oversight services can only be approved thru CCN (or VCA bridge to CCN)*
- Enter **New NON-VA CARE HCPS – HEMODIALYSIS consult** - Covers one (1) day/week ESRD Dialysis Hemodialysis Treatment at ESRD out-patient facility
- Add comment to NON-VA CARE HCPS – Hemodialysis consult:
 - *“Veteran will continue Peritoneal Dialysis and have one (1) Hemodialysis In-Center treatment per week due to fluid gains, clearances, and reoccurring calciphylaxis.”*
 - **Note:** Must always document the Frequency of the Hemodialysis Treatment that is not part of standard treatment.

Facility Community Care Staff:

- Facility Community Care Staff receives consult for additional dialysis service
 - Reviews comments to understand the Hemodialysis request is in addition to current and chronic Peritoneal Dialysis on limited frequency.

- Staff receiving consult will review and apply the appropriate SEOC for additional Hemodialysis Treatment In-Center
 - See SEOC Table: [SEOC Table](#)
- In addition, RAS Consult is located and processed as normal until “**Authorization Decision**” (Dropdown)
 - Approve Authorization
 - Select “Center Based Hemodialysis”
 - Number of Visits: Manually enter 1 visit / week

NOTE: * **IMPORTANT** * for Billing

Authorization Decision	
Authorization Decision *	Approve ▼
Dialysis Modality *	Center-Based Hemodialysis ▼
Number of Visits *	1
Frequency *	Per Week ▼
Authorization Begin Date *	11/19/2020
Authorization End Date *	9/30/2021
Purpose Of Visit(POV)	56

Community Care Network (CCN):

Dialysis Coordinator or other Dialysis Point of Contact:

- Veteran already has **COMMUNITY CARE-PERITONEAL DIALYSIS & COMMUNITY CARE-NEPHROLOGY** Oversight consult placed with appropriate Standard Episodes of Care (SEOCs)
 - Reminder that Nephrology Oversight services can only be approved thru CCN (or VCA bridge to CCN)
 - Enters **New COMMUNITY CARE-HEMODIALYSIS** consult that covers one (1) day/week ESRD Dialysis Hemodialysis Treatment at ESRD out-patient facility with associated SEOC
 - Select Chronic check box in Community Care consult
 - If DST is triggered and you have an In-center Dialysis unit, follow the process for DST
 - If DST is triggered and you do not have In-center, follow local guidance on continuing DST or “X” out of DST and place Community Care-Hemodialysis Consult
- Link to Dialysis SOP: [Dialysis SOP](#)
 Link to DST: [Specialty Programs -Chapter 1.1 Dialysis & Dialysis SOP - Decision Support Tool \(DST\)](#)
- Add comment to Community Care-Hemodialysis consult:
 - “Veteran will continue Peritoneal Dialysis and have one (1) Hemodialysis In-Center treatment per week due to fluid gains, clearances, and reoccurring calciphylaxis.”

- Note: Must always document the Frequency of the Hemodialysis Treatment that is not part of standard treatment.

Facility Community Care Staff:

- Facility Community Care Staff receives consult for additional Dialysis service
 - Reads comment to understand the **Hemodialysis is in addition** to current Peritoneal Dialysis on limited frequency.
- Staff receiving consult will review and apply the appropriate SEOC for additional Hemodialysis Treatment In-Center
SEOC Table Link [SEOC Table](#)
- Enter all required Provider information, click “OK” and sends to HealthShare Referral Management (HSRM)

Scenario 2: Request Received from DaVita for Veteran to be Authorized for 1-week Trial for Home Hemodialysis “Try It at Home Program”

Per RN at NDSC Facility requests “Try It at Home Program” in which the goal is to allow patients to experience the difference in how they feel between In-Center Hemodialysis and Home-Based Hemodialysis modalities.

During that 1 week trial at the Dialysis Home Therapy Program Unit patient will have the options to 1) have staff cannulate dialysis access and set up machine and then while they are receiving treatment the staff will demonstrate step by step on a dummy machine how they would set up a home hemodialysis machine, cannulate access and provide overall education about Home Hemodialysis modality (Or) 2) Patient may elect to initiate treatment themselves by self-cannulating, and setting up home hemodialysis machine themselves while staff provide guidance and overall education related to home hemodialysis modality. Whatever the patient is comfortable with during that 1-week trial the staff will allow and provide guidance.

Guidance:

- When a Consult is entered in CPRS, it will write to RAS. Any changes in RAS will be communicated back to CPRS.
- In addition to the **NON-VA CARE HCPS Hemodialysis consult**, two (2) additional consults will be required to cover:
 - 1. Home Based Hemodialysis for “Try it at Home” 1-week Program and**
 - 2. Home Based Hemodialysis Training (1-week training)**

Key Requirements:**National Dialysis Contract Services (NDSC):****Dialysis Coordinator or other Dialysis Point of Contact:**

- *Veteran already has **NON-VA CARE HCPS - Hemodialysis and Community Care-Nephrology** Oversight consult placed*
- Enters New **NON-VA CARE HCPS – HEMODIALYSIS consult** - Covers one (1) week ESRD
Home Based Hemodialysis Treatment
 - Add comment to **NON-VA CARE HCPS – Hemodialysis consult**:
“Veteran is trialing “Try it at Home” Program for 1-week Home Hemodialysis and
 - Indicate dates
 - Must always document the Frequency of the 1-week Hemodialysis Treatment for trial
 - Must follow-up with ESRD Dialysis Facility with outcome of Home-Based Trial and if Veteran will continue at home or back to In-Center
 - Must document and adjust authorizations or cancel consult
- Enters New **NON-VA CARE HCPS – HEMODIALYSIS consult** - Covers one (1) week ESRD
Home Based Hemodialysis Training
 - Add comment to **NON-VA CARE HCPS – Hemodialysis consult**:
“Veteran is trialing “Try it at Home” Program for 1-week Home Hemodialysis and
 - indicate the Training dates
 - Must always document the Frequency of the 1-week Hemodialysis Treatment Training dates for trial
 - Must follow-up with ESRD Dialysis Facility with outcome of Home-Based Trial and if Veteran will continue at home or back to In-Center
 - Must document and adjust authorizations or cancel consult

Facility Community Care Staff:

- Facility Community Care Staff receives two (2) New NON-VA CARE HCPS-Hemodialysis consults to request “Try it at Home” Hemodialysis Program and Training for 1-week.
 - Staff reads comment to understand the Home Hemodialysis and Training is for 1-week Trial and current In-Center Hemodialysis treatment modality placed on hold during trial.
 - NDSC Contractor should not bill for in-center Hemodialysis services for that 1-week of Home-Based Hemodialysis
- Staff receiving both additional consults will review and apply the appropriate SEOCS (DIA - Home Based Dialysis) for additional Hemodialysis Home Based Treatment and Training
SEOC Table Link [SEOC Table](#)
- Enter all required Provider information, click “OK” and sends to HealthShare Referral Management (HSRM)

Community Care Network (CCN):**Dialysis Coordinator or other Dialysis Point of Contact:**

- Veteran already has **COMMUNITY CARE-HEMODIALYSIS & COMMUNITY CARE-NEPHROLOGY** consult for oversight
- Enters one (1) NEW **COMMUNITY CARE-HEMODIALYSIS** consults
 - Select “Chronic” Check Box
 - **The one new consult will include authorized services for both Home Based Hemodialysis Treatment (1-week Trial) and Home-Based Hemodialysis Training (1-week Trial)**
- Select the appropriate **SEOCS (DIA-Home Based Dialysis)** for consult
- If DST is triggered and you have an In-center Dialysis unit, follow the process for DST
- If DST is triggered and you do not have In-center, follow local guidance on continuing DST or “X” out of DST and place Community Care-Hemodialysis Consult
Link to Dialysis SOP and DST
- Add comment to **Community Care-Hemodialysis consult:**
“Veteran is trialing “Try it at Home” Program for 1-week Hemodialysis to include 1-week training
 - Must always document the Frequency of the 1-week Hemodialysis Treatment and Training for trial
 - Must follow-up with ESRD Dialysis Facility with outcome of Home-Based Trial and if Veteran will continue at home or back to In-Center
 - Must document and adjust authorizations or cancel consult

Hemodialysis Home Based Trial Allowable Visits

Authorization Decision	
Authorization Decision *	Approve ▼
Dialysis Modality *	Home-Based Hemodialysis ▼
Number of Visits *	7
Frequency *	Per Week ▼
Authorization Begin Date *	11/19/2020
Authorization End Date *	9/30/2021
Purpose Of Visit(POV)	56

Facility Community Care Staff:

- Facility Community Care Staff receives one (1) new **COMMUNITY CARE-HEMODIALYSIS** consult(s) for Home Based Dialysis service
 - Staff reads comment to understand the Home Hemodialysis and Training is for 1-week Trial and current In-Center Hemodialysis treatment modality placed on hold during trial.
- Staff receiving consult(s) will review and apply the appropriate SEOC (DIA-Home Based Dialysis) for Home Hemodialysis Treatment
SEOC Table Link [SEOC Table](#)
- Enter all required Provider information, click “OK” and sends to HealthShare Referral Management (HSRM)

CMS Guidelines for Training: New / Re-Training

New Training: CMS expects that the patients who elect for home dialysis are appropriate candidates for home dialysis training, and therefore, will successfully complete their method of training before reaching the maximum number of sessions allotted.

An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for Peritoneal Dialysis.

Hemodialysis Home Based CMS Allowable Training - NEW

Authorization Decision	
Authorization Decision *	Approve ▼
Dialysis Modality *	Training for Home-Based Modalities ▼
Number of Visits *	25
Frequency *	Per Auth Period ▼
Authorization Begin Date *	11/19/2020
Authorization End Date *	9/30/2021
Purpose Of Visit(POV)	56

Peritoneal Dialysis CMS Allowable Training - NEW

Authorization Decision	
Authorization Decision *	Approve ▼
Dialysis Modality *	Training for Home-Based Modalities ▼
Number of Visits *	15
Frequency *	Per Auth Period ▼
Authorization Begin Date *	11/19/2020
Authorization End Date *	9/30/2021
Purpose Of Visit(POV)	56

Note: Home Based Hemodialysis or Peritoneal Re-Training: CMS only allow 3 Sessions in a 2-week timeframe

Hemodialysis Home Based CMS Allowable Training: RE-TRAINING

Authorization Decision	
Authorization Decision *	Approve ▼
Dialysis Modality *	Training for Home-Based Modalities ▼
Number of Visits *	7
Frequency *	Per Auth Period ▼
Authorization Begin Date *	10/01/2020
Authorization End Date *	9/30/2021
Purpose Of Visit(POV)	56

CMS LINK: [CMS: Medicare Benefits Policy Manual ESRD](#)

Dialysis Question Submission:

Please research or submit your question to the [Office of Community Care Q&A Database](#). This database is designed for all VA facilities to direct their questions to Subject Matter Experts (SME) and receive timely answers. The Q&A Database provides the user access to numerous Subject Matter Experts (SMEs) in their respective areas.

This database will:

- Provide users access to Office of Community Care subjects.
- Funnel questions directly to subject departments (i.e. Reasonable Charges/Billing, Accounts Receivable, Policy, POWER Plus, NPI, etc.)
- Enhanced with numerous features to provide easier searches and return information (i.e. search by question number)

1.2 Geriatric Extended Care (GEC)

Geriatrics and Extended Care Consults

Community care-GEC consults must be utilized to order Geriatrics and Extended Care (GEC) services which are purchased from community vendors, per the [OCC Field Guidebook](#) chapter 2, section 2.13. The following standardized naming convention must be utilized by local site Clinical Applications Coordinators (CAC) when building GEC consults:

- COMMUNITY CARE-GEC HOME MAKER/HOME HEALTH AIDE
- COMMUNITY CARE-GEC RESPITE
- COMMUNITY CARE-GEC ADULT DAY HEALTH CARE
- COMMUNITY CARE-GEC VETERAN DIRECTED CARE
- COMMUNITY CARE-GEC SKILLED HOME CARE
- COMMUNITY CARE-GEC HOME INFUSION THERAPY
- COMMUNITY CARE-GEC COMMUNITY NURSING HOME
- COMMUNITY CARE-GEC HOSPICE/PALLIATIVE CARE
- COMMUNITY CARE-GEC BOWEL AND BLADDER CARE
- COMMUNITY CARE-GEC PACE
- COMMUNITY CARE-GEC TBI RESIDENTIAL REHAB

The consults noted above will have Stop Code 669 associated with each service.

The [NON VA CARE GEC v6.2 templates](#) should be used for all of the GEC consult titles. The NON VA CARE GENERIC v6.2 template should be used when a NON VA CARE GEC v6.2 template is not available.

VA Medical Centers may add additional information to the consult templates locally until nationally standardized Community Care-GEC consult templates are released.

GEC consults are not approved for use of Administrative Consults, per [Office of Community Care Field Guidebook](#) chapter 2, section 2.13.

Purchased Long Term Services and Supports Programs Community Provider Standards

All Purchased Long Term Services and Supports (PLTSS) community providers caring for Veterans at VA expense must be in compliance with applicable federal or state regulations. The community provider standards for PLTSS providers apply only to non-Community Care Network (CCN) providers. PLTSS community providers under CCN contract will adhere to the standards outlined in each community provider's contract with CCN Third Party Administrators. In all cases, VA medical centers (VAMCs) will seek the best care available and provide reasonable access to Veterans.

Please see the [Community Provider Standards](#) for details.

Community Nursing Home

Community Nursing Home Program Overview

1. VHA's Community Nursing Home (CNH) program is governed by [VHA Notice 2020-32](#), titled "Community Nursing Home Program." This notice addresses eligibility, inpatient respite care, extended care copayments, quality expectations, coordination, and the CNH certification report.

