under either the Joint Commission Behavioral Health Standards or the Commission on Accreditation of Rehabilitation Facilities (CARF) Behavioral Health Standards manual (residential treatment).

If the community residential program does not meet the minimum standards, the facility should consider referring to another community residential program.

In order to provide an appropriate level of care to Veterans, community residential providers should offer at least the following services:

- Diagnostic Studies relevant to the referred condition:
    - History and Physical upon admission
- Evaluation, assessment, testing, and treatment planning for the referred condition
    - Comprehensive Biopsychosocial assessment upon admission
    - Individualized care planning that is completed upon admission and reviewed regularly
    - Ongoing documentation of sessions
    - A minimum of two evidence-based psychosocial interventions. For Veterans seeking care for Substance Use Disorder (SUD), cognitive behavior therapy is required as one of the two evidence-based practices
    - Address co-occurring mental health and substance use disorders, as well as other medical concerns on site or through consult
- Individual, family, couple, and group psychotherapy sessions
    - Service that includes both individual and group therapy and group psychoeducation.
    - At a minimum, four-hours per day of treatment or rehabilitation services that are diagnostic specific for mental health and/or substance use disorder
- Diagnostic labs relevant to the referred condition:
    - Urine drug screens, at minimum, for Veterans receiving SUD services
- Medication management and monitoring
    - Medication management and monitoring
- Medication assisted treatment for opioid use disorder and alcohol use disorder
    - Addiction-focused pharmacotherapy for alcohol, opioid, and tobacco use disorders on site or through consult
    - Provide ambulatory detox for Veterans with mild withdrawal who would otherwise be managed as outpatient
- Case Management and discharge planning
    - Individualized services tailored to Veterans' continuing care needs following residential treatment through linkage to VA or community SUD services and other mental health and medical services
    - Provides treatment and discharge information to VA
    - Assist veteran in care coordination with the VA to include discharge planning and follow up referrals
- Thai Chi, Meditation Mindfulness Based Stress Reduction, Acupuncture, Hypnosis, Biofeedback and Recreational Therapy
    - Provides services to enhance and support the therapeutic process.

1.9 Complementary and Integrative Health (CIH) Services

Complementary and Integrative Health (CIH) / Whole Health (WH) approaches

The VHA Office of Community Care (OCC) in partnership with the VHA Office of Patient- Centered Care and Cultural Transformation (OPCC & CT) agreed upon minimum standards for providers of CIH approaches in the community. The third-party administrators (TPAs) for the CCN contracts, Optum and TriWest, are responsible for building the network of providers. The TPAs relied on OPCC & CT's recommendations for minimum standards, and in some cases, will allow for self-attestation to training for certain provider types. For further questions regarding CIH community care provider minimum standards, please email [(b)(6)]@va.gov .

If a facility does not offer one of the evidence based approaches from "List 1" of VHA Directive 1137, , when appropriate, the Office of Patient-Centered Care and Cultural Transformation (OPCC&CT) recommends using vetted online videos, partnering with other VA's for TeleWholeHealth, or partnering with community volunteers before initiating a community care consult. If these options are not possible, then sites can initiate a community care consult for the following List 1 CIH approaches:

- Acupuncture
- Biofeedback
- Clinical Hypnosis
- Massage Therapy
- Tai Chi/Qi Gong
- Meditation (Specifically Mindfulness-Based Stress Reduction (MBSR))

NOTE: *Yoga is not included in the Community Care Network (CCN) contract. VA facilities can offer this approach through volunteers, telehealth agreements, vetted online resources, or local Veteran Care Agreements (VCA).*

NOTE: *Guided Imagery is not included in the Community Care Network (CCN) contract as there are many options for offering guided imagery through virtual mechanisms.*

The Integrative Health Coordinating Center (IHCC), under the OPCC&CT continually re-evaluates the need and ability to create internal mechanisms for training VA providers to deliver List 1 CIH approaches. Currently, IHCC is developing trainings and internal VHA certifications for guided imagery and clinical hypnosis.

Standardized consults for CIH List 1 approaches

OCC in partnership with OPCC&CT developed standardized consults for List 1 CIH approaches. These consults allow for consistency and standardization of consults, while also streamlining collection of data. The standardized consults include references for providers to learn appropriate evidence-based uses of CIH approaches. A Technical Guide will be provided for national standardized consults with step by step instructions to build the consults, link the standardized templates and create quick orders and any order menus for each CIH services. Local CACs will obtain the consult templates and import into CPRS.

How to find a SEOC for a CIH modality

Standardized Episodes of Care (SEOCs) are a method of ordering health care to improve continuity of care and reduce provider burden for subsequent referral by bundling services that typically go together. SEOCs improve efficiency and consistency of care delivered outside the VA Medical Center. SEOC's define the frequency and duration for which a CIH approach is approved in the community. The SEOCs for CIH were developed by Subject Matter Experts in each area and are available for the List I modalities to help inform the frequency and duration of care. A list of SEOCs are available to view in the SEOC Database.

If a Veteran is achieving benefit with a certain approach, and that is documented by the community provider, then VHA approvers can authorize additional care as needed. VHA is not placing a maximum on the number of visits or hard cap. Providers will approve additional episodes of care if there is functional improvement or benefit to the Veteran.

Furthermore, the Clinical Service of the Acupuncture SEOC is indicated to be 35-Chiropractic instead of Acupuncture. It is not expected the service will be performed by, or the referral will be directed to a chiropractor. The clinical service taxonomy is from a national system based of Medicare taxonomy. Currently, Medicare does not recognize Acupuncture and other Clinical Integration Services, thus there is not a taxonomy for these services. The clinical service is utilized for mapping SEOCs to DST and other internal mechanisms. The systems recognize the limitations of the taxonomy system and have designed mapping processes to accommodate these limitations.

NOTE: Currently, there is not a specific category of care code for CIH, although the Office of Community Care (OCC) is developing that code now. Temporarily, CIH List 1 approaches will be under the existing category of care code, acupuncture. This does not affect provision of CIH or what type of provider can offer the approach.

CIH community care trainings and resources

OCC in partnership with OPCC&CT developed an e-learning to assist VA providers in implementing CIH in the community. There is also a Whole Health and Community Care Update from September 26, 2019 available for both VA and non-VA personnel - The Whole Health System:

> **An Update on VHA Health Care Transformation** (*recorded 26 September 2019*):
> - TMS registration for VA personnel
> - VHA TRAIN registration for non-VA personnel
>
> **General CCN information**
> - The Community Care Hub
> - VA Community Care Q&A Database
>   - A VA internal webpage for community care staff to search archived answers by category on the main page
>   - Newly released answer report link
>
>   PDF
>   CIH Directive 1137
>   D 2017-05-18.pdf

1.10 Community Care Referrals to the Mayo Clinic Health System Destination Medical Center (DMC) and CCN Referral Processes

VA Medical Centers, in partnership with the VHA National Program Office of Community Care, have established care coordination efforts with three Mayo Destination Clinics, located in Rochester, MN, Jacksonville, FL, and Phoenix, AZ. The Mayo Destination Medical Center (DMC) will be utilized for complicated episodes of care for Veterans with rare diseases or challenging diagnostic dilemmas which require more flexibility in consulting various specialists. The referrals are purchased under a unique, Veterans Care Agreement (VCA) authorization which includes multiple avenues within the approval process.

Veterans may qualify to utilize the Mayo Clinic Health System or a Mayo DMC in the community utilizing one of the following pathways:

Utilization of Mayo Clinic Health System under Community Care Network (CCN)
- **Mayo Clinic Health System**
  - Authorized emergency care
  - Urgent care
  - Routine, general, authorized medical services

Note: Mayo DMC sites can ONLY be utilized for emergent care under CCN

- Mayo Clinic Health Systems may be utilized under *active* National Provider Identifiers (NPI) associated with CCN for the following:
  - Routine, general, authorized care
  - A Veteran self presents to a Mayo Emergency Department
  - CCN Mayo Clinic Health System referral follows CCN standardized processes
  - Veterans may be referred to *active* Mayo Clinic Health System providers or facilities within CCN
  - Request for Services (RFS) required for services beyond scope of SEOC

- CCN does not include referrals to the three specific sites below:
  - Jacksonville, FL
  - Phoenix, AZ
  - Rochester, MN

- Facility Office of Community Care staff follow the standardized clinical coordination procedures when referring a Veteran to a Mayo Clinic Health System under CCN.

- Standardized clinical coordination procedures under CCN include:
  - Utilization of standardized community care clinic titles and accompanying SEOCs
  - Verification of community care eligibility under the MISSION Act
  - Creation of authorization/referral in Health System Referral Management (HSRM) and REFDOC packet

Note: Currently Mayo is not utilizing HSRM for CCN. Soon, Mayo will utilize HSRM, however the current process for referrals while Mayo is not utilizing HSRM is as follows:

- All CCN referrals will be faxed to Mayo's centralized referral team at 507-538-7171

- Mayo will notify the referring facility of the Veteran's appointment date/time

Utilization of Mayo DMC under Veterans Care Agreement (VCA)
- **Mayo DMC**
  - VA has established a VCA with Mayo for its DMC locations to accept referrals for highly specialized, highly complex, difficult to diagnose (or treat) conditions
    - Jacksonville, FL
    - Phoenix, AZ
    - Rochester, MN

Veteran's condition MUST meet clinical criteria to be eligible for a VCA referral to a Mayo DMC
- Highly specialized, highly complex, difficult to diagnose (or treat) conditions that cannot be treated within VISN or network.
- Requires final approval from Office of Community Care (OCC) Chief Medical Officer (CMO)
- DMC VCA reimburses at 150% of Medicare
- No RFS Required

Note: Authorized emergency care is the only scenario in which a Mayo DMC location can receive a CCN referral.