Community Nursing Home Assessments

Threshold Standards for Participation in the Veteran Health Administration's Community Nursing Home Program

1. Community Nursing Homes (CNHs) are required to meet a minimum set of standards to participate in VHA's CNH program. These threshold standards apply to CNHs under local contracts (Basic Ordering Agreements/Indefinite Deliverables, Indefinite Quantity contracts) and Veterans Care Agreements (VCAs). CNHs under the Community Care Network (CCN) contract will adhere to the standards outlined in each CNHs' contract with CCN Third Party Administrators.
2. Threshold standards are solely based on [Medicare Nursing Home Compare](#) scores, as displayed below:

Eligibility	Nursing Home Compare Score
Eligible without waiver	3-5 Overall Stars
Eligible without waiver	2 Overall Stars <u>AND</u> 4-5 Quality Measures Stars

Eligible with waiver	2 Overall Stars <u>AND</u> 1-3 Quality Measures Stars
Eligible with waiver	1 Overall Star

Veterans Health Administration's Medicare Star Rating Waiver Process

1. Community Nursing Homes (CNHs) that fall into the “eligible with waiver” category will need a Veterans Health Administration (VHA) Medicare Star Rating Waiver for VHA to utilize this facility for Veterans' CNH care. CNHs in the “eligible without waiver” category do not need waivers. This waiver process applies to CNH local contracts and Veterans Care Agreements (VCAs); it does not apply to CNHs only in the community care network (CCN). VA medical centers (VAMCs) are not required to issue a local contract or VCA with every CNH that expresses interest.
2. Veterans Integrated Service Networks (VISNs) are responsible for oversight and management of this waiver process. This includes approval or denial of waiver requests, duration of the approved waiver, and documentation of the resolution of waivers. All approved and signed waivers and any documentation of the resolution of waivers must be uploaded to the CNH SharePoint Online document library for CNH Medicare Star Rating Waivers in the corresponding VAMC-specific folder.
3. The waiver process focuses on what CNHs are doing right, how they are improving, and why VAMCs want to use these CNHs. It is recognized that the use of CNHs that do not meet eligibility without a waiver may be necessary due to resident population or geographic considerations. In all cases, VAMCs will seek the best care available and provide reasonable CNH access to Veterans.
4. To pursue a waiver, VAMC CNH Points of Contact must take the following steps (further instructions can be found in this VHA CNH Medicare Star Rating Waiver Guide):
 - a. Collect information required to fill out waiver, and then prepare the waiver.
 - b. Submit to VAMC Director or designee for review, approval, and signature.
 - c. Submit to Network Director or designee for review, approval, and signature.
 - d. Upload to CNH SharePoint Online document library for CNH Medicare Star Rating Waivers in VAMC-specific folder
 - i. Use the following naming convention for the waiver form:
VISN_Station Number_CNH Name_Date Approved by Network Director [YY.MM.DD]_Waiver
 - ii. Use the following naming convention for waiver resolutions:
VISN_Station Number_CNH Name_Date Approved by Network Director [YY.MM.DD]_Waiver Resolution

Community Nursing Home Consults

Community Care consults must be used to order community care services, per the [OCC Field Guidebook](#) chapter 2, section 2.13. The current standardized naming convention for the Community Nursing Home consult is:

1. COMMUNITY CARE – GEC COMMUNITY NURSING HOME

Consult Toolbox for Community Nursing Home Consults

The Consult Toolbox is a software tool which aids staff in the management of consults and is linked to the Computerized Patient Record System (CPRS). Information regarding the resource can be found on the [Consult Toolbox SharePoint](#).

Community Nursing Home consults do not require the completion of all the tabs found within the Consult Toolbox. Neither the Screening Triage Tool nor the Decision Support Tool are necessary or required for processing CNH consults.

There are two activities, however, which must be documented or completed utilizing that tool:

- Delegation of Authority: Please see below for additional information and direction.
- Selection of SEOC: Please see below for additional information and direction.

If the CNH placement is made under the Community Care Network (CCN) purchasing authority, one additional step is required:

- Send to HSRM: This box, located on the Authorization tab, must be selected in order for the referral to be sent to HealthShare Referral Management for the creation of an authorization.

HealthShare Referral Management for Community Nursing Home

HealthShare Referral Management (HSRM) is the primary platform for the management of community care referrals and authorizations, as well as care coordination activities. Information regarding HSRM can be found on the [HSRM SharePoint](#).

HSRM must be utilized to create authorizations (10-7080) for any Community Nursing Home placement made under the Community Care Network (CCN) purchasing authority.

HSRM, however, should not be used for placements utilizing a local contract or VCA. Authorizations (10-7079) for this care must be generated in VistA.

Delegation of Authority for Community Nursing Home

Delegation of Authority (DOA) is used in the consult review process for determining clinical appropriateness of a requested service prior to approval ([OCC Field Guidebook](#) chapter 2, section 2.22). The determination of clinical appropriateness should be completed by staff who have been given DOA by the facility's Chief of Staff as documented on the [DOA Medical Services \(DOAMS\) list](#). Clinical appropriateness for a

service is documented on the consult utilizing the Consult Toolbox. Once the clinical review is completed and documented, the consult can be processed per established procedures.

Is the Provider entering the consult on the DOAMS list?	Did the Provider select the correct SEOC?	Are you on the DOAMS list?	Is the clinical review (DOA) requirement met?	"MSA Elig. Verification Consult Toolbox Tab action	"Consult Review" Consult Toolbox Tab action	Select SEOC on "Authorization" Consult Toolbox Tab action
Yes	Yes	N/A	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	N/A
Yes	No	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM
Yes	No	No	No	"Clinical review required"	N/A	N/A
No	N/A	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM
No	N/A	No	No	"Clinical review required"	N/A	N/A

Is the ordering provider listed as the delegated authority? Yes
Have they completed the clinical review appropriately? Yes

If the provider entering the consult is listed as the delegated authority and adds the appropriate SEOC to the consult, the clinical review requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if listed as the delegated authority, will complete and document a clinical review so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol”

must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if not listed as the delegated authority, will route the consult to the provider with a request to attach the correct SEOC.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is not listed as the delegated authority but the GEC or OCC staff receiving the consult are listed as the delegated authority, the clinical review will be completed and documented by the staff on the DOAMS list so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate

Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is not listed as the delegated authority and the GEC or OCC staff receiving the consult are not on the DOAMS list, the consult must be routed to the appropriate clinical reviewer.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Screening Triage and Decision Support Tools

Neither the Screening Triage Tool nor the Decision Support Tool are necessary or required for processing Community Nursing Home consults. Additional consult processing information is coming soon, and consult process flows can be found in the [OCC Hub SharePoint folder for GEC](#).

On-site Community Nursing Home Resident Assessment

1. VHA CNH staff must be notified in a timely fashion of every referral to the CNH program through all purchasing authorities (CCN, local contract, or VCA) so that a determination can be made about the resident assessment schedule.
2. Community Care Network (CCN) Community Nursing Home (CNH) Placement Requirements:
 - a. CCN CNH referrals are for rehabilitation services for up to 100 days per calendar year.
 - b. Prior to placement of a Veteran, VHA CNH staff (social worker, registered nurse and/or other VHA licensed staff) will determine the CNH resident visit schedule, with input from discharge planning, office of community care and/or other relevant staff. The schedule should consider the particular needs of and services to be provided to the Veteran.
 - c. A Veteran placed to CCN CNH will be visited by VHA CNH staff, on an as needed basis, to address disposition as a Veteran prepares to transition from CCN CNH status. The professional discipline of the VHA staff visiting the Veteran will be defined by the visit schedule.

- d. For any patient safety event that occurred when a Veteran received community care, a VAMC staff member identifies the patient safety event and reports it in the Joint Patient Safety Reporting System, as defined by the Patient Safety – Incident Reporting SharePoint.
3. Local Contract or Veterans Care Agreement (VCA) CNH Placement Requirements:
- a. Local contract or VCA CNH referrals are for all levels of care and durations covered under the contract/agreement.
 - b. Prior to placement of a Veteran, VHA CNH staff (social worker, registered nurse and/or other VHA licensed staff) will determine the CNH resident visit schedule, with input from discharge planning, office of community care and/or other relevant staff. The schedule should consider the particular needs of and services to be provided to the Veteran.
 - c. A Veteran placed to local contract or VCA CNH up to one year will be visited by VHA CNH staff at least every 45 days to ensure that clinical, functional and psychosocial needs are assessed, and appropriate interventions instituted to meet those needs. For Veterans in local contract or VCA CNH placement longer than one year, the VA medical center chief of staff or designee will determine the frequency of these visits, including potential use of telehealth technologies. The professional discipline of the VHA staff visiting the Veteran will be defined by the visit schedule.
 - d. CNH visits are to include review of facility records, interaction with the Veteran and interviews with CNH staff when possible. When Veteran interaction is not possible, interview with involved family member/established caregiver may be used.
 - e. The CNH resident visit schedule and the results of these visits need to be documented in the Veteran's VHA electronic medical record.
 - f. VA CNH staff may customize their documentation templates to reflect the expertise and scope of practice of the discipline performing the visits. The following items are required to be monitored and documented for each visit, regardless of discipline:
 - i. Veteran muster since last on-site CNH resident assessment (e.g. Over the past 45 days, Veteran has been residing in CNH for 40 days and in a hospital on a CNH bed hold for 5 days.)
 - ii. Veteran physical and psychosocial adjustment to care
 - iii. Whether skin has been assessed and appropriate interventions applied
 - iv. Whether pain has been assessed and appropriate interventions applied
 - v. The following most recent Minimum Data Set (MDS) fields: Item Z0200 (State Medicaid Billing) and Item A2300 (Assessment Reference Date [ARD]), Item Q0300 (Resident's Overall Expectation), Item Q0500 (Return to Community)

- vi. Veteran and/or family/established caregiver's satisfaction with care
- vii. Confirmation that an interdisciplinary assessment has taken place and a plan of care developed and implemented based on the Veteran's needs
- viii. Occurrence of falls, injuries, new onset and/or worsening of pressure sores, elopement attempts, medication errors, physical or chemical restraint use, unplanned weight loss greater than five (5) percent in three (3) months, symptoms of dehydration, loss of activity of daily living function, unanticipated deaths, complaints, and/or other adverse events
- ix. Emergency room visits or unplanned re-admissions to acute care facility that are suggestive of poor-quality care
- g. During each CNH resident visit, VHA CNH staff is to make observations about the overall quality of care in the nursing home. Examples include courtesy of staff, adequacy of documentation, social and spiritual activities to promote self-worth and sense of well-being, indications of patient abuse or neglect, and the quality of sensory and environmental aesthetics.
- h. Observations and impressions, as described in sections e and f, are to be documented for and reviewed by the VA medical center's CNH Oversight Committee.
- i. For any patient safety event that occurred when a Veteran received community care, a VAMC staff member identifies the patient safety event and reports it in the Joint Patient Safety Reporting System, as defined by the Patient Safety – Incident Reporting SharePoint.
- j. If RUG score in Item Z0200 of MDS is PA1 or PA2, or Item Q0500 (Return to Community) is "Yes," VHA CNH staff will verify a Veteran's continued need for nursing home level of care and assess for a potential transition to a lower level of care.

Annual Community Nursing Home Assessment

1. The Veterans Health Administration (VHA) conducts the annual Community Nursing Home (CNH) assessment to ensure VHA is making sound clinical and business decisions by purchasing skilled nursing and rehabilitation care at CNHs. This is an in-person discussion, unless otherwise directed by the VA medical center chief of staff, with CNH leadership; this is generally the administrator, director of nursing, and director of admissions. This discussion should cover three topics:
 - a. Veterans' experience at a CNH as documented during VHA staff on-site resident assessments, and/or as feedback from Veterans families or caregivers.
 - b. Review of CNH's current Medicare Nursing Home Compare scores.
 - c. Plans to maintain or improve care over the coming year.

2. This process replaces the annual review or inspection of CNHs as previously defined in VHA Handbook 1143.2. VHA does not regulate the care or inspect CNHs. VHA acts as an informed purchaser of care in order to purchase quality services for Veterans and enhance the Veterans' experience in CNHs.

Community Nursing Home Oversight Committee

1. The Community Nursing Home (CNH) Oversight Committee is to:
 - a. Be established by the VA Medical Center (VAMC) director and report to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services or the equivalent) and meet no less than quarterly.
 - b. Include the CNH Coordinator, multidisciplinary management-level representatives from social work, nursing, quality management, community care, contracting and medical staff associated with the CNH Program.
 - c. Provide administrative guidance with policy development, quality monitoring, resource allocation and problem solving to the CNH Coordinator and Review Team.
 - d. Report significant concerns, sentinel events and adverse patient occurrences immediately to the VAMC Director via the "Issue Brief" format.

Billing and Claims Review Process CNH

Billing Guidance to Community Nursing Homes

1. Timing of Minimum Data Set Assessments:
 - a. For non-Community Care Network (non-CCN) referrals in the Community Nursing Home (CNH) program, CNHs will provide a valid Resource Utilization Group (RUG) Health Insurance Prospective Payment System (HIPPS) code according to the following VHA non-CCN Community Nursing Home (CNH) Minimum Data Set (MDS) assessment schedule: 5, 14, 30, and 90 days after admission, then every 90 days after the initial 90 days. VHA will accept RUG HIPPS codes generated by either an Omnibus Budget Reconciliation Act of 1987 (OBRA) assessment or an Optional State Assessment (OSA).

Skilled Home Health Care

VHA-paid Skilled Home Health Care provides a wide range of services in a Veteran's home by a variety of skilled disciplines, including nursing, rehabilitation therapists, and medical social workers. Skilled home health agencies can also provide a bath aide on a limited basis. Skilled Home Health Care can be used to provide short-term and intermittent care, or to provide longitudinal care to a Veteran with ongoing needs. The intent of Skilled Home Health Care is to provide services that will support a Veteran's

ability to remain safely at home. Most often, these services are provided to a Veteran transitioning between a hospital or nursing home back to their home. Please note, Bowel and Bladder is a separate and distinct program managed by the Spinal Cord Injuries and Disorders (SCI/D) System of Care that is not addressed in this “Skilled Home Health Care” sub-section.

Skilled Home Health Care - Eligibility

Veterans must meet clinical and administrative eligibility for Skilled Home Health Care to receive services under the Skilled Home Health Care standard episodes of care (SEOC):

1. Clinical eligibility
 - a. At least one of the three criteria are met:
 - i. A need for intermittent, short-term, or long-term skilled nursing assessment, teaching, treatment services, or monitoring.
 - ii. A need for intermittent, short-term, or transitional rehabilitative therapies, such as physical therapy, speech and language pathology services, and/or occupational therapy.
 - iii. A need for intermittent, short-term, or transitional medical social work services.
 - b. VHA does not require that Veterans meet Medicare home bound criteria and/or face to face requirements to be clinically eligible for VHA Skilled Home Health Care.
2. Administrative eligibility
 - a. Veterans must be enrolled in VA for their health care and must be eligible for the Veterans Community Care Program.

Skilled Home Health Care - Consults

Community Care consults must be used to order community care services, per the OCC Field Guidebook chapter 2, section 2.13. The current standardized naming convention for the two Skilled Home Health Care consults is:

2. Community Care – GEC Skilled Home Care
3. Community Care – GEC Skilled Nursing

The current guidance for pairing these consults with standardized episodes of care (SEOCs) is to use either consult with any of the three Skilled Home Health Care SEOCs. In the future, there will be one standardized Skilled Home Health Care consult for all Skilled Home Health Care SEOCs: Community Care – GEC Skilled Home Care.

Consult Toolbox for Skilled Home Health Care Consults

The Consult Toolbox is a software tool which aids staff in the management of consults and is linked to the Computerized Patient Record System (CPRS). Information regarding the resource can be found on the Consult Toolbox SharePoint.

Skilled Home Health Care consults do not require the completion of all the tabs found within the Consult Toolbox. Neither the Screening Triage Tool nor the Decision Support Tool are necessary or required for processing Skilled Home Health Care consults.

There are three activities, however, which must be documented or completed utilizing that tool:

- Delegation of Authority: Please see below for additional information and direction.
- Selection of SEOC: Please see below for additional information and direction.
- Send to HSRM: This box, located on the Authorization tab, must be selected in order for the referral to be sent to HSRM for the creation of an authorization.

Delegation of Authority for Skilled Home Health Care Consults

Delegation of Authority (DOA) is used in the consult review process for determining clinical appropriateness of a requested service prior to approval ([OCC Field Guidebook](#) chapter 2, section 2.22). The determination of clinical appropriateness should be completed by staff who have been given DOA by the facility's Chief of Staff as documented on the [DOA Medical Services \(DOAMS\) list](#). Clinical appropriateness for a service is documented on the consult utilizing the Consult Toolbox. Once the clinical review is completed and documented, the consult can be processed per established procedures.

Is the Provider entering the consult on the DOAMS list?	Did the Provider select the correct SEOC?	Are you on the DOAMS list?	Is the clinical review (DOA) requirement met?	"MSA Elig. Verification Consult Toolbox Tab action	"Consult Review" Consult Toolbox Tab action	Select SEOC on "Authorization" Consult Toolbox Tab action
Yes	Yes	N/A	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	N/A
Yes	No	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM
Yes	No	No	No	"Clinical review required"	N/A	N/A
No	N/A	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM

No	N/A	No	No	"Clinical review required"	N/A	N/A
----	-----	----	----	----------------------------	-----	-----

Is the ordering provider listed as the delegated authority? Yes

Have they completed the clinical review appropriately? Yes

If the provider entering the consult is listed as the delegated authority and adds the appropriate SEOC to the consult, the clinical review requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the "Does not require clinical review" box under the title "Delegation of Authority Medical Services List Reviewed" on the "MSA Elig. Verification" tab in the Consult Toolbox.
- If the consult is to be processed, the "Request Approved" box must be checked on the "Consult Review" tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and "Chief of Staff approved Protocol" identified as the "Clinical Review Method." The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the "Request Disapproved" box will be selected, and the reason identified in the drop-down menu. "Not Medically Necessary" should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the "Provider was contacted for Alternate Plan of Care" box should be checked. "Chief of Staff approved Protocol" must be identified as the "Clinical Review Method." The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if listed as the delegated authority, will complete and document a clinical review so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if not listed as the delegated authority, will route the consult to the provider with a request to attach the correct SEOC.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is not listed as the delegated authority but the GEC or OCC staff receiving the consult are listed as the delegated authority, the clinical review will be completed and documented by the staff on the DOAMS list so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is not listed as the delegated authority and the GEC or OCC staff receiving the consult are not on the DOAMS list, the consult must be routed to the appropriate clinical reviewer.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Skilled Home Health Care - Screening Triage and Decision Support Tools

Neither the Screening Triage Tool nor the Decision Support Tool are necessary or required for processing Skilled Home Health Care consults. Additional consult processing information is coming soon, and consult process flows can be found in the [OCC Hub SharePoint folder for GEC](#).

Skilled Home Health Care – Covered Services and SEOCs

Every consult for Skilled Home Health Care must have a SEOC attached in order to complete the authorization process. SEOCs can be found on the [SEOC Database](#) and are written into CPRS consults through use of the Consult Toolbox. The “Authorization” tab of the Consult Toolbox includes drop-down menus (“Service Line” and “SEOC”) to identify the needed SEOC. Once the appropriate SEOC has been chosen, click the “Display SEOC” tab. The SEOC will then open in a new window and, if correct, select the “Write SEOC into Consult” box at the bottom of the screen. The content of the SEOC will then appear as an additional comment to the consult.

All three of the Skilled Home Health Care SEOCs have a duration of 180 days.

SEOC Title	When is this Used?	Purchasing Authority Hierarchy	Reimbursement Model	OASIS* Required ?	VA Staff Review of CMS 485/ Agency Care Plan
Skilled Home Health Care – Bundled	Short term and intermittent care	1. CCN 2. <i>Local Contract</i> 3. VCA	1. Medicare Prospective Payment System (PPS) 2. Negotiated rate not to exceed Medicare rate 3. Medicare PPS	Yes, and must be uploaded to Veteran’s medical record	Every 60 days**
Skilled Home Health Care – Non-Bundled	Continuing care to Veterans with ongoing intermittent needs	1. CCN 2. <i>Local Contract</i> 3. VCA	1. VA Fee Schedule 2. Negotiated rate 3. VA Fee Schedule	No	Every 60 days**
Skilled Home Health Care – Expanded	Continuing care to Veterans with ongoing daily needs	1. CCN 2. <i>Local Contract</i> 3. VCA	1. VA Fee Schedule 2. Negotiated rate 3. VA Fee Schedule	No	Every 90 days**

Note: Italicized purchasing authorities are infrequently used

*OASIS: Outcome and Assessment Information Set

****CMS 485** or agency care plan must be uploaded to Veteran's medical record and review must be documented on consult (see "Care Coordination" section).

Skilled Home Health Care – Bundled SEOC

The bundled SEOC is designed to mirror the care that would meet Medicare criteria and otherwise be covered by that funding source. This type of care is short term and intermittent in nature; defined by Medicare as skilled; and provided by registered nurses, physical therapists, occupational therapists, speech language pathologists, and social workers. This SEOC includes a bath aide on a limited basis (once or twice a week). If a Veteran requires personal care more than once or twice a week, VHA staff should consider issuing a homemaker/home health aide referral.

Reimbursement for this type of Skilled Home Health Care is bundled per the Medicare Prospective Payment System. For this reason, it is required that the community provider complete an Outcome and Assessment Information Set (OASIS). The OASIS document must be provided to the VA by the community provider and uploaded to the Veteran's electronic medical record.

*Please note, VHA does not require Veterans to meet Medicare home bound criteria and/or face to face requirements.

Skilled Home Health Care Bundled Scenario:

Veteran was just discharged from inpatient care following an admission for total knee replacement and needs home health services. The provider has entered a consult for skilled nursing for incisional wound care, education on new medications, physical and occupational therapy for home safety evaluations and strengthening, as well as a bath aide.

Skilled Home Health Care – Non-Bundled SEOC

The non-bundled Skilled Home Health Care SEOC covers care that would not otherwise be reimbursed by Medicare. This type of care is longitudinal and intermittent in nature and does not meet Medicare's skilled criteria. Examples of this type of care include: Medication management, long term catheter changes, non-progressing wounds, etc. This Skilled Home Health Care is provided by registered nurses, physical therapists, occupational therapists, speech language pathologists, and social workers. This SEOC includes a bath aide on a limited basis (once or twice a week). If a Veteran requires personal care more than once or twice a week, VHA staff should consider issuing a homemaker/home health aide referral.

Reimbursement for this type of Skilled Home Health Care is made on a fee for service basis based on the VA Fee Schedule. An agency OASIS is not required for payment under a non-bundled SEOC.

*Please note, VHA does not require Veterans to meet Medicare home bound criteria and/or face to face requirements.

Example Skilled Home Health Care Non-Bundled Scenario:

Veteran has a wound that is not progressing or healing. The provider has entered a consult for long term nursing support to prevent further deterioration of the wound.

Skilled Home Health Care – Expanded SEOC

The expanded SEOC is to be used when a Veteran's care needs exceed what would otherwise be covered by Medicare. The care is longitudinal, as well as frequent or daily in nature. This type of care is most commonly ordered for Veterans with complex medical conditions and is sometimes referred to as "private duty nursing."

The Skilled Home Health Care Expanded SEOC includes care provided by physical therapists, occupational therapists, speech language pathologists, and social workers. It is expected that any involvement of these additional disciplines will be limited as the primary focus of this SEOC is the provision of nursing support.

Reimbursement for this type of Skilled Home Health Care is made on a fee for service basis based on the VA Fee Schedule. An agency OASIS is not required for payment under an expanded SEOC.

*Please note, VHA does not require Veterans to meet Medicare home bound criteria and/or face to face requirements.

Skilled Home Health Care Expanded Scenario:

Veteran has a diagnosis of Amyotrophic Lateral Sclerosis (ALS) and is ventilator dependent. He is cared for by his wife at home who is experiencing significant caregiver burden. In addition, Veteran requires a two (2) person transfer, often needs suctioning, has a feeding tube, and requires frequent medication administration through the feeding tube. Provider has entered a consult for skilled nursing services to provide treatment, support, and assistance to maintain the Veteran at home, as well as to enable wife to leave the house for a period of time.

Skilled Home Health Care – Care Coordination

GEC Skilled Home Health Care coordinators play a vital role in the coordination and oversight of in-home care. It is important that, during the duration of the 180-day Skilled Home Health Care SEOCs, regular reviews of care plans and supporting documentation are completed to ensure the Veteran continues to need home health care. Community providers must provide VHA with, at a minimum, the CMS 485 or agency care plan. VHA staff must review this document, or the OASIS assessment, every 60 to 90 days (per grid found in 1.2.3.4 – Covered Services and SEOCs) to make the determination regarding ongoing care. The decision must be documented in the Veteran's record,

preferably as an additional comment to the consult which initially ordered the episode of care or utilizing Office of Community Care resources, such as the Community Care Coordination Plan (CCP) note. The supporting documentation utilized for this clinical review should also be uploaded to the Veteran's electronic medical record. This review is distinct from VA ordering provider's signature of CMS 485 or agency care plan.

Skilled Home Health Care – Home Infusion Therapy

Home Infusion Overview

Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home or in an Ambulatory Infusion Suite (AIS). The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Likewise, nursing services are necessary to train and educate the patient and caregivers on the safe administration of infusion drugs in the home.

Visiting nurses often play a large role in home infusion. Nurses typically train the patient or caregiver to self-administer the drug, educate on side effects and goals of therapy, and visit periodically to assess the infusion site and provide dressing changes. The home infusion process typically requires coordination among multiple entities, including patients, physicians, hospital discharge planners, health plans, home infusion pharmacies, and, if applicable, home health agencies.

Eligibility

Veterans must meet clinical and administrative eligibility for Home Infusion to receive services under the Home Infusion Therapy and the Ambulatory Infusion Suite standard episodes of care (SEOCs):

3. Clinical eligibility
 - a. Clinical criteria:
 - i. Prescribed therapy can be safely and effectively provided at home
 - ii. Veteran and/or family member/caregiver must be able to perform all aspects of managing home infusion (if not done in an ambulatory infusion suite)
 - b. VHA does not require that Veterans meet Medicare home bound criteria and/or face to face requirements to be clinically eligible for VHA Home Infusion services
4. Administrative eligibility
 - a. Veterans must be enrolled in VA for their health care
 - b. Veterans must be eligible for the Veterans Community Care Program

Consults

Community Care consults must be used to order community care services, per the [OCC Field Guidebook](#) chapter 2. The current standardized naming convention for the Home Infusion Therapy consult is:

COMMUNITY CARE-GEC HOME INFUSION THERAPY

The provider must designate on the consult the place of service, either in-home or an Ambulatory Infusion Suite (AIS)

Consult Toolbox

The Consult Toolbox is a software tool which aids staff in the management of consults and is linked to CPRS. Information regarding the resource can be found on the [Consult Toolbox SharePoint](#).

Home Infusion Therapy consults do not require the completion of all the tabs found within the Consult Toolbox. There are three activities, however, which must be documented or completed utilizing that tool:

- Delegation of Authority: Please see below for additional information and direction.
- Selection of SEOC: Please see below for additional information and direction.
- Send to HSRM: This box, located on the Authorization tab, must be selected in order for the referral to be sent to HSRM for the creation of an authorization.

Delegation of Authority

Delegation of Authority (DOA) is used in the consult review process for determining clinical appropriateness of a requested service prior to approval ([OCC Field Guidebook](#) chapter 2, section 2.22). The determination of clinical appropriateness should be completed by staff who have been given DOA by the facility's Chief of Staff as documented on the [DOA Medical Services \(DOAMS\) list](#). Clinical appropriateness for a service is documented on the consult utilizing the Consult Toolbox. Once the clinical review is completed and documented, the consult can be processed per established procedures.

Is the Provider entering the consult on the DOAMS list?	Did the Provider select the correct SEOC?	Are you on the DOAMS list?	Is the clinical review (DOA) requirement met?	"MSA Elig. Verification Consult Toolbox Tab action"	"Consult Review" Consult Toolbox Tab action	Select SEOC on "Authorization" Consult Toolbox Tab action
Yes	Yes	N/A	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	N/A
Yes	No	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM
Yes	No	No	No	"Clinical review required"	N/A	N/A
No	N/A	Yes	Yes	"Does not require clinical review"	Approve with program authority or Disapprove with reason	Select SEOC and send to HSRM
No	N/A	No	No	"Clinical review required"	N/A	N/A

Is the ordering provider listed as the delegated authority? Yes
Have they completed the clinical review appropriately? Yes

If the provider entering the consult is listed as the delegated authority and adds the appropriate SEOC to the consult, the clinical review requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the "Does not require clinical review" box under the title "Delegation of Authority Medical

Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.

- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if listed as the delegated authority, will complete, and document a clinical review so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol” must be identified as the “Clinical Review Method.” The consult will either

remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? Yes

Did the ordering provider add the correct SEOC to the consult? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is listed as the delegated authority but does not add a SEOC or the appropriate SEOC to the consult, the clinical review is not met. GEC or OCC staff who receive the referral, if not listed as the delegated authority, will route the consult to the provider with a request to attach the correct SEOC.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? Yes

If the provider entering the consult is not listed as the delegated authority but the GEC or OCC staff receiving the consult are listed as the delegated authority, the clinical review will be completed and documented by the staff on the DOAMS list so that the requirement is met.

Documentation Requirements:

- GEC or OCC staff, when processing the referral, will check the “Does not require clinical review” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox.
- If the consult is to be processed, the “Request Approved” box must be checked on the “Consult Review” tab of the Consult Toolbox. The program authority should then be selected from the drop-down menu and “Chief of Staff approved Protocol” identified as the “Clinical Review Method.” The consult can then be processed per established procedures.
- If the consult will not result in a referral to a community vendor, the “Request Disapproved” box will be selected, and the reason identified in the drop-down menu. “Not Medically Necessary” should never be chosen as the reason for the disapproval of GEC services. If the provider entering the consult should be notified, the “Provider was contacted for Alternate Plan of Care” box should be checked. “Chief of Staff approved Protocol”

must be identified as the “Clinical Review Method.” The consult will either remain open until additional information or guidance is provided or be cancelled.

Is the ordering provider listed as the delegated authority? No

Is the GEC/OCC staff receiving the consult listed as the delegated authority? No

If the provider entering the consult is not listed as the delegated authority and the GEC or OCC staff receiving the consult are not on the DOAMS list, the consult must be routed to the appropriate clinical reviewer.

Documentation Required:

- GEC or OCC staff will alert the clinical reviewer by selecting “Clinical Review Required” box under the title “Delegation of Authority Medical Services List Reviewed” on the “MSA Elig. Verification” tab in the Consult Toolbox. The consult will remain in an open status until the clinical review is completed and the consult is returned to GEC or OCC staff for further processing.

Screening Triage and Decision Support Tools

Neither the Screening Triage Tool nor the Decision Support Tool are required for processing Home Infusion Therapy consults.

Provider Profile Management System (PPMS)

The Provider Profile Management System (PPMS) contains a master directory of community provider information and is the authoritative source of community providers. PPMS is used in the community care, care coordination process after consult review to locate in network providers for Veterans to receive care in the community. Users can access PPMS at <https://dva.gov-ppms.crm9.dynamics.com/>.