Mayo DMC Referral Process- Facility Community Care Staff

- Consult Title: Community Care – Destination Medical Center Consult (DMCC)
- Unique SEOC: Mayo Destination VCA
- Referral affiliation in HSRM for Mayo DMC will be VCA

VA facilities must follow unique Mayo DMC process for referrals
- Initial approval process:
  - Obtain facility COS approval
  - Submit referral information to the National Office of Community Care DMC Review Team for approval (**Mayo DMC Referral Power App**)
    - Facility Community Care Office staff enters referral into the Mayo DMC Referral Power App for submission to the National Office of Community Care DMC Review Team for approval via this link; https://apps.gov.powerapps.us/play/fe8ae514-abd5-46e4-a512-4ec06f1d8623?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf&source=portal

  - Step by step instructions are provided in the job aid located at this link; Mayo DMC Referral Power App Job Aid
  - OCC CMO reviews for final approval of clinical appropriateness. Approval/Disapproval is documented in the Mayo DMC Referral Power App
  - If OCC CMO approved, facility Community Care Office staff document the OCC CMO approval on consult. Facility Community Care Office staff apply Mayo Destination VCA SEOC to consult and send to HSRM.
  - Assign DMC VCA
    - Rochester MN VCA: 1922074434
    - Phoenix AZ VCA: 1558332494
    - Jacksonville FL VCA: 1790772317

- If VCA is inactive in PPMS, send email to National Office of Community Care DMC Review Team requesting activation.
  - Any questions or concerns can be sent to the National Office of Community Care DMC Review Team via email at CCMAYODMCReviewTeamDL@va.gov
  - Request read-only access to Mayo CareLink portal.
    - Facility Community Care Office staff enter CareLink to verify Veteran attended first appointment and initial medical documentation is received.
    - Capture CareLink medical documentation appropriate for the Veteran's VA Electronic Health Record (EHR) using CareLink.
      - While viewing document appropriate for the Veteran's EHR click on the print icon in the upper right-hand corner of the CareLink page.
      - The document will open in a new window. Verify the printer to be "Adobe PDF" and press the "Print" button.
      - When prompted to "Save PDF File As", save document and upload to the EHR according to your local medical documentation capture process.
    - Document Veteran attended first appointment and initial medical documents received.
  - Facility Community Care Office staff can access initial medical documentation within 3 days following the date of first appointment. Another source to obtain Mayo documentation is JLV within CPRS. eHealth Exchange Records may be retrieved using JLV if the Veterans have been properly correlated.
  - Throughout the episode of care, Mayo will add notes and clinical documents to the patient's record in CareLink
  - Create consult result note
  - Mark episode of care complete in HSRM

The facility Chief of Staff (COS) will be notated as the referring provider in the Mayo DMC referral database called CareLink, where referrals will be communicated to Mayo DMCs.

Please see instructions for COS access in the **Mayo Destination Medical Center Chief of Staff CareLink Access Reference Guide**

Training and Resources

- Mayo Destination Medical Center Reference Sheet
- Mayo Destination Medical Center SOP
- Mayo Destination Medical Centers Training PPT

1.11 Transgender and Intersex Veterans

It is VHA policy that staff provide clinically appropriate, comprehensive, Veteran-centered care with respect and dignity to enrolled or otherwise eligible transgender and intersex Veterans, including but not limited to hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following gender confirming/affirming surgery. It is VHA policy that Veterans must be addressed based upon their self-identified gender identity; the use of Veteran's

preferred name and pronoun is required. ***NOTE:*** *VA does not provide or fund gender confirming/affirming surgeries because VA regulation excludes them from the medical benefits package. In addition, VA does not provide plastic reconstructive surgery, in accordance with the medical benefits package and VHA Directive 1091, Plastic Reconstructive Surgery, dated February 21, 2014.*

VA is committed to addressing health disparities, including disparities among our transgender and intersex Veterans.

VHA provides health care for transgender and intersex Veterans, no matter how they present. Not all Veterans who identify as transgender or intersex undergo a transition process. For those who do, they may present to VHA at various points in their gender transition. VHA does not discriminate based on state of gender transition. This applies to all Veterans who are enrolled in VHA's health care system or are otherwise eligible for VHA care.

VHA will provide care to all transgender and intersex Veterans in a manner that is consistent with their self-identified gender identity.

Transgender and intersex individuals are provided all care in VA's medical benefits package, including but not limited to:

- **hormonal therapy**

- **mental health care**

- **preoperative evaluation**

- **medically necessary post-operative** and

- **long-term care following gender confirming surgeries** to the extent that the appropriate health care professional determines that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

  NOTE: *VA will not provide or fund gender confirming/affirming surgeries because VA regulation excludes them from the medical benefits package. In addition, VA does not provide plastic reconstructive surgery, in accordance with the medical benefits package and VHA Directive 1091, Plastic Reconstructive Surgery, dated February 21, 2014.*

- **permanent hair removal**

  - Must be medically necessary, such as for pre-surgical hair removal for genital surgery. VA provides pre-operative and long term post-operative care for gender affirming surgeries.
  - For non-cosmetic medically necessary hair removal, laser hair removal is appropriate to prevent major complications following genital surgery.
  - For Veterans who are not candidates for laser hair removal due to hair color (white/gray/ blonde), electrolysis may be provided.
  - Currently, each VA decides if hair removal is indicated on a case-by-case basis after an evaluation of medical necessity. Some VA facilities have the equipment to perform laser hair removal and/or electrolysis, while others

will need to access community care when this procedure is medically indicated.

- **Medically necessary vocal coaching**
    - o VA speech pathologists can offer this care, or if this service is not available at your facility, it can be offered through non-VA community-based care.

Medically Necessary Hair Removal and Electrolysis Providers

Electrolysis and laser hair removal is regulated under cosmetology licensure. Hair removal specialists may be available through network group Dermatology Provider Groups. When the care is not available through a network Dermatology provider, it may be provided through an independent Electrolysis provider under the cosmetology licensure.

How to Obtain an NPI

Electrolysis providers not associated with a network Dermatology group practice must obtain a National Provider Identifier (NPI). The NPI number is required for providers to be loaded into VA's Provider Profile Management System (PPMS), enter into a Veterans Care Agreement (VCA), and be paid as a community provider. The preferred method to get an NPI is through the online application process, providers may visit https://nppes.cms.hhs.gov/#/ to create an account and NPI number. The process will walk the provider through the process asking for specific information, such as name, tax identification (social security number) and address. Providers may also request an NPI number via a mail in application. The application may be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.pdf.

Veterans Care Agreement (VCA) Process

Providers with cosmetology licensure cannot be enrolled in the Community Care Network (CCN) contracts. After first seeking out local electrolysis services sought out through CCN in the form of dermatology, facilities may enter a Veterans Care Agreement (VCA) with other independent Electrolysis providers. Local community care staff should initiate the VCA process after the Provider has obtained an NPI number.

The VCA is an agreement of payment for the services rendered. A VCA will require the provider's signature on the last page. Once, signed and submitted to the local community care staff, the VA Director's signature will be coordinated, and the final agreement mailed to the provider. Providers who have never been paid for these services by the VA may also be required to fill the VA-FSC Vendor File Request Form. The form and instructions may be found at https://www.va.gov/COMMUNITYCARE/revenue_ops/provider_payments.asp

For questions regarding this process, please contact the local community care staff

Resources:

- VHA DIRECTIVE 1341(2) PROVIDING HEALTH CARE FOR TRANSGENDER AND INTERSEX VETERANS (Amended June 2, 2020)

- Transgender SharePoint: for cultural awareness and sensitivity education, as well as clinical trainings. **NOTE:** *This is an internal VA website that is not available to the public.* For local trainings, the LGBT Veteran Care Coordinator will have access to the most current information.

- Medically Necessary Hair Removal and Electrolysis Provider 508

1.12 Traveling and Permanently Relocating Veterans Guidance

Traveling and permanently relocating Veterans are expected to receive the same standard of care even when not assigned to a Patient Aligned Care Team (PACT). Care of traveling and permanently relocating Veterans is carefully coordinated via the Traveling/Permanently Relocating Veteran (T/RV) Consult Process to ensure a seamless continuation of services. This may require one or more services provided through community care referrals. For example, traveling Veterans who need maternity services or specific specialty care that is unavailable at the Alternate VA Medical Facility (A-VAMF) must be provided with continuous, coordinated coverage during travel as medically appropriate.

Community care eligibility is still required to be met regardless of whether the Veteran is traveling or permanently relocating. In order for the Veteran to receive approved care in the community the Veteran must meet the MISSION Act community care eligibility criteria for the episode of care. Due to current Health Share Referral Management (HSRM) limitations, a T/RV Interfacility Consult (IFC) cannot be forwarded to a Community Care consult. If care is needed in the community, a new community care consult will need to be placed. If the care being requested is available within the VA Medical Facility where the Veteran is traveling to, an internal consult to the clinical service must be entered, or the T/RV Consult can be forwarded to the clinical service, per local policies. If the Veteran is eligible for community care, the internal consult will be forwarded to Community Care using the consult toolbox. However, if the Veteran is eligible using a forwarded T/RV IFC to a clinical service, a new internal consult to the clinical service must be entered and then forwarded to Community Care using the consult toolbox. For additional information, see VHA Directive 1101.11(3), Coordinated Care for Traveling Veterans, or subsequent issue, and the TVC SharePoint at: Seamless Care for Traveling Veterans - Home (sharepoint.com)

a. **Facility Community Care staff at the Alternate VA facility is responsible for:**

(1) Coordinating the Community Care referral review process for traveling and permanently relocating Veterans who require health care services and are eligible for community care, in accordance with Community Care Coordination, Chapter 3, in the Office of Community Care Field Guidebook (see Field Guidebook Home Page: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx)

(2) Performing an administrative eligibility review of the community care referral, upon receipt of a community care referral in CPRS. The administrative eligibility review

involves verifying the community care administrative eligibility and enrollment status of the traveling or permanently relocating Veteran for VHA care.

(3) Performing a clinical review of the community care referral, with input from the Traveling Veteran Coordinator (TVC), upon receipt of a community care referral in CPRS. The initial clinical review will be performed by the delegated approving official on the Delegation of Authority Medical Services (DOAMS) List. If the ordering provider who enters the consult is also the delegated approving official, the review requirement is met, and a subsequent clinical review is not needed to authorize the service for community care. **NOTE:** *If the provider entering the consult is also listed as the delegated authority to approve the ordered care, the clinical review requirement is met, and subsequent review is not needed to authorize a referral into the community. Similarly, consults entered by specialty services or reviewed by a Referral Coordination Team (RCT) are considered to have met the clinical review requirement. The RCT members do not need to be listed on the DOAMS list as it is presumed that a clinical member of the RCT is reviewing the community care consult for clinical appropriateness, prior to routing to the facility community care office.*

(a) If the service requiring clinical review does not have a clinical reviewer delegated to it on the DOAMS List, the Chief of Staff or other designee will review these services for clinical appropriateness. As a best practice, a second level review of consult denials may be performed by a Licensed Independent Practitioner or other designee as delegated by the Chief of Staff and as available.

(b) Consult reviews must be completed within the final decision documented on the consult in the following timeframes:

1. Stat/urgent: Must be reviewed and a decision documented on the consult within 24 hours. A Stat consult requires direct communication between the ordering provider, the approving official and facility community care office staff (if necessary) to expedite the delivery of care.

2. Routine: Must be reviewed and a decision documented on the consult within three (3) business days.

(4) Alerting appropriate community care team member(s) to enter the process referral in HSRM and schedule the appointment for the traveling Veteran. The authorized service(s) must be arranged in a timely manner utilizing established procedures and care will be provided near the Veteran's extended travel location. The subsequent claims for services rendered are the responsibility of the alternate facility.