Additional resources for PPMS:

[PPMS SharePoint](#)

[OCC Field Guidebook Tools](#)

HealthShare Referral Manager (HSRM)

HSRM is a secure, web-based system VA uses to generate and submit referrals and authorizations to community providers. HSRM allows community providers and VA to better manage community care for Veterans. The system’s robust functionality facilitates reduced turnaround time for processing referrals, providing care, submitting claims, and receiving payment.

Home Infusion Therapy referrals must be sent through HSRM to the Third-Party Administrator (TPA). Please see the [HSRM User Information Site](#) for additional information and assistance.

Covered Services and SEOCs

Home Infusion Therapy Consults must have a SEOC attached in order to complete the authorization process. SEOCs can be found on the [SEOC Database](#) and are written into CPRS consults through use of the Consult Toolbox. The Authorization Tab of the Consult Toolbox includes drop-down menus (Service Line and SEOC) to identify the needed SEOC. Once the appropriate SEOC has been chosen, click the “Display SEOC” tab. The SEOC will then display and, if correct, select the “Write SEOC into Consult” box at the bottom of the screen. The content of the SEOC will then appear as an additional comment to the consult.

There are two SEOC’s associated with Home Infusion Therapy:

Home Infusion Therapy – Care is provided in the Veterans home

Ambulatory Infusion Suite – Care is provided in an outpatient suite

Covered Services under the Home Infusion Therapy SEOC include skilled nursing services related to the initial evaluation for formulation of a treatment plan, assessment, teaching, laboratory draws, IV maintenance, patency checks and occlusion treatment. Also included is medication delivery per provider orders, that includes drug, IV therapy supplies and any needed DME related to home infusion care. Lab Processing is also included when VA lab locations are not readily available.

Skilled RN services other than those directly pertaining to the home infusion order are not included under these two SEOCs. If skilled nursing care for any other purpose is ordered, e.g. wound care, medication management, etc., a separate Community Care-GEC Skilled Home Care consult and Skilled Home Health Care SEOC are required.

***Please note**, VHA does not require Veterans to meet Medicare home bound criteria and/or face to face requirements for VA Community Care infusion.

Care Coordination

GEC home infusion therapy coordinators play a vital role in the coordination and oversight of in-home or ambulatory suite care. It is important that, during the duration of the 180-day infusion therapy SEOCs, regular reviews of care plans and supporting documentation are completed to ensure the Veteran continues to require infusion therapy. Community providers must provide VHA with, at a minimum, the agency care plan or medication delivery ticket as documentation of start of care. In addition, home

infusion therapy providers should provide VHA with updated care plans should changes to care be ordered.

Safety

Any patient safety event that occurs during the episode of care and is related to home infusion, should be reported in the Joint Patient Safety Reporting System. Information related to safety events may be found on the [Patient Safety – Incident Reporting User Information Page](#).

HSRM Task Associated with GEC Documents

“HSRM Task Associated with GEC Documents”, was developed by the HSRM team and the GEC program office. This represents instructions for field staff on how to proceed if documents and/or medical records are received via HSRM. GEC’s individual program sections of the Field Guidebook will set policy regarding mandated documentation.

- HSRM Task Associated with GEC Documents include:

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
Review GEC Documents	1) When GEC Homemaker/Home Health Aide Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Homemaker/Home Health Aide Treatment Plan/Timesheet.	GEC clinical staff/Facility community care clinical staff	Treatment Plan <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	Treatment Plan <ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Timesheet***</p> <ol style="list-style-type: none"> 1. Administrative staff receives timesheet and reviews to ensure hours worked match

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>authorization and hours invoiced</p> <ol style="list-style-type: none"> Discrepancies noted are reported to GEC Program Coordinator Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	<p>2) When GEC In Home Respite Care Treatment Plan* document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Respite Treatment Plan/Timesheet.</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> GEC Program Coordinator reviews treatment plan Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> If treatment plan is received by administrative staff, send for clinical review GEC Program Coordinator reviews treatment plan and returns to administrative staff Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed**</i> <p>Timesheet***</p> <ol style="list-style-type: none"> Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<ol style="list-style-type: none"> Discrepancies noted are reported to GEC Program Coordinator Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i> section of the Veteran's medical record.</p>
	<p>3) When GEC Community Adult Day Health Care Treatment Plan* document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Adult Day Care Treatment Plan.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<ol style="list-style-type: none"> GEC Program Coordinator reviews treatment plan Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>**These steps may be completed by administrative staff.</p>
		<p>GEC administrative staff/Facility community care administrative staff</p>	<ol style="list-style-type: none"> If treatment plan is received by administrative staff, send for clinical review GEC Program Coordinator reviews treatment plan and returns to administrative staff Mark record as received, upload document to EHR and attach to consult for closure** Mark HSRM task as <i>Completed</i>** <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>4) When GEC Veteran Directed Care Spending Plan document is uploaded.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<ol style="list-style-type: none"> GEC Program Coordinator reviews and approves spending plan Mark record as received, upload document to EHR and attach to consult for closure**

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			3. Mark HSRM task as <i>Completed</i> ** **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	1. If spending plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews spending plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i> ** **If not managed by clinical staff, administrative staff completes these steps.
	5) When GEC PACE Treatment Plan* document is uploaded. *Document name will be coming in HSRM in the future.	GEC clinical staff/Facility community care clinical staff	1. GEC Program Coordinator reviews treatment plan and confirms level of care 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i> ** **These steps may be completed by administrative staff.
		GEC administrative staff/Facility community care administrative staff	1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i> ** **If not managed by clinical staff, administrative staff completes these steps.
	6) When GEC Bowel/Bladder Care	GEC clinical staff/Facility	Treatment Plan 1. GEC Program Coordinator reviews treatment plan (may be

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
	Treatment Plan* document is uploaded. *Change in document name will be updated in HSRM in the future to: GEC Bowel/Bladder Care Treatment Plan/Timesheet.	community care clinical staff	<p>Spinal Cord Injury coordinator who reviews)</p> <ol style="list-style-type: none"> 2. Send to ordering provider for signature, if needed 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff or PACT team, administrative staff completes these steps.</p> <p>Timesheet***</p> <ol style="list-style-type: none"> 1. Administrative staff receives timesheet and reviews to ensure hours worked match authorization and hours invoiced 2. Discrepancies noted are reported to GEC Program Coordinator 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>***Subsequent documentation received after initial consult closure may be uploaded to the <i>Documents</i></p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			section of the Veteran's medical record
	7) When GEC Skilled Home Health OASIS/485 document is uploaded.	GEC clinical staff/Facility community care clinical staff	<p>OASIS</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews OASIS document 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>485</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews 485 document 2. Send to ordering provider for signature, if separate process for signing orders is not established** 3. When signed order is returned, send to vendor, if separate process for returning orders is not established** 4. Mark record as received, upload document to EHR and attach to consult for closure** 5. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
		GEC administrative staff/Facility community care administrative staff	<p>OASIS</p> <ol style="list-style-type: none"> 1. If OASIS document is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews OASIS document and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>485</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<ol style="list-style-type: none"> 1. If 485 document is received by administrative staff, simultaneously send for clinical review and ordering provider, if separate process for signing orders is not established** 2. When signed order is returned, send to vendor, if separate process for returning orders is not established** 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i>** <p>**If not managed by clinical staff, administrative staff completes these steps.</p> <p>Note: Medical Centers may establish separate processes for review of 485 document to determine the need for ongoing care and provider review and signature of 485 document.</p>
	<p>8) When GEC Inpatient Hospice Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Hospice Outpatient/Inpatient Treatment Plan or Discharge Summary.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan 2. Send to ordering provider for signature/orders, as needed** 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed</i>** <p>Discharge Summary</p> <ol style="list-style-type: none"> 1. Send to ordering provider to review discharge summary and write orders, as needed 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed</i>** <p>**These steps may be done by administrative staff.</p>
		GEC administrative	Treatment Plan

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
		staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Send signed treatment plan to agency** 5. Mark HSRM task as <i>Completed**</i> <p>Discharge Summary</p> <ol style="list-style-type: none"> 1. If discharge summary is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews discharge summary and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>9) When GEC Home Infusion Treatment Plan document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Home Infusion Treatment Plan/Pharmacy Delivery Notice.</p>	GEC clinical staff/Facility community care clinical staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan 2. Send to ordering provider for signature/orders, as needed** 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Pharmacy Delivery</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews documentation 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be done by administrative staff.</p>

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
		GEC administrative staff/Facility community care administrative staff	<p>Treatment Plan</p> <ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Pharmacy Delivery</p> <ol style="list-style-type: none"> 1. Administrative staff receives pharmacy delivery slip 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>10) When GEC Community Nursing Home document is uploaded.</p> <p>*Change in document name will be updated in HSRM in the future to: GEC Community Nursing Home MDS/Care Plan/Notes.</p>	GEC clinical staff/Facility community care clinical staff	<p>MDS</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews initial MDS 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Upload subsequent MDS, as needed** 4. Mark HSRM task as <i>Completed**</i> <p>Care Plan/Notes</p> <ol style="list-style-type: none"> 1. GEC Program Coordinator reviews documentation 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative	MDS

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
		staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If MDS is received by administrative staff, send for clinical review to evaluate MDS 2. GEC Program Coordinator reviews MDS (if document is initial MDS, or MDS is a change in level of care, update authorization) and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>Care Plan/Notes</p> <ol style="list-style-type: none"> 1. If documentation is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews documentation and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure** 4. Mark HSRM task as <i>Completed**</i> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>
	<p>11) When GEC TBI Residential Rehabilitation Treatment Plan document is uploaded.</p> <p>*Document name will be coming in HSRM in the future.</p>	<p>GEC clinical staff/Facility community care clinical staff</p>	<ol style="list-style-type: none"> 1. GEC Program Coordinator reviews treatment plan and confirms level of care 2. Mark record as received, upload document to EHR and attach to consult for closure** 3. Mark HSRM task as <i>Completed**</i> <p>**These steps may be completed by administrative staff.</p>
		GEC administrative staff/Facility community care administrative staff	<ol style="list-style-type: none"> 1. If treatment plan is received by administrative staff, send for clinical review 2. GEC Program Coordinator reviews treatment plan and returns to administrative staff 3. Mark record as received, upload document to EHR and attach to consult for closure**

Automated Task	Trigger	Receiver of Task	Actions to Complete Task
			<p>4. Mark HSRM task as <i>Completed</i>**</p> <p>**If not managed by clinical staff, administrative staff completes these steps.</p>

Caregiver Support Program Authorities Added to HSRM for Community Care

On Monday, May 24, 2021, two new Program Authorities specific to the Caregiver Support Program (CSP) will be available in Health Share Referral Manager (HSRM) to ensure the appropriate funding is used for the Caregiver Support Program. They are:

- (110) Caregiver Respite-1720G-8210
- (112) Caregiver Non-VA Oversight

Beginning May 24, 2021, when completing administrative processing of community care consults below for Geriatrics and Extended Care (GEC) Caregiver Support Program services, staff will select the appropriate Program Authority in HSRM to ensure the appropriate funding is used.

Program Authority	Consult Title	SEOC Title	Type of Care	Determine Correct Program Authority Based On:
(110) Caregiver Respite 1720G-8210	COMMUNITY CARE-GEC RESPITE	Caregiver Support Respite	Non-skilled in-home respite services for Veterans enrolled in Caregiver	SEOC Title

			Support Program	
(110) Caregiver Respite 1720G-8210	COMMUNITY CARE-GEC SKILLED HOME CARE	Skilled Home Health Care Expanded	Skilled in-home respite services for Veterans enrolled in Caregiver Support Program	Additional comment on the consult and/or Program Authority in CTB
(112) Caregiver Non-VA Oversight 1720G-8210	COMMUNITY CARE-GEC SKILLED HOME CARE	Skilled Home Health Care Expanded	Skilled Caregiver Support Program oversight visit(s)	Additional comment on the consult and/or Program Authority in CTB
(112) Caregiver Non-VA Oversight 1720G-8210	COMMUNITY CARE-GEC SKILLED HOME CARE	Skilled Home Health Care Non-Bundled	Skilled Caregiver Support Program oversight visit(s)	Additional comment on the consult and/or Program Authority in CTB
(112) Caregiver Non-VA Oversight 1720G-8210	COMMUNITY CARE-GEC SKILLED HOME CARE	Skilled Home Health Care Bundled	Skilled Caregiver Support Program oversight visit(s)	Additional comment on the consult and/or Program Authority in CTB

1.3 Guidance for Clinical Application Coordinators (CAC)

This section contains links to the Technical Setup Guides, TXML Templates and Support Documents the Clinical Application Coordinators (CAC) require for creating Community Care Consults, Letters and other standardized Community Care documentation.

Community Care standardized consult templates [can be found here](#)

Standardized Community Care Consult Templates

The Office of Community Care is releasing standardized community care consult templates. This is in support of the mandatory use of standardized consult titles and new and/or enhanced templates when initiating requests for community care.

The new templates will promote greater standardization and efficiency within the community care consult process in accordance with the objectives of the One Consult Model deployed in September 2017.

These new consult templates are being developed in collaboration with national program offices to improve the Veteran's community care experience by standardizing the information captured by ordering providers when requesting services in the community. This will ensure clinically appropriate services are referred to community providers with the relevant clinical information necessary to effectively address the Veteran's health care needs.

Consult standardization supports the coordination and delivery of timely, clinically appropriate care and will facilitate a smoother transition to the referral process in Cerner once facilities implement the new electronic health record (EHR).

The new templates will also facilitate the selection of the appropriate Standardized Episode of Care (SEOC) to attach to the consult to ensure community providers are reimbursed correctly for authorized services.

The new templates will be released in batches as they become available. The first group of new templates consists of the consult titles below and are scheduled to be released around April 15, 2020:

Beneficiary Travel Consults:

The Community Care Beneficiary Travel process requires the use of two (2) standardized Consults to be built at each site and implemented. Local site Clinical Applications Coordinators (CAC) must build both consults in a standardized format.

- COMMUNITY CARE- BENEFICIARY TRAVEL (AUTHORIZED)
- COMMUNITY CARE – ADMIN BENEFICIARY TRAVEL (EMERGENT)

The Community Care Beneficiary Travel Tech Guide will detail the process of creating the two (2) consult services in VistA in a step-by-step manner.

Community Care do not manage these consults. Beneficiary Travel staff will enter these consults in response to pre-authorized special mode requests and bills received secondary to emergency unauthorized use of special mode transport referred to BT for processing by OCC after review of emergency services in non-VA ER and approval of that care under 38 CFR 17.4020 (c) or other transports associated with care approved under 1703 authority. Appointments are not captured in the consult. The consults serve as the authorization for bills processed in eCAMS. For pre-authorized care, it is an associated care during the authorized period of service. For unauthorized (emergent) it is the specific transport bill within eCAMS being transported.

Radiology Templates:

New consult templates are available for the following imaging consult services:

- COMMUNITY CARE-IMAGING MAMMOGRAPHY FEMALE SCREEN
- COMMUNITY CARE-IMAGING MAMMOGRAPHY FEMALE DIAGNOSTIC
- COMMUNITY CARE-IMAGING MAMMOGRAPHY MALE DIAGNOSTIC
- COMMUNITY CARE- IMAGING MRI
- COMMUNITY CARE-IMAGING CT
- COMMUNITY CARE-IMAGING ULTRASOUND

The new templates replace the current “NON VA CARE V6.2” templates.

The new templates can be found in the COMMUNITY CARE -V10.1 CONSULT TEMPLATE folder, with the new naming convention beginning with “CC V10.1”.

All Clinical Applications Coordinators (CAC) must implement the new consult templates upon release.

Facilities are responsible for training their staff on the new templates once the CACs have completed the implementation.

Consult titles should adhere to the standardized naming conventions to promote consistency and facilitate tracking. Any locally created consults previously used for these services should be disabled from menus once all pending Veterans under the old names have been resolved.

In the future, facilities will be notified of the availability of new community care consult templates via an email announcement.

Hematology/Oncology:

A new consult template for “Hematology/Oncology” is being released to the field. The new template may be found in the COMMUNITY CARE -V10.1 CONSULT TEMPLATE folder.

Note: A NON VA CARE V6.2 template was not available for this consult service. A technical guide and template are available in the “COMMUNITY CARE-HEMATOLOGY/ONCOLOGY” sub-folder.

Complementary and Integrative Health (CIH)/Whole Health consults:

The following new consult services for Complementary and Integrative Health (CIH) are being released to the field.

COMMUNITY CARE-CIH ACUPUNCTURE
 COMMUNITY CARE-CIH MASSAGE THERAPY
 COMMUNITY CARE-CIH MEDITATION
 COMMUNITY CARE-CIH TAI CHI
 COMMUNITY CARE-CIH BIOFEEDBACK/NEUROFEEDBACK
 COMMUNITY CARE-CIH CLINICAL/BEHAVIORAL HYPNOTHERAPY
 COMMUNITY CARE-CIH YOGA* not included in CCN contract

The Technical Guides and templates for each of the above CIH services can be found in the COMMUNITY CARE-CIH SERVICES folder.

Community Care-Infertility

The current COMMUNITY CARE-ART IVF TREATMENT program is being replaced by the COMMUNITY CARE-INFERTILITY Program. This will require building three (3) new consult services and a standardized template to be associated with each.

The process also uses nine (11) triaging order menus which will guide the ordering provider to request for the appropriate consult service.

The technical guide and templates can be found in the COMMUNITY CARE-INFERTILITY 2019 folder.

Preparation Required for Health Share Referral Manager (HSRM) Deployment (Pre/Post CCN)

In preparation for the deployment, the following Technical updates for matching Community Care Specialty Consult names and Clinic names must be completed. This will result in the ability for Health Share Referral Manager (HSRM) to add an appointment to the VistA scheduling system and changes the Community Care Consult from an "Active" to "Scheduled" status when an exact match for the "Specialty" is found for a Community Care Consult and a Community Care Clinic name.

The following preparatory activities must be completed by CACs & MAS (Clinic Builders at each VAMC) prior to your facility HSRM go-live dates.

VAMC consult builders and clinic builders will need to work together during the review/renaming process.

The following is being provided as guidance for facilities to assist with updating "Specialty" naming conventions in preparation for HSRM rollout:

The Community Care Clinic naming is changing from "COMMUNITY CARE-SPECIALTY" to "COM CARE-SPECIALTY." Since these clinics are non-count, renaming the clinics is acceptable per National HIMs. There is no need to build new clinics.

Please note: Clinic naming is restricted to 30 characters, which includes spaces. It is recommended to only use 28 characters in order to add "ZZ" when a clinic is inactivated. *See Clinic Char Count in Example below

EXCEPTION: For the COMMUNITY CARE Health Claims Processing System (HCPS) consults, HCPS must be in the standard nomenclature so that the information from VistA will transmit to HCPS. These 2 consults must remain as NON VA CARE naming conventions.

NON VA CARE HCPS HEMODIALYSIS

NON VA CARE HCPS PERITONEAL DIALYSIS

The "COMMUNITY CARE-SPECIALTY" consult naming convention will remain the same.

The "SPECIALTY" must be identical in name for the clinic title and consult title. Please see examples below:

CORRECT:

Consult Name	Clinical Name	Count
Community Care-Orthopedic General	Com Care-Orthopedic General	27
Community Care-Orthopedic Surgical	Com Care-Orthopedic Surgical	28
Community Care-Bowel and Bladder	Com Care-Bowel and Bladder	26

INCORRECT:

Community Care-General Surgery	Com Care-Gen Surg
Community Care-Pulm	Com Care-Pulmonary

The Community Care Consult/Clinic Naming Convention link provides suggested examples for Consult and Clinic naming, along with examples of Fileman searches for community care clinics and consults.

The 'Clinic Profile Management Guide 2.0 FINAL' is also listed to assist with clinic configuration.

For more information on the need to use a PIV card when capturing the appointment information in HSRM in order for HSRM to write back to VistA reference the CCRA Patch Fact Sheet.

COMMUNITY CARE- COVID 19 TESTING Consult and associated CPRS Notes:

In order to facilitate the tracking of community care referrals, specific for COVID-19 testing (Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel) the Office of Community Care has created a COMMUNITY CARE- COVID 19 TESTING consult template. Guidance on the referral process for COVID-19 testing in the community care be found on chapter 6, section 6A.

Please review the [Community Care COVID 19 Testing Technical guide](#) for further information.

This consult will allow VA Medical Centers to appropriately track the number of Veterans being referred to the community for this testing. When referring a Veteran to community care for COVID-19 testing, the COMMUNITY CARE- COVID 19 TESTING consult should be used in conjunction with the laboratory and pathology SEOC.

Additionally, the Office of Community Care has created the Community Care COVID-19 Test Billing Info Note and the COVID-19 Outside Results Note, the template for both can be found [here](#).

Community Care Letter Templates:

As part of the Request for Service (RFS) Process, the technical guide for the RFS Letter is available at the following link. It provides the CAC with directions for building the progress note title and attaching the reminder dialog: [COMMUNITY CARE-REQUEST FOR SERVICE \(RFS\) LETTER Set-Up](#). More guidance on the RFS process can be found in Chapter 3, section 3.43 of this guidebook.

Community Care Consult Justification Reasons:

The justification reason drop-down for community care consult titles has been updated. The updated options, which are in line with the community care MISSION eligibility criteria, are as follows:

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.

Community Care-Urgent Care Record

The implementation of the Mission Act has now added Urgent Care as a covered service under the Office of Community Care Program. Facilities will be receiving clinical documentation for Urgent Care visits. There will not be a consult entered for these documents. This will require that a new progress note title, COMMUNITY CARE-URGENT CARE RECORD to be created and made available so the urgent care documentation maybe attached to this note title when scanning the received documentation. [Community Care Urgent Care Record Note Setup Guide](#)

Care provided in the community can be a key component to a Veteran receiving clinically appropriate care at the right time by the right provider. Per the Managerial Cost Accounting Office (MCAO) consults for care rendered in the community are assigned stop code 669 in order to designate that the care is occurring in the community, but can have a subsequent stop code assigned in order to further specify the type of care being rendered.

Community Care Stop Codes

Community care consults must have the 669 Stop Code associated with it, with a few exceptions such as dialysis care per [MCAO guidance](#). While this allows OCC to identify care performed in the community, it cannot distinguish the type of care. In order to be both clinically and cost effective with care provided in the community, OCC has created an Additional Stop Code initiative to further the use of current MCA approved Stop Codes Listing. This initiative is to improve the data mining/capabilities for community care consults/referrals and allow for better comparison of care sent to the community vs. done within the VA. Some benefits of these community care consult updates include:

1. **Comparative Data Availability:** Ability to capture and compare the type of care being referred to community care against the type of care being conducted within the VAMC.
2. **Comprehensive Utilization Analysis:** By understanding the volume and type of care going to community care, VAMCs can strengthen their internal services and target their enhancement of appointment modality options based on specific data.
3. **Improved Consult Structure:** Enhance the community care consult set up, by ensuring that consults are appropriately created, named, and appropriate stop codes assigned to capture the type of care referred to community care.



Facility Clinical Application Coordinator (CACs) will work with the appropriate staff within the facility in order to follow the steps below.

<p>a. Access the <u>Consult – Request Services Classification</u> report via the <u>VSSC Consult Switchboard</u></p> <p>b. Select appropriate facility, Stop Code to 669, <u>Primary Request Type</u> to Community care then <u>View Report</u></p> <p>c. All Consult Service Names listed do not have an additional stop code and need to be added</p>	<p>a. Review services to be covered on the consult template.</p> <p>b. Refer to the <u>Stop Code to Service Table</u> for the full list of clinical categories and associated Stop Codes. Assess which of the 78 Category of Care (CoC) the services on the consult best align.</p> <p>c. Determine <u>one Additional Stop Code</u> for the consult.</p>	<p><i>Note: User must have access to Vista to proceed</i></p> <p>a. Open Vista and navigate to Consult Associated Stop Code (SD Associated Stop code) menu option</p> <p>b. Search for the desired consult and enter in the new additional stop code</p> <p>c. Ensure the stop code appears in the consult after the 669 Community Care code</p>	<p>a. Review <u>Consult – Request Services Classification</u> report on the <u>VSSC Consult Switchboard</u> to validate the consult has an additional stop code</p> <p>b. Review the <u>RCI VSSC Dashboard</u> to ensure consult's additional stop codes appear</p> <p><i>Note: Once the additional stop code is added and report update is completed, all VSSC reports will retroactively include the code</i></p>
---	--	--	--

Additional Resources have also been developed in order to assist with updating community care consults appropriately:

- [Community Care Consult Enhancement – Adding Additional Stop Code SOP](#)
- [CACs Guide: How to Add additional Stop Codes to Community Care Consult Titles](#)
- [Stop Codes to Service Mapping \(List of Additional Stop Code Options\)](#)

- Assigning Additional Stop Codes to Community Care Consults – Report Review Demonstration

1.4 Indian Health Service and Tribal Health Program

VA – Indian Health Service (IHS) and Tribal Health Programs (THP) Reimbursement Agreements Field Guidebook

Contents

1. Background	1
2. Stakeholder Roles and Responsibilities	1
3. Establishing an THP Reimbursement Agreement	3
4. Eligibility – Veteran Eligibility	4
5. Quality of Care	4
6. Coordination of Care	5
7. IHS-THP Pharmacy – VA Non-Formulary Request Approval	5
8. IHS-THP Reimbursement Agreement Claims	6
9. Program Documentation - IHS -THP SharePoint Site	6
10. Scheduling Care.	7

1. Background

The Department of Veterans Affairs (VA) (IHS/THP) Reimbursement Agreements Program allows IHS and THP health facilities to receive reimbursement from the VA for direct health care services provided to eligible American Indian/Alaska Native (AI/AN) Veterans and authorized care to Non-Native Veterans in Alaska available under 38 C.F.R. 17.38, VA Medical Benefits Package.

The VA - IHS National Reimbursement Agreement was signed on December 5, 2012; and its principles will serve as a standard reimbursement agreement for eligible AI/AN Veterans and their individually designated tribal units and self-governing operated facilities, Indian tribes, tribal organizations and tribal health programs

This program is part of a larger effort set forth in the VA and IHS Memorandum of Understanding signed in October 2010 to improve access to care and care coordination for our nation's Native Veterans.

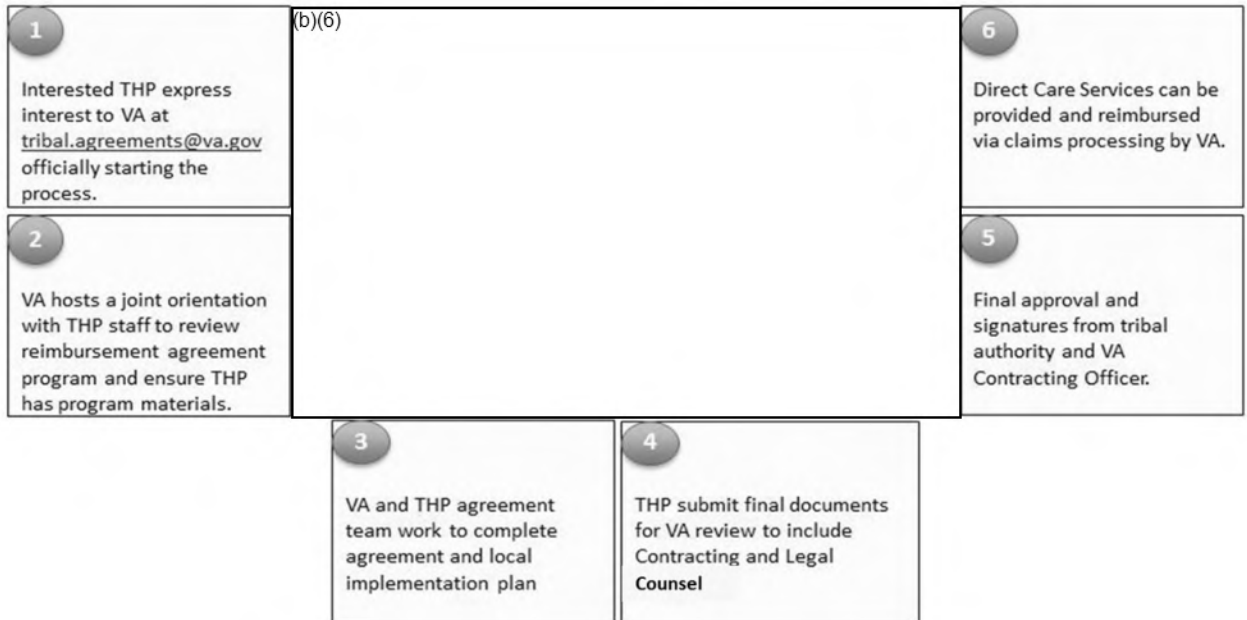
2. Stakeholder Roles and Responsibilities

- **Department of Health and Human Services – Indian Health Service (HHS-IHS)** – An agency within the Department of Health and Human Services (HHS) that provides federal health services to American Indians and Alaska Natives. VA has a National Reimbursement Agreement with IHS that includes several IHS Outpatient and Hospital Healthcare facility. IHS representatives are responsible for managing and coordinating the VA-IHS reimbursement agreement program between the VA and the IHS facilities/providers.
- **Tribal Health Programs (THP)** – Health programs operated by federally recognized tribes that control sovereignty over their own health care. VA has established THP Reimbursement Agreement with the individual tribes to provide healthcare services to eligible AI/AN Veterans. The Tribal representatives are responsible for coordinating all agreement management actions with the IHS/THP Reimbursement Agreements Program, Contracting Officer, and VAMC/VAHCS representatives.
- **VHA Office of Community Care (OCC) IHS/THP Reimbursement Agreement Program** – Office within VHA OCC focused on providing AI/AN veterans with access to health care at qualifying IHS/THP facilities. The program office performs the following:
 - Administers reimbursement agreement program,
 - Provides program guidance and communication,
 - Coordinates the completion of tribal agreements and modifications,
 - Responds to tribal statements of interest,
 - Schedules and holds orientation calls,
 - Manages program documentation, SharePoint site, and websites,
 - Provides stakeholder training,
 - Manages risks and issues,
 - Provides reports and data, and
 - Performs other activities to support the Reimbursement Agreement Program.
- **VHA Health Eligibility Center (HEC)** – VHA's authoritative source for the verification of a Veteran's eligibility for VA health care benefits, including enrollment determination processing and notification, priority group assignment, and income verification. They provide VA enrollment and eligibility training, assist with Veteran eligibility verification and Veterans Enrollment.
- **Department of Veterans Affairs (VA) Office of Tribal Government Relations (OTGR)** – VA office designed to build and strengthen relationships between the VA, tribal governments and other key federal, state, private and non-profit partners to improve service to American Indian and Alaska Native Veterans.
- **Veteran Integrated Service Network (VISN)** – The VHA is divided into 23 areas called VISNs. They have oversight over VAMC and VAHCS that are involved in the VA-IHS/THP Reimbursement Agreement Program.
- **Veterans Affairs Medical Center (VAMC) / Veteran Affairs Health Care Systems (VAHCS)** – VHA's integrated health care system which many medical centers throughout the United States. VAMC and VAHCS are directly involved the VA-IHS/THP Reimbursement Agreement Program through the completion of individually signed reimbursement agreement with the tribe and implementation plans with IHS healthcare facilities. VAMC and VAHCS supports the program by:

- Assigns an agreement manager, benefits coordinator, quality manager, and pharmacy representative.
- Assists the IHS and THP with Veteran eligibility verification and enrollments.
- Facilitates care of coordination for eligible AI/AN Veteran and Alaska Non-Native Veterans, if care cannot be provided within the participating HIS and THP facility.
- Assist in the approval of VA Non-Formulary pharmaceuticals request from IHS and THP.
- Coordinates IHS and THP request for durable medical equipment (DME).
- Provide additional information about other VA programs or resources for Veterans.
- Provides patient advocacy services when needed.
- **VISN 20 Network Payment Center (NPC)** – A centralized VA IHS/THP claims processing facility for AI/AN veterans and Alaska Non-Native Veteran receiving direct care at IHS/THP facilities.
 - Supports the IHS or THP reimbursement agreement terms for the processing of inpatient, outpatient, and pharmacy claims.
 - Validates the enrollment and eligibility of AI/AN Veteran prior to claims payment.
 - Provides customer service to IHS and THP stakeholders related to health care claims inquiries and appropriately redirecting questions related to other programmatic areas.
- **Contracting Officer (CO)** – Has the authority and responsibility to issue, modify, and extend individual VA-THP Reimbursement Agreements. COs are aligned under and work within the VA Office of Acquisition and Logistics (OAL). They are assigned to one of 23 VISNs. VHA OCC does not have oversight of the Contracting Officers.

3. Establishing an THP Reimbursement Agreement

The following is the process for establish THP Reimbursement Agreement with the VA:



Once the THP has expressed interest in participating the VA THP Reimbursement Agreement. The VA IHS/THP Reimbursement Agreements Office will locate the nearest VAMC/VAHCS (based on geographical location) that will be aligned with the THP in the agreement implementation plan. The assigned VAMC/VAHCS will be contacted by the program office to provide information to complete the agreement implementation plan and assign their agreement manager, benefits coordinator, quality manager, and pharmacy representative.

The VA IHS/THP Reimbursement Agreements Office coordinates a one-hour joint orientation call between the THP and VAMC/VAHCS staff. In addition to the IHS/THP Program office leading the call, VA staff invited will include all those listed on the Implementation plan; the appropriate OTGR representative, Rural Health representative, Agreement Manager, Quality Manager, Pharmacy representative, Contracting Office and benefits manager if available. At a minimum, the Agreement Manager is required to attend.

The VAMC/VAHCS Agreement Manager and Contracting Officer will support and be involved in the agreement completion.

VAMC Agreement Manager will be liaison between with the IHS and THP and their local VAMC. They provide facilitate communication, coordinate, and provide information to the IHS and THP in support of the agreement.

Contracting Officer have been delegated to execute and manage the THP Reimbursement Agreements within their respective network. CO will ensure the agreement is entered into eCAMS and is the Government signatory for Reimbursement Agreements. The CO will follow the guidance provided in VHA Procurement Manual Vol 7 Chapter VI: Tribal Agreement SOP. (FYI: Don't have the new link as this still being updated, will provide it when available)

4. Eligibility – Veteran Eligibility

VA, IHS and THP are responsible for determining eligibility for health care services within their respective programs.

The term eligible AI/AN Veteran for the VA-IHS/THP Reimbursement Agreement program means an AI/AN Veteran who has the following qualifying criteria:

- Eligible for services from IHS/THP in accordance with 42 CFR Part 136, and VA does not determine tribal eligibility or enrollment; the IHS/THP is responsible for ensuring that a Veteran being treated at a tribal health facility is eligible to receive such services.
- AI/AN Veteran enrollment in the VA Healthcare System of patient enrollment is a requirement and condition for receiving the 'Medical Benefits package' set forth in §17.38 under the IHS/THP Reimbursement Agreement program, in accordance with 38 U.S.C. §1705 and 38 CFR §17.36 or is eligible for hospital care and medical services.

5. Quality of Care

VA through the VA Medical Center (VAMC) or VA HealthCare System (VAHCS) will work collaboratively with the IHS and THP facility staff to ensure access to quality care for AI/AN Veterans. The following defines the requirements for quality:

Information Exchange

VAMC/VAHCS and IHS/THPs shall develop a process to share patient records consistent with relevant privacy laws and will continue activities to share data electronically.

Collaboration

VAMC/VAHCS and IHS/THPs shall promote quality health care services through collaboration activities to review, measure and report on quality of care delivered.

Certification and Accreditation

In order to receive reimbursement, each IHS/THP facility must meet Centers for Medicare and Medicaid Services (CMS) certification and CMS conditions of participation or must have accreditation through the Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC). IHS facilities will be asked to provide the certification or accreditation prior to getting reimbursed while THPs will be asked to provide the certification or accreditation prior to signing the Reimbursement Agreement.

Medical Quality Assurance Activities

At least annually, VAMC/VAHCS and IHS/THPs agree to use existing medical quality assurance activities that as required under accreditation or certification standards are maintained for reporting. IHS/THP agrees to share information with VA regarding its medical quality assurance activities, which shall include periodic review of care utilization (health system level trends) and care delivery consistent with current standards of care and evidence-based practices.

Office of Assistant Deputy under Secretary of Health, Quality Safety and Value (QSV) on an annual basis will provide training and follow-up through a survey questionnaire with all the VISN Contract Agreement Managers and POCs

(VAMC/VAHCS Agreement and Quality Managers) who have oversight of the IHS/THP agreements to ensure VA is compliance with the agreements in conducting quality reviews and to ensure the IHS/THP are providing quality care to Veteran.

6. Coordination of Care

IHS/THP Reimbursement Agreement Program will only provide payment for direct care provided within the IHS/THP facility. This does not include Contract Health Services, unless those services are provided within the walls of the IHS or THP facility.

VAMC/VAHCS will work with IHS/THP to coordinate the care of the eligible AI/AN Veterans.

VAMC/VAHCS through the Agreement Manager will provide IHS/THP with the points of contacts and local process for coordinating care (e.g., VHA Office of Community Care authorization and referral process)

Clinical Integration is currently developing the Community provider Ordering (CPO) processes, tailoring for the IHS/THP Reimbursement agreement program, and will add more to this section when completed.

Alaska THP will follow the care coordination process from Alaska VAHCS, embedded Alaska Tribal Sharing Guidebook Jan 2020:



Alaska Tribal Sharing
Guidebook Jan 2020;

7. IHS-THP Pharmacy – VA Non-Formulary Request Approval

Under the agreement, the IHS and THP will receive reimbursement for outpatient medications prescribed by an IHS/THP provider and dispensed by the IHS or tribal facility to eligible AI/AN Veterans. VA will reimburse IHS and/or THP only for pharmaceutical drugs on the VA National Formulary used by VA in accordance with 38 CFR 17.38(a)(iii).

Requests for reimbursement of pharmaceutical drugs not on the VA formulary will be submitted for approval to the local VAMC Pharmacy in advance of the request for reimbursement. Here is the link to the VA National Formulary listing at <http://www.pbm.va.gov/NationalFormulary.asp>.

VA Non-Formulary requests will be handled according to the local VAMC/VAHCS policy and VHA Handbook 1108.08 (VHA Formulary Management Process) IHS and THP will work with the VAMC/VAHCS Pharmacy representative identified in the agreement implementation plan.

Alaska THP will follow the pharmacy VA-Non-Formulary request process from Alaska VAHCS, Alaska Tribal Sharing Guidebook Jan 2020.

8. IHS-THP Reimbursement Agreement Claims

All IHS and THP claims are submitted and processed centrally at VISN 20 Network Payment Center.

Guidance on how the IHS and THP providers can submit claims and conduct claims status inquiry can be found in the program website:

https://www.va.gov/COMMUNITYCARE/providers/info_IHS-THP.asp and the Reimbursement Agreement Provider guide, embedded here:

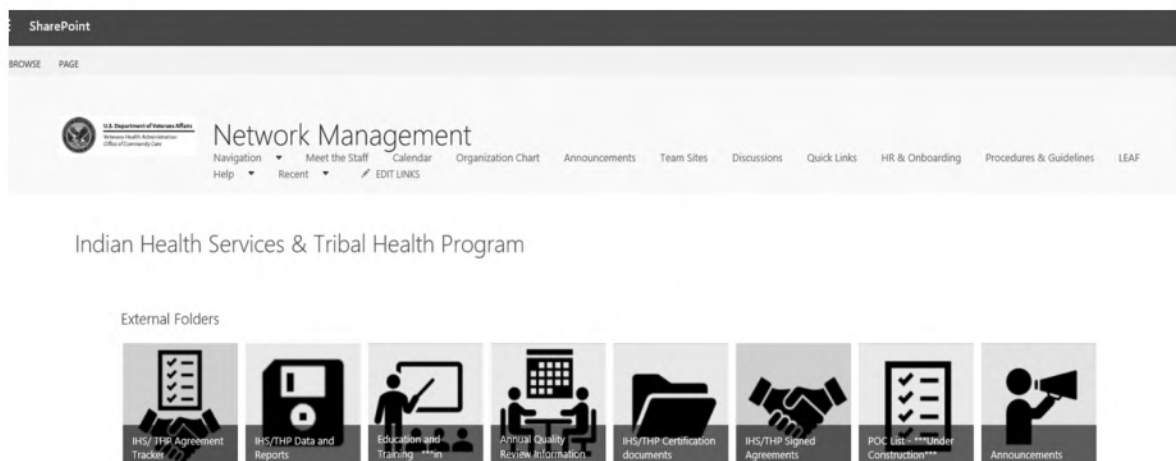


1. VA IHS-THP
Provider Guide Nover

9. Program Documentation - IHS -THP SharePoint Site

This site contains the IHS and THP information by tribe to include their status, points of contacts, quality and accreditation/certification, sign agreements, and other information from the implementation plan. Link:

<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/PRS/NM/SitePages/Indian%20Health%20Services%20%26%20Tribal%20Health%20Program.aspx>



VA-IHS/THP Reimbursement Agreement monthly report at the national, VISN and IHS/THP facility level can be found in site. The report contains current agreement data, reimbursement amount, claims processed, and unique Veterans numbers. Here is the link -

<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/PRS/NM/IHS%20%20THP%20Monthly%20Disbursement%20Reports/Forms/AllItems.aspx>

10. Scheduling Care.

(IHS/THP) (Pre/Post CCN)

The VHA Office of Community Care, the Office of Tribal Government Relations, and VA medical centers (VAMCs) work together to implement the Tribal Reimbursement

Agreements Program. The Tribal Reimbursement Agreements Program provides a means for Indian Health Services (IHS) and Tribal Health Programs (THP) facilities to receive reimbursement from VA for direct care services provided to eligible American Indian/Alaska Native Veterans. This program is part of a larger effort set forth in the Department of Veteran Affairs and IHS Memorandum of Understanding, signed in October 2010, to improve access to care and care coordination services for our nation's Native Veterans.

The Facility Community Care Office is not involved in scheduling activities for Veteran appointments within the IHS/THP, instead Veterans directly contact their local IHS/THP facility to schedule their care. The VA will reimburse invoices for direct care services provided directly by the IHS/THP facility after the effective date of their signed Reimbursement Agreement.

For more information about the Indian Health Service-Tribal Health Program, please refer to the "IHS/THP Reimbursement Agreement Program FAQs" and the "IHS Memorandum of Understanding" located here:

- **IHS/THP Reimbursement Agreement Program FAQs**
- **Memorandum of Understanding between the VA and IHS**
- **Reimbursement Agreement Between VHA and IHS**
- **Reimbursement Agreement Provider Guide**

11. Training

The VHA Office of Community Care (OCC) is pleased to provide an updated 2020 VISN/VAMC training on VA-HIS/THP Reimbursement Agreement Program (RAP) dated 08/31/2020 and located on the [SharePoint Site](#).

The target audience for this training include a range of partners who help to oversee and execute the HIS/THP RAP program at the local levels, including, but not limited to: VISN and VAMC Leadership, facility community care leadership and staff, HIS/THP RAP Agreement Managers, Contracting Officers, VAMC/VISN Quality points of contact (POCs), and Patient Care Service POCs.

IHS/THP RAP training topics include:

- VA-IHS/THP Reimbursement Agreement Background
- Direct Care Services
- Key Stakeholders and Benefits
- Roles in the Agreement
- Eligibility and Enrollment
- Establishing Reimbursement Agreement
- Payment Rates and Fees
- IHS/THP Quality Requirements
- VA Non-Formulary Requirement
- Coordination of Care
- Status/Reports and VISN/VAMC IHS & THP
- IHS/THP SharePoint Site
- Resources and Contact Information
- Questions

- Appendix: Facility List

Additional Resources:

- IHS/THP Video: [Overview Video](#)
- IHS/THP Website: https://www.va.gov/COMMUNITYCARE/providers/info_IHS-THP.asp

Support

- Direct any questions to tribal.agreements@va.gov.

1.5 ART/IVF Overview / Maternity / Newborn Referral Processes

Assisted Reproductive Technology (ART) In Vitro Fertilization (IVF) Overview

Recent legislation entitled Service-Connected Infertility and IVF Services for Eligible Veterans (Title 38 Code of Federal Regulations (CFR) 17.380 and 17.412) (passed on September 29, 2016 and finalized on March 7, 2019) allows the Department of Veterans Affairs (VA) to provide treatment using ART/IVF to the service connected Veteran and spouse. The Veteran and spouse must meet the following clinical and administrative legislative criteria to be eligible for ART/IVF services:

Criteria
<ul style="list-style-type: none"> • Veteran has been evaluated by an infertility specialist and received an infertility diagnosis • Infertility diagnosis is verified by VA Provider • Veteran's service-connected condition causes infertility (or the Veteran's infertility is associated to a service-connected condition) • Veteran is legally married • Legally married couple must possess both: testicular tissue from which sperm can be retrieved in the male; the presence of a uterus, and at least one viable ovary for the female. Exception: Male and female Veterans may utilize previously preserved, self-autologous cryopreserved gametes.