(5) Communicate the status, approval, and/or denial of the community care referrals submitted for traveling Veterans to the Designated TVC Provider at the A-VAMF and document this communication through a view alert on the consult or a care coordination plan note.

b. **Examples of Planned vs Unplanned Care**

(1) <u>Planned Episode of Care</u>. A planned episode of care is a request for care directed by the Preferred VA Medical Facility (P-VAMF) provider to be delivered by an Alternate VA Medical facility (A-VAMF). Care is initiated and coordinated via the Traveling/Relocating Veteran Consult process. This information can be reviewed on the "VHA Traveling and Permanently Relocating Veteran Consult Process: Planned Episode of Care Flow Map" on the TVC SharePoint site at: <u>Seamless Care for Traveling Veterans - Home (sharepoint.com)</u>

(a) Can care be initiated and delivered via Community Care within timeframe Veteran is traveling? A-VAMF TVC is monitoring for scheduling of care in the community.

<u>1.</u> If **Yes:** Care delivered in the Community.

<u>2.</u> If **No:** A-VAMF TVC communicates back to the P-VAMF Provider and P-VAMF TVC via Significant Findings on the Traveling/Relocating Veteran Inter-facility Consult the need to care coordinate at the P-VAMF.

(b) Can **entire** episode of care be delivered via Community Care within timeframe Veteran is traveling? A-VAMF TVC is monitoring for scheduling of care in the community.

<u>1.</u> If **Yes:** Care delivered in the Community.

<u>2.</u> If **No:** A-VAMF Community Care staff communicates to A-VAMF TVC the inability to complete the entire episode of care for the traveling Veteran in the Community, and documents in the EHR. A-VAMF TVC communicates back to the P-VAMF Provider and P-VAMF TVC via Significant Findings on the Traveling/Relocating Veteran Interfacility Consult the need to care coordinate at the P-VAMF.

(2) <u>Unplanned Episode of Care</u>. An unplanned episode of care is when a Veteran presents to the A-VAMF requesting care not previously coordinated by the P-VAMF (i.e., new care need, unresolved care conditions, etc.). This information can be reviewed on the "VHA Traveling and Permanently Relocating Veteran Consult Process: Planned Episode of Care Flow Map" on the TVC SharePoint site at: <u>Seamless Care for Traveling Veterans - Home (sharepoint.com)</u>

(a) Is the Traveling Veteran returning to the P-VAMF area and require additional care coordination by the P-VAMF?

<u>1.</u> If **Yes:** Community Care Provider within the A-VAMF, or designee, places a TVC consult to include details related to Veteran's care needs to be delivered at the P-VAMF. A-VAMF TVC follows TVC consult process for care coordination to the P-VAMF.

<u>2.</u> If **No:** Episode of care ends. Veteran follows up with Preferred Facility Provider if necessary.

(3) <u>Unplanned Episode of Care Requested by Community Provider</u>. This is when a Community Provider requests authorization from the A-VAMF, not previously coordinated by the P-VAMF (i.e., urgent and emergent episodes of care, discharge care needs, outpatient care, etc.). This information can be reviewed on the <u>Community</u>

Care Flow map for Traveling or Permanently Relocating Veterans: Unplanned Episode of Care Requested by Community Provider.

(a)   Does the Veteran require additional care (Request for Services) to be completed from this unplanned episode of care within the A-VAMF and/or Community?

1.   If **Yes:** Community Care Provider at the A-VAMF, or designee, places orders according to local Community Care process.

2.   If **No:** Episode of care ends. For traveling Veterans, follow-up with Preferred Facility Provider if necessary. For permanently relocating Veterans, follow local PACT assignment process.

(b)   Is the traveling Veteran returning to the P-VAMF area and require additional care coordination by the P-VAMF?

1.   If **Yes:** Community Care Provider within the A-VAMF, or designee, places a TVC consult to include details related to Veteran's care needs to be delivered at the P-VAMF. A-VAMF TVC follows TVC consult process for care coordination to the P-VAMF.

2.   If **No:** Episode of care ends. Veteran follows up with P-VAMF Provider, if necessary.

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
Community Care – Strong Practices

Strong Practices	1.0	**Referral Coordination Initiative (RCI)**
	1.1	**Unscheduled Community Care Consults**
	1.2	**Improving Community Care Scheduling Timeliness**
	1.3	**Community Care Self-Scheduling**
	1.4	**Request for Services (RFS) Processes**
	1.5	**Health Share Referral Manager (HSRM)**
	1.6	**HSRM Community Provider Sign Up**
	1.7	**Consult Closure**
	1.8	**Natural Disasters Community Care Contingency Plans**
	1.9	**Maximizing Appropriate Use of Emergency Departments in the Community**

The Office of Community Care (OCC) recognizes that all stations have unique circumstances; i.e., different levels of community care staffing, network adequacy levels and provider engagement, varying levels of implementation of OCC/Access Office required programs, the Referral Care Initiative (RCI), and varying natural disasters & COVID-related obstacles to care. This chapter focuses on "Strong Practices" that compliment current OCC guidance, which have been implemented by several stations and may be useful to others in similar situations.

Note: If your facility has strong practices that can benefit others, please submit to your OCC Field Assistant *for review with the: need/challenge, a breakdown of the process implemented, why this is a "strong practice", and any resources/references/supporting data.*

1.0 Referral Coordination Initiative (RCI)

The Veterans Health Administration (VHA) has been closely monitoring MISSION Act implementation to ensure we meet legislative requirements while operating in the best interest of the Veterans we serve. We identified an opportunity to streamline the referral and consult management process by ensuring timely care delivery and helping Veterans make more informed decisions about where to receive their health care. VHA is implementing Referral Coordination Teams (RCTs) at each facility that will be responsible for identifying community care eligibility and having a meaningful discussion with Veterans about care modalities both within the VHA and in the community to help Veterans make an informed decision. The informed Veteran will become an advocate for their health care with the guidance from the VHA. By streamlining the referral and consult management process and implementing RCTs, VHA expects to:

- Ensure specialty care trained RCTs or providers have an opportunity to review Veteran specialty care referrals and make recommendations for appropriate care options prior to scheduling appointments either in the community or in the VHA.
- Improve timeliness of scheduling both VHA and Community Care referrals by removing non-value-added steps for consult review and scheduling.
- Ensure informed Veterans receive care at the right time with the appropriate care team.
- Streamline the Community Care scheduling process.
- Clarify roles and responsibilities throughout the referral coordination process.
- Decrease inconsistent and inappropriate Best Medical Interest (BMI) usage that doesn't include fully informing the Veteran of all the potential care options.
- Maximize the interaction between the informed Veteran, RCT, and providers
- Improve Veteran satisfaction.

Please see the VHA Referral Coordination Initiative SharePoint for more information on RCI & Promising Practices.

1.1 Unscheduled Community Care Consults

Please see Field Guidebook Chapter 3 for Care Coordination, Chapter 6 Section 6A for guidance on utilization of the CTB Appointment Tracking Tab, 6.18 for more information on the OCC Unscheduled Consult initiative & Chapter 4 Section 4.4 for Network Adequacy Discussions with the TPA as needed.

VISN-Level Guidance for Working on Unscheduled Consults

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?"	Resources / References
VISN 23 identified need for assisting and reporting for stations with aging / unscheduled consults.	Accountability report sent to stations for top 5 unscheduled.	VISN-level overview and accountability of unscheduled / aging consults allows for visibility and development on all levels.	VSSC/Pyramid Consult Cube Open Consult Report

Common Communication

Common Communication
  1) BIM - Identify highest hit Categories of Care (COC).
     a. Communicate Number of Unscheduled Consults for each.
     b. Add Column identifying percentage allocated (Percent of All Unscheduled).
  2) Accountability – send this list of COC to those leaders in the station for action.
     a. Action – Leadership at station must be prepared to speak to what their current ability is to schedule in the community for each COC.
     b. Follow-up on all actionable items.

Example:
I'll be asking on the huddle today about the services below for some reporting up to national we need to do. These are our top 5 services of unscheduled consults. Please be prepared to speak to what your current ability to schedule in the community is for each of these.

Service	Unscheduled Consults	Percent of All Unscheduled
Optometry	999	8%

Chiro/Acupuncture	830	7%
Orthopedics	803	7%
Dental	688	6%
Colonoscopy	535	4%
	3855	**32%**

Options for Site Leadership to accomplish Scheduling Triage
First in First Out
Focusing on the consults greater than 30 days and provide a list for each team to focus.
- The red highlights are 90 days and older
- The yellow indicates have not been touched greater than 30 days.
Future State: Focusing on consults greater than 21 days.

Process
- Pull report from Pyramid Analytics or VSSC
- Build spreadsheet to template

Consult great than
30 days as of EnterD

- Main columns to review and highlight consults:
  - Elapsed Days from File Entry Date - Greater than 90 days highlighted in red
  - Days Since Last Activity - Greater than 30 since last touch highlighted in yellow
- These consults should be your primary top ones to request records on
- Close the loop by assuring veterans are attending the appointments by requesting the records.
Success has been identified with staff getting access to Regional Health which is a big portion of record gathering needs. This expedites records request and verifying appts.

Communication to Staff Example
Focusing on the consults greater than 30 days and provide a list for each team to focus.
- The **red highlights are 90 days and older**
- The **yellow indicates have not been touched greater than 30 days**.
The scheduled greater than 90 went down but not touched greater than 30 has went up so please make sure you are doing your record request.
KUDOS to all teams for making greens.
Team 1 Prior Week:
- Total Active 62
- Red-3
Employee Team:
- Total Active -46

- Red-4
- Yellow- 0 (Focus on these)

Team 2 Prior Week:

- Total Active-21
- Red-0

Total active summary greater than 30 days old: ADD TOTAL

Total active summary greater than 30 days old from previous report: 2 ADD TOTAL

Medical Record Request Summary:

- Total from last week: **ADD TOTAL**
- Total for this week: **ADD TOTAL**
- Greater than 90 days old: **ADD TOTAL** (Highlighted in red) decrease from **ADD TOTAL**
- Greater than 30 days from last touch: **ADD TOTAL** decreased from **ADD TOTAL** ***Have not been touched for greater than 30 days)

AudioCARE

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?	Resources / References
Omaha VA identified wasted man hours due to dead calls. (ex…3-4 minutes per employee per call wasted when Veterans don't answer, and staff must leave a voicemail)	Use of AudioCare to use batching for follow up contact calls.	This increases employee activity by allowing more focus on "new" consults, care coordination, vendor follow-up's, and scanning.	(b)(6) @audiocare.com AudioCare SOW AudioCARE Script VISN 23 AudioCare

PROCEDURES

General Considerations:

- AudioCARE is a fully-automated scheduling solution. That helps reduce costs, improve productivity, and empower health care staff to deliver and rely on communications that have a direct impact on delivery of care.
- AudioCARE provides tailored communications that can be customized to your site and communication needs.
- Omaha VA decided to use AudioCARE for follow up calls instead of first calls. This was because they wanted to be able to provide Veteran centric customer service.
- If more than 1 unit at your facility is using AudioCARE calling, you must work with them to not run your AudioCARE calls at the same time.

Set up Steps:

1. Reach out to (b)(6) @audiocare.com to get a meeting set up and access information.
2. Ensure Reflection FTP Client and Reflection Workspace are downloaded on VA computers.
   -This is found under Micro Focus Reflection folder, under the Start Menu.