The ART/IVF initiative intends to meet the following objectives:

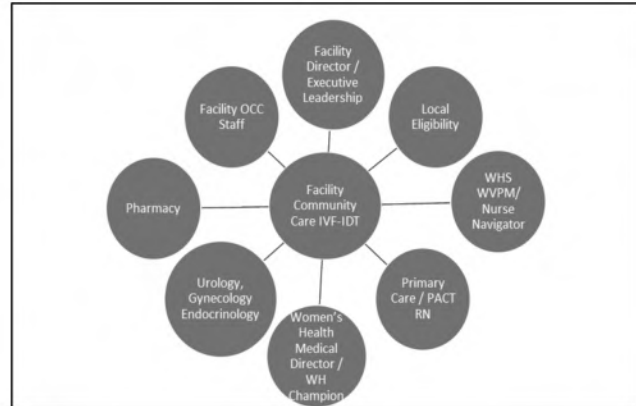
- Provide a standardized process to ensure couples seeking ART/IVF services meet all clinical and administrative legislative criteria
- Ensure that couples seeking ART/IVF services receive timely treatment in the community
- Centralized tracking of ART/IVF couples and associated benefits and metrics
- Provide bidirectional communication and support for local IVF- Interdisciplinary teams and the third-party administrator (TPA)

Note: For all Community Care Clinical Coordination Contact Center (C6) eligible Veterans, all care coordination will be handled by the local facility.

Developing Specialized Interdisciplinary Teams (IDTs)

Figure 1: Stakeholders of IDT Teams

To help meet the aforementioned objectives, this project requires facility community care offices to organize specialized interdisciplinary teams (IDTs) to review clinical and administrative eligibility for ART/IVF couples; members and stakeholders of these IDT teams are included in Figure 1. The responsibilities of the specialized IDTs include:



- Ensure couple meets all clinical and administrative criteria for IVF services
- Expedite new IVF requests
- Review complex cases
- Communicate status of the IVF approval process with the couple
- Upload the referral packets to PC3 Portal
- Communicate with the PC3 IVF Complex Care Coordination Team through the PC3 Portal, email or telephone

Specialized IDTs will be accountable for the body of knowledge associated with CFR 17.380 and 17.412 to approve IVF services for eligible couples. Additionally, each specialized IDT will use the community care decision tree consult template for Infertility and ART/IVF services based on the Veteran's eligibility and the standardized VHA OCC CI IVF Approval Checklist (IVF Approval Checklist) to verify if the Veteran and legal spouse meet required legislative criteria. More information regarding the clinical and administrative requirements of these specialized IDTs are included within the resources below.

An ART/IVF team has been implemented within OCC Clinical Integration (CI) to train and act as a resource for facility community care offices as they create their IDTs. The OCC CI IVF team receives and reviews the approval checklists from the IDTs to ensure all criteria has been met as required by legislative guidelines for CFR 17.380 and 17.412. Additional training will be provided to facility community care offices that will overview creating and processing ART/IVF consults, reviewing eligibility criteria, submitting data for the central repository for community care ART/IVF services, and deploying the IDT teams.

Contract Modalities for ART/IVF Services

As of Fall 2019, the Patient Centered Community Care (PC3) with TriWest is the only contract to administer and pay for ART/IVF services. Community Care Network (CCN) Regions 1, 2, and 3 contract modifications are pending. For updates on contracts administering ART/IVF, please access the ART/IVF SharePoint and the OCC Field Guidebook, Chapter 3.3.

IVF/ART Contracts: Current and Future State Comparison	
Current State (PC3/TriWest)	Future State (CCN)
All IVF services are currently referred to community care using the PC3 contract.	Contract modifications for IVF services are pending.
PC3 will sunset on March 31, 2021.	IVF services are included in the CCN Region 4 contract.
	IVF services will be available to Veterans in CCN Regions 5 and 6.
	PC3 authorizations shall not exceed the contract end date.

Support

- Resource: [IVF National Training Question and Answer Document](#)
- Resource: [ART/IVF SharePoint](#)
- Resource: [Community Care ART - Veterans](#)
- Resource: [OCC Field Guidebook, Chapter 3.3](#)
- Resource: [IVF Infertility Consult Setup technical Guide](#)
- Contact: [OCC Clinical Integration ART/IVF Team email](#)
- Correspondence regarding the availability of the consult is forthcoming, however, the OCC-CI IVF Approval Checklist can be found on the [ART/IVF SharePoint site](#)
- More information regarding the roles and responsibilities are located on the following link [Facility IVF – IDT](#)
- Resource: [Community Care Network InVitro Fertilization \(IVF\) in Region 1-3 Training Recording](#).

Maternity / Newborn Referral Process

Only one consult/SEOC/referral needed for maternity. The Veteran mother's Community Care-Maternity consult covers all prenatal care, delivery, post-partum care and 7 days newborn care. Claims are paid against mom's referral. The revenue loop was relaxed to account for the non-subscriber (newborn) claims to be paid by looking at the DOB and the DOS and as long as the DOS falls within the first 7 days, the claim will be paid.

Newborns should be registered as Collateral Records in VistA/Enrollment System (ES). This process is completed by the facility Eligibility and Enrollment department. Each facility should work with their facility Eligibility and Enrollment department regarding this process.

1.6 Radiology

HealthShare Referral Manager (HSRM) users of a defect that was identified and remediated during the week of January 27, 2020.

Remediation of Radiology Provisional Diagnosis Code Defect

The HSRM team investigated a recurring issue in HSRM where consults were arriving without the required provisional diagnosis codes. The HSRM team discovered that the defective consults were coming from the VistA radiology application, and not directly from Consult Toolbox (CTB). This root cause of this issue was related to how the radiology application pulls information and assembles it for transmission.

To remediate this issue, the HSRM team installed a patch that pulls the provisional diagnosis codes for radiology from an alternate location and populates it in the correct field in the consult. No changes were made to the VistA radiology application.

Radiology consults are now processing normally with the required provisional diagnosis code.

When the Radiology Order to Consult process is utilized to convert a radiology order to a consult, a generic ICD-10 diagnosis code is auto-populated on the consult.

If sites experience issues with radiology exams being returned due to the provisional ICD-10 diagnosis code, sites with returned orders have two options to address the returned referral:

Option 1: Contact the appropriate Third-Party Administrator (TPA) regional support staff member to assist with educating the community provider to accept the provisional ICD-10 code, as the reason for the request is also included on the consult and referral. A listing of the TPA regional support staff member can be found on the [CI Solutions Page](#).

Option 2: The facility community care office can work with the ordering provider or take the following actions within the facility community care office; cancel community care consult, edit/resubmit and update ICD 10 code in order for the referral to be resubmitted to the community provider.

1.7 Veteran's Care Agreement (VCA)

The Office of Community Care is committed to ensuring our Veterans continue to receive the highest quality in clinical care. As providers transition to CCN we are monitoring quality and patient safety issues where a potential gap in service may present.

Reminder: the CCN network is the preferred pathway for community care referrals and all efforts should be made to get key providers into the CCN network. Veterans who are determined to be high risk for treatment continuity, based on clinical review, can continue to seek care under a VCA with medical justification. This is done on a case by case basis. Potentially high-risk patients can include, but are not limited to, those receiving Mental Health care, radiation or chemotherapy.

OCC has activated the following process to ensure clinical continuity under VCAs, where indicated:

- During a provider transition from PC3 or VCA to CCN OCC will allow an individual VCA to remain in place for these identified high risk patients to include an extension until the credentialing into CCN is complete. OCC will also allow new considerations of VCAs with medical justification until the credentialing into CCN is complete.
- If the local facility or VISN indicates the process needs to be expedited due to clinical urgency, OCC has the capability to provide same day turn around for VCA activations.
- If a community provider elects not to participate in CCN and continuing with the provider is critical to a positive clinical outcome, the VCA can be continued. OCC will also allow new considerations of VCAs with medical justification. However, this provider will be deactivated in PPMS so no new referrals can be sent for new patients. This determination will be on a case by case basis.

There are various mechanisms in place to monitor our high-risk Veterans. OCC's Quality and Patient Safety process is robust, and OCC actively monitors issue briefs that originate from local facilities.

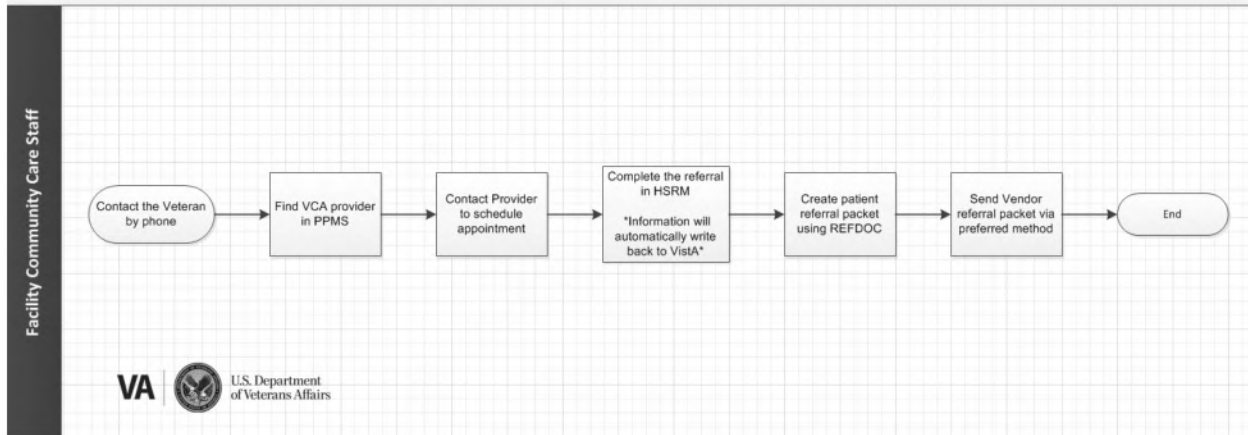
Resources:

- VCA team email group: 13NM4VCAREVIEWTEAM@va.gov
- [VCA team SharePoint](#)

How to Schedule Using Veteran Care Agreements (Pre/Post CCN)

In accordance with the VA MISSION Act of 2018 (MISSION Act), and with regulations published for the new community care program under MISSION, community providers who provide services and/or specialties that are not included in VA's national PC3/CCN contract must sign a VCA with the VA to provide Veterans care effective June 6, 2019. Community providers of all other specialties must agree to participate in VA's national PC3/CCN contract, if available, to continue to provide care to Veterans. The Office of Community Care has contracted with a Credentials Verification Organization that will provide credentialing services to ensure quality providers who are treating Veterans under a VCA. Local facilities will need to obtain basic information from the provider that is critical to this process. Once the provider has been approved/credentialed, the Veteran may be scheduled using the active VCA.

5.1.6 How to Schedule Using Patient-Centered Community Care (VCA)



Veteran Care Agreements (VCA)

Local VA facilities will need to assign appropriate resources to conduct outreach for VCAs. All care will need to be purchased through the National contract (PC3/CCN) when services are provided with the contract. In instances where services may not be part of the National contract, Region, VISN or local contracts may be pursued. Any request for Region, VISN or local contracts should follow the existing process outlined in the May 9, 2018 Memo titled, "Direct Purchasing of Community Care", which includes thorough analysis and justification to be submitted to the Office of Community Care for review and approval.

If National and other contracts cannot be used, VCA's can be established. It is critical to communicate to key community partners that participation in National contracts or a VCA will be required for them to continue to receive authorizations from the VA. Per the MISSION regulation, there will be no exceptions. Providers cannot be active until they sign the VCA template, approved, and uploaded into the Provider Profile Management System (PPMS). The provider will then be fully credentialed through a VA contracted credentials verification organization (CVO), activated and available to be used to provide care to veterans.

The Community Care Network (CCN) is intended to serve as the primary contract vehicle and network through which Department of Veterans Affairs (VA) purchases care for Veterans from community providers. As CCN is established nationwide, VA must transition away from using Veterans Care Agreements (VCAs) to avoid using VCAs for services covered under CCN. This helps ensure the integrity of CCN as VA's primary network of community providers, and that VCAs are only used in limited circumstances, when contracts are impracticable or inadvisable. Please review the [Transitioning to the Community Care Network](#) reference sheet for additional information.

PPMS Note:

As a follow up to the discussion on VCAs in PPMS, but not in HSRM, we have received clarification from PPMS and HSRM teams and have the following guidance:

During the transition from Provider Agreements (PAs) to Veteran Care Agreements (VCAs), the PPMS and HSRM teams were made aware of the issue where many VCAs were not appearing in HSRM, though they were active in PPMS. The root cause of the issue has been identified as providers not having a specialty assigned in their provider profile page, but rather just in the agreement service.

In order to get any missing VCAs loaded into HSRM, please ensure that after creating an agreement service to go back to the profile page and update the specialty section as well with the matching specialty assigned in the agreement service. Also, after creating a service for a group provider please click on the provider's name to visit the profile page and update the specialty section.

Though this was not a requested step in the process in the past, we are requesting that this step be done now to ensure that all VCAs appropriately make it to HSRM.

For additional information on PPMS, please visit the [PPMS SharePoint](#). For more information regarding the VCA Outreach Packet, please refer to the [VCA Outreach Packet](#).

For more information regarding VCA Intake Process, please refer to [VCA Intake Process SOPs](#). This guidance describes the processes and criteria:

- To follow when initiating outreach to a potential VCA provider.
- For Establishing a Veterans Care Agreement (VCA) after the VCA Outreach Packet has been returned to facility community care staff.
- For requesting an emergent/expedited VCA for a provider that already meets OCC contractual agreement standards through PC3/CCN.
- If an emergent patient need exists and the necessary provider or group practices/agencies is already covered under VA and/or PC3/CCN national contracts, please refer to the Expedited VCA Credentialing document for Urgent Patient Care Needs Post CVO Deployment. OCC Credentialing will review VA facility requests for VCAs. Please note that expedited credentialing does not negate nor replace the need for full credentialing through the CVO. Full credentialing must be completed within 30 days. If any adverse actions are discovered through the credentialing process, a review of patient care may be warranted to ensure appropriate standard of care.
- For entering into a VCA that exceeds either CMS reimbursement rates or the VA Fee Schedule. VCA requests for services outside of national contracts exceeding the CMS rate or VA Fee Schedule when applicable will require review by the VHA Office of Community Care (OCC).
- For more information regarding Authorization Processes for VCA providers, please refer to the Authorization Processes for VCA providers SOP. This guidance describes the process and criteria for facility community care staff on how to:

- authorize a Veteran to receive care through a Veterans Care Agreement (VCA) before the implementation of HealthShare Referral Manager (HSRM)
- refer a Veteran to receive care through a Veterans Care Agreements (VCA) upon implementation of the HealthShare Referral Manager (HSRM)

For more information regarding Credentialing Appeals, please refer to [the Credentialing Verification Organization SOP](#). As required by MISSION Act Section 108 and other regulations, community care providers can be excluded from network participation. The VA Secretary may deny, revoke, or suspend the eligibility of a community provider to see Veterans if the Secretary determines the action is necessary to immediately protect the health, safety, or welfare of Veterans. This guidance describes the process and criteria for providers that have been excluded from credentialing as a Veterans Health Administration (VHA) Office of Community Care (OCC) provider to appeal that decision.