PROCEDURES

3. Fill out your station script and email to your AudioCARE contact that you received at your initial meeting.
4. Work with local IT to get AudioCARE the que trigger.
    -This allows AudioCARE program to transfer calls directly into the Care in the Community customer service line que.

Preparations for AudioCARE:

- Data is pulled from MCAA first thing in the morning.
- Data is reviewed for which consults that will be sent out, those not being sent out are deleted from the report.
    - C1C, C2C, C3C, etc...
    - Untouched Active consults for staff that are out for extended period or called out sick for the day.
- Remove all data except the following information:
    - Column A: Veteran Name
    - Column B: Blank or can be SSN (Omaha decided not to use SSN)
    - Column C: Phone Number
    - Column D: Date of Birth
- Save the file is a Text.tab (delaminated) format.
- Log into the Reflection Application (Reflection FTP Client)
- Drag and drop a copy of the file into the application.

Running and Loading the AudioCare Call:

- Log into Reflection Workspace and plug in data for the system to run.
    -Input Link to SOW
- After hitting run, the bot will take the text file and call each Veteran using an automatic calling system; like how VA sends reminder texts for appointments.
    - If Veteran wishes to schedule or has questions, they will be directed to CITC customer service line (call center).

If Veteran doesn't answer or the line is busy, they will show up on the Reflections report as: answering machine, busy, no answer, hang up, PV- no response, PV-PAT Not Available, etc..

Reporting in Reflections Workplace:

- While still in the system run the report to view the days data.
    - Input Link to SOW
- Identify if the report had any Veterans that had "errors."

PROCEDURES

- Fax tone, phone invalid, PV-wrong phone, phone switch and phone company
- Send these errors to staff to call Veterans for follow up or scheduling.
- Errors happen when the AudioCARE system was unable to dial Veteran.

• Wait about 20 minutes after the data set is run, so that staff can document and complete phone calls that might have come into the call ques. Then email the staff the Veterans names to document in CPRS.

- Staff will document using CTB, under unsuccessful attempts to schedule Veteran, if the Veteran consult was not worked during the AudioCARE run.

Omaha's Data

- Omaha launched AudioCARE calling in February of 2021
- That data below shows in just a short time the results

Omaha' was tracking the following data to review for review:

- Number of Consults/Calls going out
- Percentage that was answering
- Percentage that wanted a call back later
- Percentage of error's

Day Example:

Date	Total Consults	Answered Yes to A	Answered Yes to B	% No Answer	% That Answer	% Call Back Later	% Want to talk to CITC	Phone Switch/Company Error	% of Error	Total Transferred to CSL	% Transferred	Arrived at CSL	Lost in Transit	% on CSL	% Lost
6-May	98	38	10	51%	49%	10%	39%	0	0%	38	39%	37	1	38%	3%

Averages as of May 5.8.2021 for the previous 30 days:

Average

% No Answer	% That Answer	% Call Back Later	% Want to talk to CITC	% of Error	Total Transferred to CSL

PROCEDURES

| 68%	32%	5%	27%	1%	32

They also did a data review after just a few weeks and then again after just a few months and could see the positive effect:

They went from an average of 450 total active consults to 300 and an average of 2,500 total scheduled consults to 2,900.
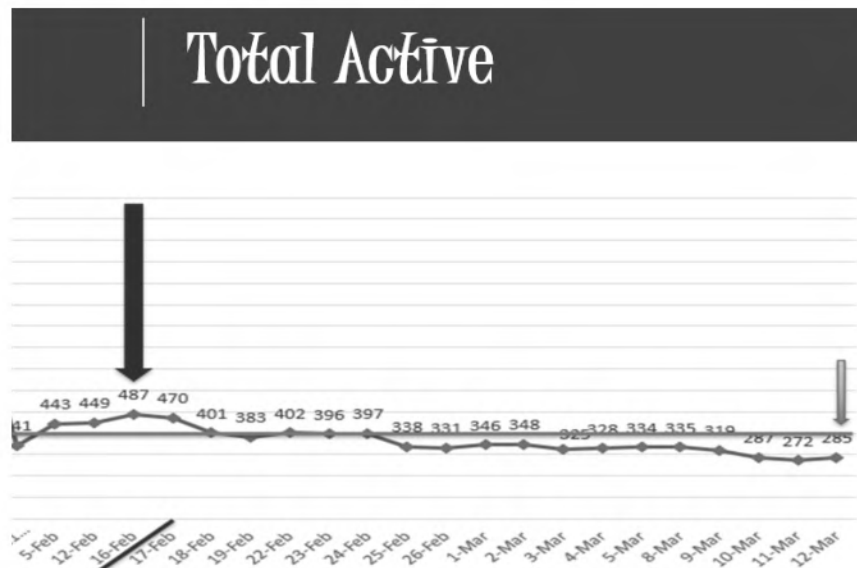
Just a few weeks…

Just a few months…

PROCEDURES

ERN IOWA HEALTH CARE SYSTEM

Just a few weeks…

Total Scheduled

2,6... 2,837 2,901 2,940 2,915 2,891 2,925 2,949 2,972 2,973 2,973 2,882 2,889 2,874 2,898 2,906

52

Feb 16th

5-Feb 22-Feb 23-Feb 24-Feb 25-Feb 26-Feb 1-Mar 2-Mar 3-Mar 4-Mar 5-Mar 8-Mar 9-Mar 10-Mar 11-Mar 12-Mar

Just a few months…

PROCEDURES

5-Feb 5-Mar 5-Apr 19-Apr 20-Apr 21-Apr 22-Apr 23-Apr 26-Apr 27-Apr 28-Apr 29-Apr 30-Apr 3-May 4-May 5-May 6-May 7-May

Lesson's Learned

1. How many calls do you run at once?
   - Omaha typically ran between 40-100 calls at once, depending on staffing that are available to answer the CITC CSL. If there are not many staff available, they would run the calls in small batches, so they didn't overload the CITC CSL. When they first rolled out the CSL, they had to adjust daily to find the "right" number.

2. Which staff work the calls?
   - Omaha has both admin and clinical staff on the CITC CSL. Typically, all the calls go to the admin staff, but clinical staff are always on the CSL if a Veteran wishes to speak to one.

3. When do you run the AudioCARE calls?
   - Omaha runs the AudioCARE call's typically first thing in the morning. This is something they had to find the "right" time for. They had to make sure there were enough staff clocked in and when Veterans were more likely to answer. They found that more Veterans answered the phones in the morning around 8/830am and were more likely to answer on Mondays.

1.2 Improving Community Care Scheduling Timeliness

Monitoring referral management timeliness is essential to avoid delays in consult management resulting in extended wait times for Veterans to receive an appointment. Please see OCC Field Guidebook Chapter 6 Manager and Leads References, Section 6.4, How to Evaluate Referral Management Timeliness for more information.

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.

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?	Resources / References
Eastern Colorado Health Care System identified the need to provide even more satisfactory customer service and have utilized My HealtheVet to do so.	Assigned staff complete TMS modules, then are activated in the My HealtheVet admin portal. A Community Care Team has been created by their local Site Admin:	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	My HealtheVet Home My HealtheVet Promotion and Communication My HealtheVet: Secure Messaging (SM) Administrative User Manual.

	- Triage Group: Community Care - VISN: - Facility: - Add Community Care staff that would respond to messages. Veterans with Premium-Level My Health*e*Vet will see it as an option in their secure messaging. Community Care staff assigned to the group must respond to Veteran inquiries within three (3) business days.	for Veteran outreach, 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.	

Omaha Overhaul

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?	Resources / References
Omaha VA Identified the need for a complete overhaul of their Community Care Department due to the following: low morale, high employee turnover, large amounts of backlog for scanning, pending, active and scheduled consults, staff did not have measurable or attainable goals.	Rapid Process Improvement Event performed to gauge issues, create plans, set their own metrics and implement changes. Avg days from file entry to first scheduled: FY16 4th QTR: 26.5 FY21 1st QTR: 5.3	Omaha has built a functional Community Care department that schedules consults on average in less than 3 business days by fostering a positive and challenging work environment	Office of Community Care Field Guidebook Chapter 3. Omaha Station Review

PROCEDURES

Employee Morale, Turnover, Training & Workload:

Omaha identified that they had the below issues with their employees and worked to address:

- High turnover rate
- Low employee morale
- No employee training program
- Large amounts of overtime and comp time

PROCEDURES	
	• Administrative and Clinical staff not co-located
1	• Developed an Eight (8) week New Employee Orientation "Train the Trainer" program • Improved Communication • Implemented Bi-Weekly unit meetings • RN and MSA daily huddles with RN manager and Assistant Chief • Integrated admin and clinical staff to form teams and grouped teams together in work pods • Slowly eliminated overtime and comp time by eliminating the need
2	**Improved Employee Morale and decreased turnover by utilizing:** • Team Building • Team Walks • Potlucks • Outside of work get-togethers • Birthday Club • Bringing in food trucks • Volunteering together • Dress Up Days • Team Lunches • Team Trivia • Employee Association Events • Holiday Parties • Streamlining work while eliminating wasted time & rework • SUPPORTING EMPLOYEES
3	**Integration of Clinical and Administrative staff to form work teams.**

PROCEDURES

	Admin Staff MSA/PSA MSA/PSA MSA/PSA MSA/PSA MSA/PSA MSA/PSA MSA/PSA ■ Team ■ Pod
4	**Veteran-Centric approach: Teams broken out into Alpha Split as applicable.** **Workload: Clinical Staff** **Alpha Split** → Admin staff use the STT to process the following: Primary Care, Physical Therapy, Allergy, Aqua Therapy, Audiology, Colonoscopy, Direct Scheduling Consults, EEG, EMG, Endocrine, ENT, Lab, Mammogram, Maternity, Neurology, Nutrition, OT, Optometry, PT, Podiatry, Rheumatology, Sleep Med, Speech and Ultrasounds. RNs are assigned all other consult types by alpha, that are not process by admin staff with the STT. **Service Line** → • Emergency • LTAC • GEC • Dental • Dialysis

PROCEDURES

Line

•CNH
•IVF

Positives

Alpha Split

- Veteran centric
  - 1 person working all consults
  - 1 POC for veteran questions
  - Only called by 1 team in the department
- There is only 1 POC for internal staff about each veteran
- Ability to cover other teams/pods
- Easy way to split workload fairly
- MSA's have a standard workflow process because "specialized consults" are not on workflow
- RN can do patient-centered care coordination and management
- Improved transitional care case managing and healthcare outcomes
- If Veteran has more than 1 consult, MSA works all consult during 1 phone call

Service Line/Consult Type

- Only 1 POC's for vendors
- Knowledge of needs/care coordination
- Only has adapt to their service line changes
- Process expert for questions

PROCEDURES

	Type	• Unable to provide quality patient-centered care management • Transitional care not directed to a particular team/Veterans may get bounced around or lost
5		**Q. What is that MSA ratio compared to the RN?** **A.** *2 MSA to 1 RN or 3 MSA to 1 RN. Some alpha splits have larger consult volume.* **Q. Are staff currently teleworking during COVID?** **A.** *We currently have 50% of our staff teleworking. We are looking into how to continue due to efficiency and using it as an incentive to maintain staff. We do see a lot of IT issues with teleworking and are looking how to overcome this.*
		Calls are also rolled to ensure that Veterans and community providers are not sent to Voicemail. **Q. Is everyone on the customer service line (Call Center)?** **A.** *All MSA's and RNs are on the CSL from start of shift until 30 mins before the end of their shift. Veterans can choose to speak to admin or clinical in the call tree. Typically, vendors have RFS questions.*
		Results: • Employee turnover reduced from 37% to 3% prior to COVID, increased to 9% (COVID) • Improved employee morale • Improved Veteran satisfaction • Improved team communication and care coordination • Reduced overtime to from $113,974 in FY 17 to $37,376 in FY20: which was strictly for special projects, not backlog • Reduced comp time from 181 hours in FY16 to 0 hours in FY20: which allows more staff in office, during normal duty hours

PROCEDURES

Goals, Standards and Metrics:

- Omaha created their own metrics that were greater than national metrics
- These standards are measurable, and goals attainable
- This was not to stray from national guidance, but to encourage excellence
- Site averages 210 consults received per business day
- As of 04/2021 the Scheduling Average from File Entry Date to is 3.1 days

1 **Pending**
National Metric: Pending ≤ 7
Unit Metric: ≤ 1 day
  - Unit Metric <100 consult total
  - Unit shift in thinking to real time scheduling
  - RN and Screening Triage Team completes clinical review same day as receipt or within 1 business day
  - CCP note is placed for complex consults and/or as needed

Active
National Metric: Active ≤ 30 days
Unit Metric: ≤ 1 day
  - Unit Metric <50 active alert consults
  - Goal is <20 active consults per 2 MSA team
  - Goal is <15 active consult per 3 MSA team
  - Alert consult are active consults that have not been touched by an admin staff member
  - Veteran receives call from VACC within 1 business day
  - Calling $\geq 75\%$ of Veterans same day-of alert to MSA by RN
  - Unit shift in thinking to real time scheduling
  - 3 calls every 5 days until consult is placed in cancelled status
  - Follow up with vendor schedules daily

Scheduled
National Metric: Scheduled ≤ 90 days
Unit Metric: Call within 1 week of appointment
  - Verified Veteran attended and 1st records request w/in 1 week of appointment

PROCEDURES		
	• Follow 10N1-23 Memo *"Clarification of Administrative Closure of Community Care Consults"* and complete additional record requests after consult closure **RFS** National Guidance: Review and respond within 3 business days • LMSA scan/document RFAS within 1 business day of receipt • RFS reviewed w/in 3 business days by RN • Urgent RFS same day with a warm hand off to RN **Scanning** National Metric: $\leq$5 days of receipt Unit Metric: $\leq$1 business day of receipt • MSA places ER CCP note same day of scanning • MSA documents any no-show notes same day of scanning	
2	**Maintained Changes and Reviewed Results:** Avg days from file entry to first active FY16 4th QTR: 17 days FY21 1st QTR: 1.3 days Avg days from file entry to first scheduled FY16 4th QTR: 26.5 days FY21 1st QTR: 5.3 days Avg days from first active to first scheduled FY16 4th QTR: 15.8 days FY21 1st QTR: 4 days Avg days from appointment to completed consult FY16 4th QTR: 61.9 days FY21 1st QTR: 7.3 days Avg days from first forwarded from to closed FY16 4th QTR: 151.3 days FY21 1st QTR: 18.2 days Avg days to schedule **Oct FY20**: 4.4 days and 99% consults scheduled w/in 30 days	

PROCEDURES	
	Avg days to schedule as of **April 2021**: 3.1 days and 100% consults scheduled w/in 30 days
3	**Meetings:** Omaha utilizes their meeting time wisely and is intentional about who attends what meetings and when.

- **National/VISN Meetings**
  - Weekly
    - Community Care Huddle ★
    - Consult PI Weekly Call ★
  - Monthly
    - PPMS Office Hours ✓
    - HSRM Office Hours ✓
    - DST/CTB Office Hours ✓
    - Network Adequacy with OPTUM ⟳
    - VISN 23 Clinical Collaboration Call/Clinical Network Manamgent ★
    - VISN 23 Community Care Committee ★
  - Quarterly
    - VISN 23 SVH Partnership Quarterly Call ⟳
    - State Veterans Home Partnership Quarterly Call ⟳

★	Leadership Only
✓	Assigned Staff and then they brief at Operational Meeting
👥	All Staff
📄	Admin Staff
⟳	Mixed Staff
🩺	Clinical Staff
✚	Ran by CITC Leadership
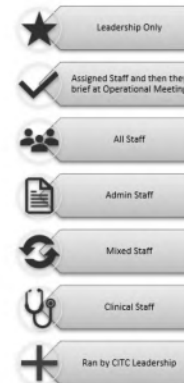
Service Line/Outreach

- When Requested ⟳
  - Vendor+
  - Other Clinic+
  - VFW+

- Weekly/Bi-Weekly
  - Clinical Leadership Supervisor Meeting ★
  - COS All Chiefs Meeting ★
  - Optum Touch Base ⟳

- Quarterly ✓
  - Veteran Service Officer+
  - Scheduling Auditor Open Form

- Monthly ✓
  - Women's Health CITC Meeting+
  - Women's Veteran Health Committee
  - Veterans Advisory Group
  - All Employee Forum
  - Employee Association
  - Patient Satisfaction Committee
  - MSA Supervisor Monthly Meeting
  - Scheduling a & Access Steering Committee
  - Pharmacy+
  - Compliance and Business Integrity Committee
  - Transition Team/Care Manager Forum
  - ADPAC+
  - Clinical RN Outreach+ 🩺
  - NWI Nurse Executive Leadership+

★	Leadership Only
✓	Assigned Staff and then they brief at Operational Meeting
👥	All Staff
📄	Admin Staff
⟳	Mixed Staff
🩺	Clinical Staff
✚	Ran by CITC Leadership
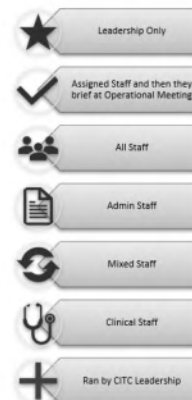
PROCEDURES

All Unit Quarterly+ 👥   ✚ [Ran by CITC Leadership]

– 1 hour meeting
– Topics: Emergency Manamgent drills, guest speakers
  (suicidal veterans, EEO, awards, events (like Fisher House,
  White Ribbon Campaign ect..)

Bi- Monthly Meeting+ 🩺 📄   ⭐ [Leadership Only]
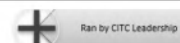
– 1 to 1.5 hours   ✔ [Assigned Staff and then they brief at Operational Meeting]
– Separate meetings for each scope of practice
  • Administrative, ADPAC, and Clinical   👥 [All Staff]
– Topics: job specific changes/trends, SOP review, AES review, concerns
  brought up by other leadership, LMSA's, hot topics   📄 [Admin Staff]

Morning Huddles+ 👥   🔄 [Mixed Staff]
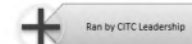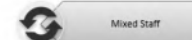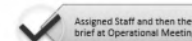
– Goal of 15 mins.
– Held opposite *All Unit Huddle*   🩺 [Clinical Staff]
– Helps with team awareness and helps determine who has ability to help
  team members   ✚ [Ran by CITC Leadership]
– Separate meetings for different teams
  • Transition's team, MSA (LMSA ran), LMSA and RN Pod's
– Topics: coverage for the day, staff leaving early, review of open consult
  reports (Pending/Active), hot topics from emails.

Operational (OPS) + 🔄   ⭐ [Leadership Only]

• Every Friday   ✔ [Assigned Staff and then they brief at Operational Meeting]
• 1.5-hour meeting
• Chief is Chair and Assistant Chief is Co-Chair   👥 [All Staff]
• Invited: All Care in the Community Managers, CITC Provider, ADPAC, LMSA's and assigned
  staff (varies based on agenda)   📄 [Admin Staff]
• Topics are on the following slides
• Meeting is used to make sure all key players on are on the same page each week, forecast   🔄 [Mixed Staff]
  staffing/projects, bring up issues and concerns and brainstorm action plans/discuss projects
                                                            🩺 [Clinical Staff]

                                                            ✚ [Ran by CITC Leadership]
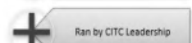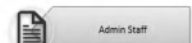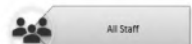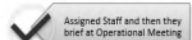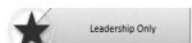
Operational Meeting Agenda

• **Congressional Due Outs**
  – Review of current items that need processed and if anything is
    needed to assist getting them done on time.

• **VISN Action Items**
  – Review of current items that need processed and if anything is
    needed to assist getting them done on time.

PROCEDURES

- **PATS-R's**
  - Review of current items that need processed and if anything is needed to assist getting them done on time.
- **Old Business**
  - Anything from last meeting that had due-outs.
- **IT Tickets/System Issues**
  - Review of current issues and efforts to get them fixed.
- **Staffing**
  - Review of staffing efforts, barriers, current staff training and their end dates, etc.
- **Admin Updates**
  - Anything going on with the RN's, pilots, training, issues, etc.
- **GEC Updates**
  - Anything going on with the RN's, pilots, training, issues, etc.
- **RN Updates**
  - Anything going on with the RN's, pilots, training, issues, etc.
- **CITC Med Director Updates**
  - Anything that is "need to know".
  - Examples: patient safety concerns, provider complaints/issues from internal, trends, expected increases in consults due to providers out of office, ect...
- **Department Metric's Trends**
  - Omaha reviews the following metrics and if there is a large variance in data, discussions revolve around reasons and an action plan to get data back on track:
    - Pending >1
    - Active >30
    - Active Alerts >1
    - Total Active
    - Scheduled >90
    - Total Scheduled
- **Network**
  - Talk about issues, new vendors added, or trends noticed.
- **New Items**
  - New items discussed are hot topics, current project, or brainstorming to resolve problems. The Friday before the Oversight Council Meeting, they discuss agenda, slides, and person responsible.

PROCEDURES

- **Around the Room**
    - Anyone can bring up anything they want.

Examples: updates on something, talk about projects that were not mentioned etc.