For information regarding Provider Exclusion, please refer to the [VCA Provider Exclusion SOP](#). This guidance describes the criteria, process, and responsible parties for excluding a provider from the VA network, including but not limited to provider exclusion as indicated in Section 108 of the VA MISSION Act of 2018.

For more information regarding VCA Material Size, please refer to [VCA Material Size SOP](#). This guidance describes the annual process and criteria for identifying Veterans Care Agreement (VCA) providers of material size, defined as providers who have exceeded five million dollars in payments for one fiscal year, in accordance with Section 102 of the MISSION Act.

For information regarding VCA Disputes, please refer to [VCA Disputes Process](#). This guidance describes the process and criteria for processing provider dispute requests around authorizations or payments. All dispute requests must be submitted within 90 calendar days of accrual of dispute.

For more information regarding VCAs and Dental care, please refer to the [Veteran Community Care Dental Care Reference Sheet](#).

Individual caregivers providing Bowel and Bladder (B&B) Care must sign a [Bowel and Bladder Veterans Care Agreement \(VCA\)](#) to ensure continued payment for services provided. If individual caregivers do not obtain a VCA by September 30, 2019, they will not receive payment for services that they provide. Please refer to the [Bowel and Bladder Guidance for Veterans Care Agreement \(VCA\)](#) and ensure correct steps are followed to enter a signed VCA for continued payment for services. Please also review the [Guidance for Bowel and Bladder family members](#)

The National Dialysis Service Contract (NDSC) provides coverage for end stage renal disease (ESRD) Outpatient (OP) dialysis through numerous providers throughout the country. If there are is not a network provider feasibly available to provide the care, a facility may enter into a Veterans Care Agreement (VCA). Please refer to the [Dialysis Clarification Job Aid](#) for additional Information.

Note: Section 207 of the Veterans Access, Choice and Accountability Act of 2014 (VCP) required that Veterans who are referred for surgery have available to them (if they wish to review) the surgeon's education, training, licensure, registration and certification by authorizing state or national entity. Office of Community Care recently created a fact sheet for Veterans, providing web-sites and helpful links to assist Veterans in finding this information, if they wish.

The fact sheet can be found on the Veteran-facing Community Care website, providing surgeon qualifications/information to Veterans preparing to undergo surgery. Please ensure all Veterans scheduled for surgery either through the Patient Centered Care (PC3) contract, Community Care Network (CCN) contracts or VCAs are aware the fact sheet is available to assist them in finding this information if they wish to review prior to surgery.

For Frequently asked VCA Questions, please refer to the VCA FAQs.

Veterans Care Agreement VA Form 10-10171

Direct link to the form on the internet:

<https://www.va.gov/vaforms/medical/pdf/vha%2010-10171-fill.pdf>

Transitioning to the Community Care Network

The Community Care Network (CCN) is intended to serve as the primary contract vehicle and network through which Department of Veterans Affairs (VA) purchases care for Veterans from community providers. As CCN is established nationwide, VA must transition away from using Veterans Care Agreements (VCAs) to avoid using VCAs for services covered under CCN. This helps ensure the integrity of CCN as VA's primary network of community providers, and that VCAs are only used in limited circumstances, when contracts are impracticable or inadvisable (See Expedited VCA Credentialing document for Urgent Patient Care Needs Post CVO Deployment). Please review the Transitioning to the Community Care Network reference sheet for additional information.

How to Vendorize a Veterans Contract Agreement (VCA) in VistA

The processes outlined within this section allows contract vendorization of a Veterans Contract Agreement (VCA) provider's vendor file.

Correctly establishing and entering the VCA contract ID number is critical for identifying and tracking VCA utilization. A VCA contract ID number is assigned at the time the VCA is added to the provider's profile in PPMS.

Upon establishing the VCA contract ID in PPMS, the VCA ID is entered into VistA as a Contract ID which then makes the VCA contract ID number selectable in the FBCS authorization and payment modules.

Requirements:

Before a user may vendorize a VCA in VistA, the user must be assigned the FBAASUPERVISOR security key. Also, all new VCA Agreements must first be entered and established (from the provider's profile) in PPMS.

Establishing a VCA in PPMS automatically generates the VCA Agreement ID, which must be entered during the contract vendorization process as associative to the provider's vendor file in VistA.

Procedure:

The assigned VCA contract ID should be entered into VistA exactly as it appears in PPMS; with the VCA prefix and including all 10 digits, into all VCP provider's vendor file as initiated through the Contract File Enter/Edit option located in VistA.

If the number isn't completely and accurately entered into the Contract ID prompt in VistA; the VCA contract ID will not be available to select in the FBCS authorization or payment modules.

To begin Vendorization process:

1. Launch local facility VistA and access the Medical Fee Main Menu: Supervisor Main Menu
2. Enter Contract File Enter/Edit

```

Select Medical Fee Main Menu Option: Supervisor Main Menu

Clerk Look-Up For An Authorization
Contract File Enter/Edit
Delete Reject Flag
Edit Pharmacy Invoice Status
Enter/Edit Suspension Letters
Fee Basis 1358 Segregation of Duty Report
Fee Schedule Main Menu ...
Finalize a Batch
FPPS Update & Transmit Menu ...
List Batches Pending Release
MRA Main Menu ...|
Update FMS Vendor File in Austin [FBAA FMS UPDATE]
Delete Vendor MRA [FBAA MRA DELETE VENDOR]
Reinstate Vendor MRA [FBAA MRA VENDOR REINSTATE]
Pricer Batch Release
Print Rejected Payment Items
Queue Data for Transmission
Re-initiate Rejected Payment Items
Release a Batch
Reprocess Overdue Batch [FBAA REPROCESS BATCH]
Resend Completed Batch [FBAA RESEND VOUCHER MSG]
Site Parameter Enter/Edit
Unauthorized Claims File Menu ...
Void Payment Main Menu ...

```

3. Select Fee Basis Contract Number: Enter VCA Contract ID number located in PPMS within the provider's profile under the section labeled "Agreements."
4. Prompted to Confirm: "Are you adding VCA9999999999 as a new FEE BASIS CONTRACT? No/!" Enter Y for YES
5. Hit Enter

6. Status: Enter "A" for ACTIVE
7. Select VENDOR: Enter Vendor Tax ID. If a list populates, choose the correct number for the applicable vendor
8. Enter "Y" for Yes when prompted if adding APPLICABLE VENDORS
9. Select VENDOR: Hit Enter Key (no entry)
10. CHOICE INDICATOR: Hit Enter Key (no entry)
11. CHOICE PROVIDER AGREEMENT: Hit Enter Key (no entry)

```

Select Supervisor Main Menu Option: contract File Enter/Edit
Select FEE BASIS CONTRACT NUMBER: VCA999999999
Are you adding 'VCA999999999' as a new FEE BASIS CONTRACT (the 22ND)? No// Y (Yes)

CONTRACT NUMBER: VCA999999999 // Enter

STATUS: A ACTIVE

Select VENDOR: 123456789

1 123456789 VCA VENDOR 123456789 HOME HEALTH SER
P O BOX 999
DENVER, CO 99999-9999 TEL. # (999) 999-9999

2 123456789 VCA VENDOR2 123456789999 HOME HEALTH SER
111 E 1st ST.
DENVER, CO 99999-9999 TEL. # (999) 999-1111

CHOOSE 1-2: 1 VCA VENDOR 123456789 HOME HEALTH SER
P O BOX 999
DENVER, CO 99999-9999

Are you adding "VCA Vendor" as
A new APPLICABLE VENDORS (the 1st for this FEE BASIS CONTRACT)? No// Y (YES)

Select VENDOR:
CHOICE INDICATOR:
CHOICE PROVIDER AGREEMENT:

```

This information may also be found on the [VCA Vendorization in VistA Job Aid](#).

Additional Resources:

- [CCN Transition SharePoint site](#)
- [TMS Trainings:](#)
 - **VA 38804** Creating a Veterans Care Agreement using the Provider Profile Management System
 - **VA 38803** Adding Additional Providers to a Veterans Care Agreement
 - **VA 38805** National Provider Identifier (NPI) Validation Failures

How to Notify CCN Contractor if Requested Provider is Not in Network (Post CCN)

PROCEDURES

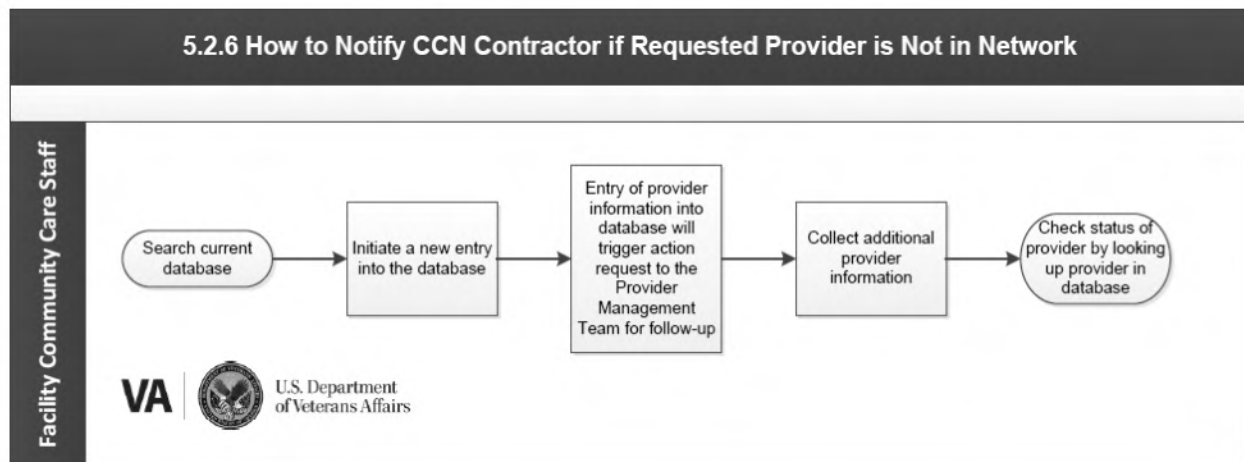
General Considerations:

In cases where when gathering the Veteran's appointment preferences, the Veteran requests a provider that does not currently participate within the CCN network, VA staff should follow the following procedures to document the out-of-network provider and send a request to the Provider Management Team for outreach.

Detailed process guidance can be found here via the links below.

(Placeholder)

STEP	ACTIVITY
1	Search PPMS to ensure the community provider doesn't already have an existing agreement or currently in the outreach process.
	Pending Provider opts in and pending receipt of outreach packet
	Under Review All outreach documents in review and approval process; VCA pending signature by Medical Center Director
	Active VCA approved and signed by MCD (Medical Center Director). Care can be referred to provider
	Inactive VCA no longer meets qualifications criteria or expired. No longer eligible
	Ineligible Does not meet qualification criteria i.e., no current Licensure or provider found on an exclusionary list.
	Declined Potential provider declines to participate as community care provider
	Providers may have the following status (suggested based on PPMS): If VA staff did not find the community provider in PPMS, proceed to Step 2 to continue with initiation of provider outreach. If VA staff did find the community provider in PPMS and provider is ACTIVE, proceed to scheduling under the CCN Contract, see Section 5.3
2	Initiate a new entry into the database by: <ul style="list-style-type: none"> · Selecting the date of initial outreach process · Select VISN and facility · Enter organization information (billing name, phone number, tax ID, address, and VA Primary Category of Care) · NPI and other Categories of Care (if applicable)
3	Entry of provider information into database will trigger action request to the Provider Management Team for follow up.
4	Collect additional provider information and enter into database. <ul style="list-style-type: none"> · Additional points of contact · Fax number · Email address
5	Check status of provider, if needed, by looking up provider in database to see if approved or where they are in the outreach process.



NOTE: VHA Office of Community Care (OCC) is aware of current challenges and increased demand VA facilities face regarding availability for Behavioral Health treatment for Veterans in the community. In an effort to maximize VA facilities' ability to schedule Veterans for Behavioral Health treatment, OCC is temporarily waiving the Veterans Care Agreement (VCA) approval process requirement for services covered under Community Care Network (CCN) contract as outlined in the Field Guide Book, for issuing VCAs for behavioral health providers through September 30, 2021. This includes bypassing the facility Director's consideration memo and uploading to the OCC VCA Review Team SharePoint. VAMC staff members are encouraged to continue to utilize the CCN providers for treatment if available. However, if CCN providers are not available, VAMC staff may work with non-network providers to procure VCAs to deliver behavioral health treatment for our Veteran population.

VAMC staff should verify that the non-network provider has the ability to schedule Veterans timely **before** starting the VCA process with the provider. This will prevent adding providers who currently do not have the capacity to see Veterans. After the provider's office has verified the ability to see Veterans timely, VAMC staff should begin the VCA process with the provider. Once the VCA has been finalized (completed and signed by both the provider and the facility Director), the VAMC staff will enter the VCA into the Provider Profile Management System (PPMS). When the VCA has been entered into PPMS, VAMC staff should contact the VCA Review Team at (b)(6)@va.gov in order for the VCA to be credentialed/certified by the OCC Credentialing Team (verifying licensure and other credentialing requirements) in order for the VCA to be activated.

After the September 30, 2021, OCC will review and reassess the current community care availability and determine if more time is needed for the VCA approval waiver for behavioral health. As a reminder, VCAs cannot be done retroactively and all authorizations must be issued in advance on a completed VCA. The waiver of the approval process *only applies to behavioral health VCAs*. Any additional questions may be sent to the VCA Review Team at (b)(6)@va.gov.

Resources

- [VCA team SharePoint](#)
- [Field Guidebook, Specialty Programs, subsection 1.7 \(VCA\)](#)

1.8 Residential Treatment and Rehabilitations Programs

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

The VA MISSION Act of 2018, effective June 6, 2019, established the Veterans Community Care Program (VCCP). Veterans who are eligible for both VA domiciliary care and VCCP may receive residential care from community providers with whom VA has a contract for such services.

By national policy, MH RRTPs are VISN resources. VISNs should ensure adequate access to MH RRTP care across the VISN. When the care cannot be provided by a MH RRTP, and the Veteran meets the eligibility standards for MH RRTP care and elects to receive care in the community, VA will authorize that care to be provided by a community provider with whom VA has a contract for the provision of the necessary services.

When can a Veteran be referred to community care:

- A Veteran who meets criteria for a priority admission (within 72 hours) that cannot be accommodated by a MH RRTP. Referrals to an alternate MH RRTP should be exhausted before a community referral.
- A Veteran who must wait greater than 30 days for admission to a MH RRTP. Referrals to an alternate MH RRTP should be exhausted before a community referral.

General requirements for MH RRTP/Community Residential Care referrals:

- Veteran is assessed as not meeting criteria for acute psychiatric or medical condition(s).
- Veteran has attempted a less restrictive treatment alternative, or one was unavailable.
- Veteran is assessed as requiring the structure and support of a residential treatment environment.
- Veteran is assessed as not being a significant risk of harm to self or others.

Wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services. MH RRTP services are considered institutional extended care services and therefore these standards are not factors that require consideration for a community referral.

Minimum Standards for Community Residential Care Programs:

Community residential programs should meet the minimum standards. At a minimum, the facility must be state-licensed and accredited for the provision of the mental health or substance use disorders provided. In addition, the programs must be accredited