PROCEDURES

Scanning Backlog:

- Unscanned medical documents measured in the thousands and inches
- Backlog was reduced and incoming medical documents are now scanned within 1 business day

STEP	
1	• Eliminated paper mail/faxes decreases receipt of duplicate medical documents • DocManager improves efficiency of staff and is faster than scanning using Vista Imaging
2	
3	
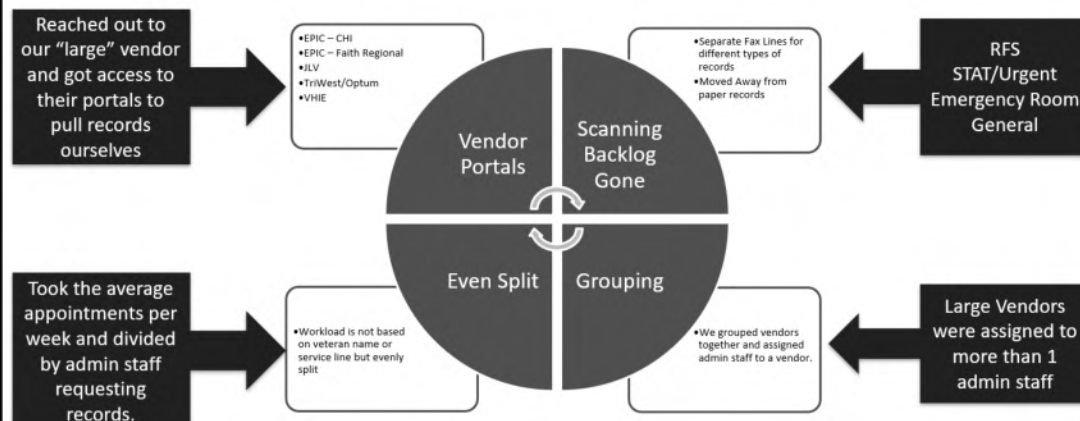
PROCEDURES
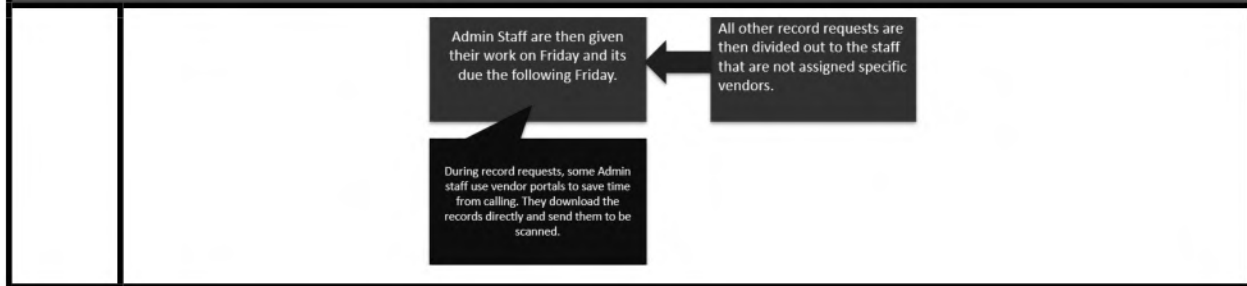
PROCEDURES

EPIC

Site has obtained access to Epic to withdraw medical documents from the system for large health networks.

Q. Who did you contact at the large vendors to get access to EPIC?
A. We contacted their business office and ending up with their HIMS department. We also, checked with OIT/ISSO's, Compliance, and Privacy Office to get approval on the VA side.

Q. Do you find Vendors still send paper records even with the EPIC access?
    A. We no longer accept paper records in the mail.

PROCEDURES

Real Time Scheduling:
- Real Time Scheduling is the process of competing consults as they are placed.
- Real Time scheduling has the goal of little to no backlog.

Input-Output Analysis of Economics:
"The analytical phase of input-output work has been built on a foundation of two piers. The first pier is a set of accounting equations, one for each industry . The first of these equations says that the total output of the first industry is equal to the sum of the separate amounts sold by the first industry to the other industries; the second equation says the same thing for the second industry; and so on. Thus, the equation for any industry says that its total output is equal to the sum of all the entries in that industry's row in the input-output." John Hopkins University

	PROCEDURES
	What comes in, must go out!
1	**Create a Daily Standard for assigning workload:** $($ Consults $+$ RFS $) \div$ Staff $=$ Daily Standard
2	**Hold staff to the Daily Standard:** • If a staff member is out, missed workload is added to the standard For example: If the standard is 16 consults per business day and an RN was out 1 day, the RN for the next 5 business days needs to complete 19-20 consults per day to make up the work, reduce backlog, and move to real time again • Team members assist each other when other staff are out • Teams and Employee Pods assist when able to do so
3	**Why is Real Time Scheduling important?** – Veterans get their care faster – Veterans are happier – Decrease in Veteran Complaints – Employees are less stressed – If you do not work Real Time, you will always have a backlog. – Realtime eliminates 98% of backlog – Improve station metric's
4	**Why does Real Time Scheduling Work?** – Veterans are expecting a call after seeing internal provider – It decreases backlog – Improves employee and veteran experience – A higher number of Veterans typically do not answer the call after 5 business days from leaving the internal providers' office
5	**What if a backlog occurs?** If a backlog occurs, it is processed using the 2:1 method • 2 new consults, then 1 old consult • "Squeezing" the work like a sandwich (Sandwich effect) • This method was used to reduce Omaha's pervious backlog

PROCEDURES	

6	**Results:** • Improved Veteran satisfaction • Consult management focuses on moving pending consults • MSAs actively worked same day for real time scheduling • Total pending and active consults decreased over time • Pending and active consult backlogs eliminated • Decreased phone tag with Veterans • Decreased congressional scheduling complaints

7	**How does Omaha handle Vendors that require records before scheduling?**
	   – Call frequently
	     • The requirement is at least every 5 days, but most staff call daily
	   – Avoid using these vendors as often as possible
	   – Send the Veteran HSRM letter and add team contact information to each letter
	   – Omaha gives the Veteran the vendors phone number, so they can follow up too
	     • Omaha informs Veteran an appointment needs to be made in 14 days. If the vendor doesn't schedule, we may need to find a new vendor
	   – Use CTB blurbs to follow up
	     • PRQ: Vendor requires records before scheduling
	     • FUV: Vendor Follow Up
	
	   – Use in-house blurbs to follow up
	     • PRQ: Vendor informed of 14-day policy
	     • UTS: Unable to Schedule
	
	 Responses from Staff:
	 • *"I send the records and call every day until I have appointment letting them know I need a date within 14 days."* Christine A. MSA
	
	 • *"I call the provider the day after I send records to check to see if recs have been received and to see if veteran has been scheduled, I call every day after to check as well, I always check Epic first depending on the provider."* Stephen W. MSA

PROCEDURES

- *"I usually send all the records over and depending on who the vendor is I will either call back later on in the day and ask to schedule it or call the following day to get it scheduled. I'm inpatient and don't like waiting so I usually don't let it sit there for very long before following up."* (b)(6) *MSA*

- *"I try to follow up the next day or even the same day depending on the vendor. If the vendor says they have called the Veteran and was unable to get a hold of them, I ask if its ok to try a 3-way call with the Veteran; to see if they will answer to get scheduled. In cases where the vendor does not answer, I will also call the Veteran to see if the vendor has contacted them for scheduling."* (b)(6) *LMSA*

- *"I call the provider the day after the documents have been sent to see if the Veteran has been scheduled and records been received, and I continue to call vendor until Veteran is scheduled. If I'm not slammed busy, I call daily."* (b)(6) *LMSA*

- *"FUV radio button in CPRS CTB and document if and appt has not been scheduled - I confirm that the packet has been received and let them know that I will follow up in a couple of days. I check EPIC before calling to save some time."* (b)(6) *LMSA*

- *"I call the vendor the day after to follow up that they have received the packet and whether the Veteran was able to get scheduled. I also check in EPIC for those vendors that are in EPIC i.e.- GPH, UNMC. etc. before I call the vendor. If Veteran had not been scheduled yet after making the initial f/up call day after, I call every day until Veteran is scheduled along with checking EPIC."* (b)(6) *MSA*

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Clinical Care Coordination of Diagnostic Radiology Consults

Identified Need/Challenge	Process Implemented	Why is this a "strong practice?	Resources/References
Northern California VAMC facility identified need for more support for their diagnostic radiology consults.	Clinical Care Coordination of diagnostic radiology consults.	VANCHCS has succeeded in bringing the average file entry date to appointment scheduled metric from 145 days to 12 days for radiology consults.	TMS course VA 4550594 Creating a Community Care Imaging Consult. Field Guidebook Special Programs Chapter, Section 1.6 Radiology.

PROCEDURES

- **Clinical review & editing of consults.**
- **Coordinating Care & Scheduling.**
- **Tracking consults & Requesting Records**

ACTIVITY

1. 1.RN/LVN reviews diagnostic radiology consult for MD/NP/PA signature, Opt-in to community care, and MISSION Act eligibilities, correct non-generic ICD-10 code, and correct imaging orders (with or without contrast, etc.).
2. Cancels consults with missing information and adds (examples):
   a. Correct non-generic ICD-10 code.
   b. Is this test to be completed with or without contrast?
   c. Most recent eGFR & creatinine labs for those tests requiring contrast(within the last 30 days).

PROCEDURES

      d. Correct order wording. Example: an order for an "upper extremity MRI" might be conferred with the ordering provider and the wording changed to "right shoulder arthrogram with contrast."

3. If the Veteran requires labs for the test and the labs have not been ordered, RN will enter the order and hold for provider signature. If the labs have been ordered and the Veteran has not had them drawn, RN will have the conversation with the Veteran to get the labs drawn so the outside provider can review prior to scheduling, and to please call and let the community care RN/LVN know when the labs are completed.

4. Once order is completed and signed, RN/LVN will:
   a. Receive the consult utilizing the consult toolbox and process in the Field Guidebook Chapter 3. Adds SEOC and sends referral to HSRM.
   b. Calls Veteran and documents conversation & adds Veterans preferred provider into the consult via the consult toolbox. (Utilizes PPMS to ensure provider is in network).
   c. Complete the Care Coordination Note if applicable.

5. RN/LVN then creates REFDOC with order, consult and labs.
6. Faxes the offline referral form, REFDOC packet, and any images related to the consult to the community provider.
7. RN/LVN calls the Veteran to inform them that the imaging is approved, ensure they have the provider information, and to call once they have an appointment.
   a. Staff will also routinely check in with local providers to see if there are any barriers to scheduling, if Veterans have been scheduled and the information has not been relayed, or if anything is needed for any unscheduled referrals they have.
8. Once appointment information is received, RN/LVN completes a warm hand-off with the administrative staff who enters appointment information into HSRM, VSE & CPRS and finalizes the authorization.

Prior to starting this process (January 2020) with the backlog and COVID, scheduling diagnostic radiology was around 145 days. With this new process (started October 2020), scheduling diagnostic radiology takes on average 12 days.

9. After appointment date, RN/LVN/MSA/PSA calls provider's office to request faxed report and images on a disc and will fax three requests for records on three separate days to providers office to assist with obtaining the records.

PROCEDURES
10. Facility community care and radiology department are working together to continue support for retrieving diagnostic radiology reports and imaging discs in a timely manner.

1.3 Community Care Self-Scheduling

To maintain Veteran-centric care and allow Veterans to be active participants in their own care delivery, the Office of Community Care (OCC) 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. And the OCC Field Guidebook Chapter 3 *How to Perform Care Coordination*, Section 3.16, *Community Care Veteran Self-Scheduling Process.*

Veteran Self-Scheduling and Appointment Documentation:

Identified Need/Challenge	Process Implemented	Why is this a "strong practice?"	Resources/ References
Cheyenne VAMC facility community care office identified community care usage continually	Local SOP created for staff to gather scheduling preferences,	Educating Veterans and eliminating Veteran community care scheduling from VA empowers Veteran	OCC Field Guidebook chapter 3, section 3.16. OCC Veteran Self-Scheduling SOP

| increasing and outpacing staffing levels, combined with lack of consistent and documented practices and a gap in Veteran knowledge on community care. | create, and send referral packets, and close consult. Veterans are provided with information needed to make their own appointments. | responsibility and engagement in their care, while also freeing up FTE resources which can be used for other administrative tasks, creating fewer mistakes, and shortening scheduling times. | Self Scheduling Report Use of the Consult Tracking Manager (VISN specific). Scheduling letters printed to off-site HIPPA-compliant location (time not needed for folding). |

PROCEDURES

General Considerations:
- In the Veteran self-scheduling (VSS) process, the VA provides administrative support so that Veterans and community providers can work together to schedule appointments. The VA does not schedule community provider appointments, unless scheduling assistance is determined to be necessary by a RN or a Supervisor.

STEP	
1	*After a Community Care consult is received and approved by a RN…* Contact the Veteran and opt them in by confirming their eligibility information, collecting their scheduling preferences, and finding a suitable community provider. ▪ The Veteran will receive two (2) phone calls (3 if consults if for Mental Health services) and an Opt-In no contact letter that expires in 14 days. ▪ Mental Health consults receive three phone calls and an Opt-in no contact letter that expires in 14 days. ▪ Once a no contact letter has expired, the consult is referred to a RN to be reviewed / cancelled.
2	*Immediately after opting the Veteran in…* Create a REFDOC packet; the REFDOC includes scheduling information, clinical notes, and consult information. Upload the REFDOC to the HSRM referral.

PROCEDURES	
	Add the community provider's details and the program authority to the HSRM referral. Send the REFDOC, offline referral form and HSRM information sheet to the community provider, via fax/HSRM. Create a Community Care Scheduling Letter in CPRS for the Veteran. The Scheduling Letter includes scheduling instructions, community provider information, and the VA referral number from HSRM. The Veteran and the community provider have 21 days from the opt-in date to relay appointment information back to the VA.
3	*Once appointment details are received by the VA…* Add the appointment information to the HSRM referral - This finalizes the authorization so that TriWest can pay for the services in the SEOC. - Document the HSRM referral number on the original consult, so that non-Community Care VA staff can refer to it. - Schedule the appointment in VSE or CTM, linking the consult to the appointment (if an appointment is not already scheduled and/or the consult is not already linked).
4	*21 days after sending the appointing letter, if no appointment details have been received…* Refer the consult to a RN if an appointment cannot be confirmed. - The RN will either cancel the consult or ask for more attempts to schedule an appointment. - If the consult is cancelled, fax the community provider a memo stating that the referral has been cancelled and is no longer valid.
5	*After the Veteran's initial appointment date has passed…* Contact the community provider to determine if the Veteran attended their appointment and, if they did attend the appointment, request that copies of the visit notes be faxed to the VA community care office. - Three attempts to request records are required. - Records can be located in JLV; look there before making any record requests by phone or fax.

PROCEDURES	
	- Refer the consult to a RN if you cannot confirm that the Veteran attended an appointment and you have exhausted the required attempts to request records. - The RN will either administratively close the consult or ask for more attempts to request records.
6	*If a Veteran no-shows or cancels a community appointment…* - Send the Veteran a no-show letter, giving them an additional 14 days to make their appointment. - After a combination of 2 no-shows and/or patient cancellations, refer the consult to a RN for review / discontinuation.
7	*If records are received by VA…* - Upload the records in VistA Imaging, attaching the records to the original Community Care consult. - This will close the Community Care consult if it is not already closed.
	. Phone Queue Process - If receiving confirmation that the Veteran <u>scheduled</u> their appointment: - Add the appointment date to the HSRM referral. - Schedule the consult in CTM/VSE as needed. - Document the referral # on the consult. - If receiving confirmation that the Veteran <u>attended</u> their appointment: - Verify whether VA received medical records for the Veteran's visits. - Request that the community provider fax us records if none have been received. - If receiving notification that the Veteran <u>no-showed or cancelled</u> their appointment: - Cancel the appointment in HSRM. - No-show or cancel the appointment in CTM/VSE - If this is the first no-show or patient cancellation, send the Veteran a no-show note (through CRPS), giving them an additional 14 days to schedule their appointment.

PROCEDURES	
	- Update the consult status with the expiration date of the no-show letter **Note: If this is the second no-show or patient cancellation, refer the consult to a RN for review / discontinuation.** - If the community provider states that they did not receive a copy of the VA referral… **Note: If this is the second time the provider states that they have not received a copy of the referral, do not resend the referral; a new provider will be chosen and the opt in process starts over.** - Resend the referral to the community provider. - Send a new appointing letter to the Veteran, giving them an additional 14 days to schedule their appointment. - Update the consult's CTB comment with the new expiration date. - Billing Issues - Verify whether the Veteran's bill was for care that was authorized under a Community Care referral - Billing issues related to ER visits go the OCC ER referral team at 844-724-7842 - Billing issues related to care provided on a PC3 or CCN referral go to Third Party Administrator. - VA Billing issues and billing issues for care that was not authorized under a Community Care referral go to the Patient Advocate **Voicemails are checked at least 4 times per day: Start of day, mid-morning, mid-day, and end of day.**

1.4 Request for Services (RFS) Processes

Use of the RFS Form 10-10172 is encouraged 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.

Breakdown of RFS Process

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?"	Resources/References
Poplar Bluff VAMC identified need for direct guidance on which community care staff members complete which	Process for receiving and completing Request for Services (RFS Forms).	Poplar Bluff has implemented this process with clearly defined roles and responsibilities, to streamline	Request for Services (RFS) RFS and CPO Frequently Asked Questions (FAQ) Request for Additional Services (RFS) Letters (samples)

part of the RFS process and how.		their RFS process.	**Field Guidebook** Chapter 3, Section 3.42 Request for Services Chapter 3, Section 3.43 Request for Services and Management of Community Provider Request for Services.

PROCEDURES
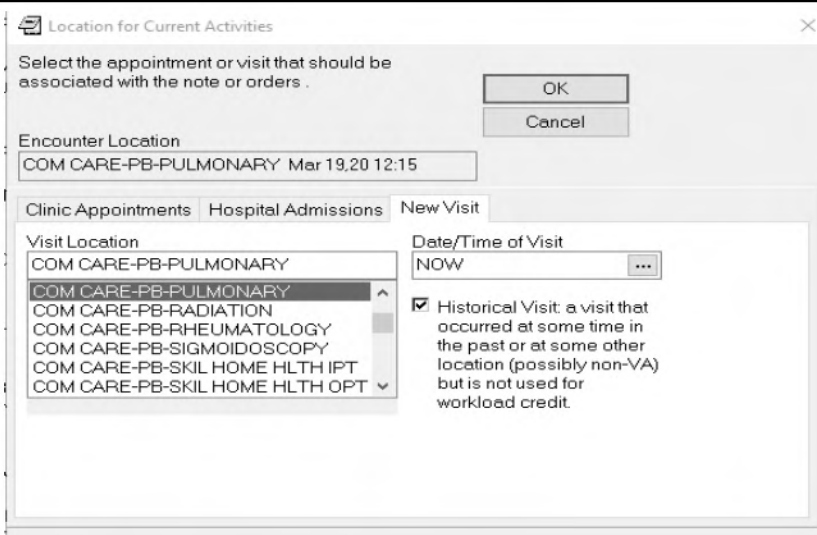
- **AMSA/PSA steps in RFS Process.**
- **RFS has been received.**
- **RFS received via Mail, Fax, E-Fax, HSRM or TriWest Portal.**

ACTIVITY
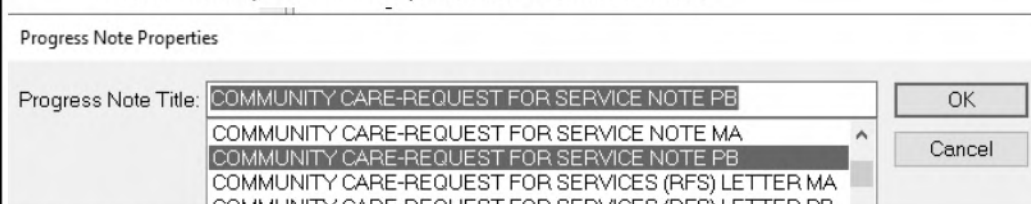
1. Review RFS for Physician Signature and attached medical documentation.
2. If this information is missing, follow local VAMC protocols for obtaining this information.
3. Open CPRS.
4. Open Vista Imaging Capture.
5. Locate Secondary Authorization Folder on W: Drive.
6. Select RFS or SAR to index.
7. Go to CPRS and pull up Veteran.
8. Go to Notes section.
9. Select New Note (from Action drop down).
10. New Visit.
11. Visit Location – (Com Care-Clinic Name)*

*Will depend on what is being requested. Usually it will be the service that sent in the request

PROCEDURES

12. Select Progress Note Title:

    Community Care-Request for Service Note

13. Click OK.

14. This will bring up a boiler plate template.

15. Review RFS/SAR to make appropriate selection:

    - DME/Prosthetics
    - Care Referral RFS Request

16. Enter all required Fields:

PROCEDURES

Make Date DME require: (Date requested by:)
ICD-10 Dx Code can reflect dx listed on the RFS

```
○ DME/Prosthetics RFS Request
◉ Care Referral RFS Request
  ☑ A Request for Service (RFS) form 10-10172 has been received which includes the
    following:
      Care Requested:*
      Patient need to have Pulmonary Function Testing Performed.        ⌃
      To be performed at (b)(6)                                          ⌄

      ICD-10 Dx code: *R09.89 R06.02 R07.9 I10 R42

      Date VA received request: *Mar 18,2020  ⋯

      Date DME required: *Mar 18,2020  ⋯

      Requesting Community Provider Information:
        Name of Ordering Provider: *(b)(6)
        Office:*(b)(6)
        Address, City, State:*
      (b)(6)

        Phone Number: *(b)(6)
  ☑ Signed RFS 10-10172 form is available for reference.
  ☐ Utilization Review:
  ☐ Order transposed into CPRS
```

17. Add RN for selected Service.
18. In Vista Imaging Capture:
    Select the Community Care-Request for Services Note
    Make Addendum
    Electronically Filed
19. Complete form.

PROCEDURES

    Image Desc – Will be

        RFS (Service Type) Date RFS Signed or received

20. Capture.

21. Refresh CPRS to ensure RFS is attached.

22. Follow local facility practice for RFS saving if any.

PROCEDURES

- **RN steps for the RFS Process.**
- **RFS has been received and AMSA/PSA steps have been completed.**

ACTIVITY

1. RN will get an additional signer alert in CPRS for Community Care-Request for Service Note PB (both the Primary RN and the backup).

2. RN will then review the RFS Note/RFS that is in VistA Imaging for any further action.

3. RN will make addendum to the Note and reload the boilerplate text.

4. RFS's require these actions be done:

    a) If **no action** is required (e.g. Adding CPT codes) then RN must have conversation with Community Provider office to explain (this should decrease the amount of RFSs we receive)

PROCEDURES

b) If a **new consult** is required (e.g. Continuation of care/extending time/referral to another specialty) then the RN will enter those consults in the Primary Care Providers name and hold for signature. RFS Letter is required to the requesting Community Provider to let them know what action has been taken.

c) For **services available at the VAMC** (e.g. Prosthetics, radiology, labs, cardiology, urology, GI) see the additional slides for internal consults. Will require an RFS Letter telling the requesting Community Provider what action has been taken on their requests.

5. Make addendum to note, reload boilerplate:

New Progress Note...	Shift+Ctrl+N
Make Addendum...	Shift+Ctrl+M
Add New Entry to Interdisciplinary Note	
Attach to Interdisciplinary Note	
Detach from Interdisciplinary Note	
Encounter	Shift+Ctrl+R
Change Title	Shift+Ctrl+C
Reload Boilerplate Text	
Add to Signature List	
Delete Progress Note...	Shift+Ctrl+D
Edit Progress Note...	Shift+Ctrl+E
Save without Signature	Shift+Ctrl+A
Sign Note Now...	Shift+Ctrl+G
Identify Additional Signers	

- Template:

Template: COMMUNITY CARE-REQUEST FOR SERVICE NOTE PB

DME/Prosthetics RFS Request
Care Referral RFS Request
Request Status: ...

PROCEDURES

- Request for Services Letter Template has been added to the Boilerplate, you must click OK to load the RFS Letter:

◉ Request Status: ...
    ◉ Service has been approved. ...
    ○ Service has been denied. ...
    ○ Service will be provided under VA Provider. ...

[OK]   [Cancel]

- Enter providers address also include the Fax Number so the letter may be faxed to the correct location

Template: COMMUNITY CARE-REQUEST FOR SERVICE NOTE PB

Request Status:

Provider/Address:

Veteran Information:

Patient Name:
Date of birth:

The *   has received the request

*   from you for services that were not
originally authorized in the Veterans Administration for this
Veteran. Upon review, the following determination has been made:
Service has been approved.

(Authorization #   )

Should you have questions, please contact us at *
                                    to
speak with a patient service
representative. As a reminder, if applicable, return medical records within 30
days for routine services.

PROCEDURES

- When you are done, you can hit OK and you may add free text to this template to address the requesting Community Providers' needs.

```
Request Status:

Provider/Address:
xxxx
xxxx
xxx
xxxxx
xxxxxxxxxxx


Veteran Information:

Patient Name:
Date of birth:

The xxxxxxx has received the request
xxxxxxx from you for services that were not
originally authorized in the Veterans Administration for this
Veteran. Upon review, the following determination has been made:
Service has been approved.

(Authorization #xxxxxxxxxx)

Should you have questions, please contact us at xxxxxxxxxxxx to
speak with a patient service
representative. As a reminder, if applicable, return medical records within 30
days for routine services.
```

1.5 Health Share Referral Manager (HSRM)

Health Share Referral Manager is the VA system for processing community care referrals and authorizations. HSRM facilitates Veteran access to community care, enables faster care administration/better care coordination. HSRM supports clinical and administrative processses for care coordination by:

- Consolidating multiple systems and generating reports.
- Utilizing Standard Episodes of Care (SEOCS) and providing Veterans with timely in-network community care referrals.
- Providing community providers with referrals and authorizations which are consistent with industry standards, and providing up-to-date tracking for every referral.
- Decreasing the administrative burden on facility community care staff
- Facilitating communication between facility community care staff, third-party administrators, and community providers (who use HSRM).

More information on how to utilize HSRM can be found in the OCC Field Guidebook, Chapter 3 and in the HSRM SharePoint.
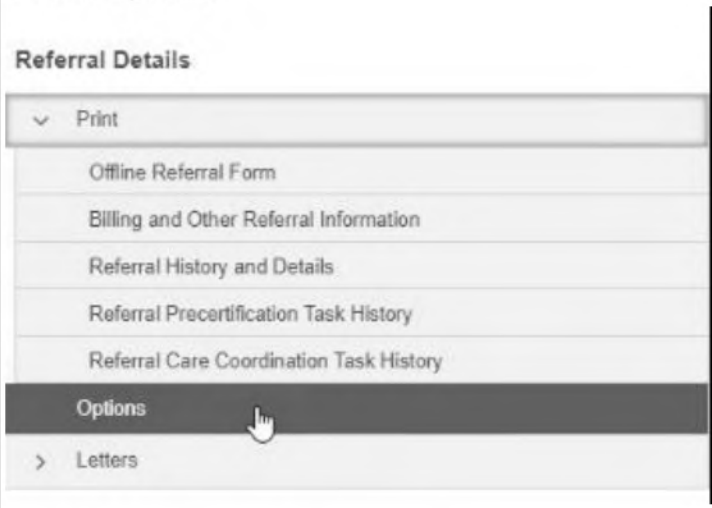
Adding Multiple Providers to an Offline Referral Form in HSRM:

Identified Need/Challenge	Process Implemented	Why is this a "strong practice?"	Resources/ References
Northern California VAMC facility identified a described but un-documented process for adding multiple providers to offline referral forms in HSRM.	Adding multiple providers to the offline referral form in HSRM.	This process allows staff to record appointed providers in lieu of using Adobe DC to edit the offline referral forms which does not record in HSRM.	HSRM Tool HSRM SharePoint HSRM End User Guide 9.0 PPMS SharePoint PPMS Tools PPMS site
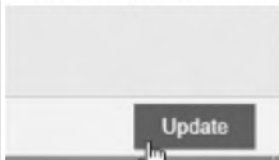
PROCEDURES	
General Considerations: • Community Care staff often have scheduling difficulties when additional providers are required for the same episode of care and request their names be on the referral form. • Some stations have been using Adobe Pro to change the provider information on the form but that does not record in HSRM. • Example: Veteran requires orthopedic surgery, with diagnostic radiology, labs, physical therapy, etc., with a provider that is not located within a large hospital. The ancillary providers may require their information to be on the authorization prior to scheduling/rendering care.	
STEP	**ADDING ADDITIONAL PROVIDERS TO THE HSRM 10-0780 APPROVED REFERRAL FOR MEDICAL CARE (OFFLINE REFERRAL) FORM**
1	In the referral, select the Component Menu (3 vertical dots) in the top-right corner.
2	Select Options.
3	Click on Record Appointment.
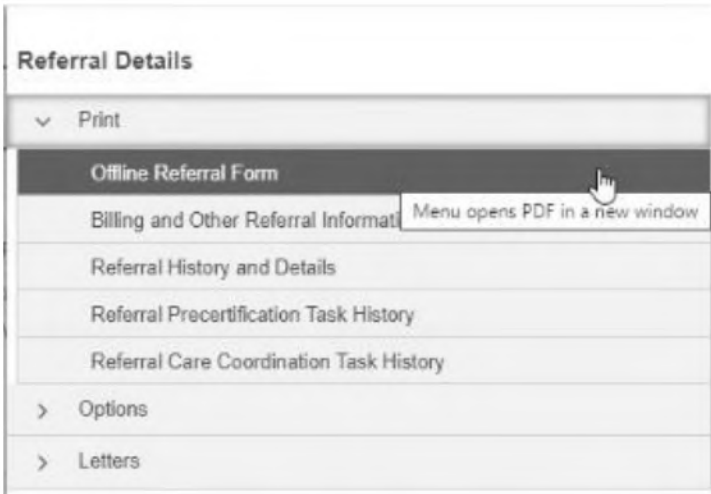
PROCEDURES

4	Select most appropriate from the drop down bar under Appointment For.

5	Select Scheduling method.

PROCEDURES

6	Enter Date & Time and leave Treating Specialty as is. Select PPMS Provider Search.
7	Under PPMS Provider Search, enter the NPI of in-network provider. Select Provider, information will fill into the form automatically.
8	Select Update in the bottom right hand corner.
NOTE	THIS PROCESS SHOULD ONLY BE DONE IN THE RECORD APPOINTMENT SECTION OF HSRM.
9	Return to the referral, select the Component Menu (3 vertical dots) in the top-right corner.
10	Click on Offline Referral Form.

PROCEDURES	863

	Referral Details

	✓ Print
	    Offline Referral Form
	    Billing and Other Referral Informati Menu opens PDF in a new window
	    Referral History and Details
	    Referral Precertification Task History
	    Referral Care Coordination Task History
	> Options
	> Letters

	Starting on page 3, section Appointments/Providers Assigned to the Referral will have the listed Provider and Appointment dates for all providers.

1.6 HSRM Community Provider Sign up

Identified Need/Challenge	Process Implemented	Resources/References
The Kansas City VAMC is pursuing a variety of avenues to connect with community vendors in efforts to promote community provider enrollment and utilization of the Health Share Referral Manager (HSRM). Due to their efforts, the VA Heartland Healthcare System (Kansas City, VA Medical Center) is within the top 10 number of sites having successfully signed-up community providers who are also utilizing HSRM.	The Kansas City VAMC advocates for many of the benefits in reducing phone calls/faxes while also increasing (direct) communication between VA and community providers. Thus, improving timeliness in appointing and care coordination efforts; conducts cold calls to vendors identified as having issues with obtaining referral information, and uses multiple listings of identified vendors (obtained through multiple resources) as an opportunity to elicit community provider sign-up/usage of HSRM.	Register for Virtual HSRM Training HSRM Provider Information Sheet HSRM Account Creation Information Sheet HSRM Community Provider User Guide HSRM Community Provider Quick Reference Guide Fact Sheet: HSRM Single Sign-on External (SSOE) Quick Reference Guide HSRM Help Desk Support Information Guide HSRM End User Tracker Template HSRM Help Desk: (b)(6) (b)(6) HSRM Support Email: HSRMsupport@va.gov HSRM Support Points of Contact List ID.me Registration: https://id.me ID.me FAQs and Trouble Shooting Support Interactive Map of VISNs

PROCEDURES

General Considerations:

- VA facilities are promoting outreach to community vendors that are not enrolled in HSRM (adding HSRM and ID.me registration documentation to referral packets and/or within email communications).
- VAMC utilizes VA administrative community care staff to connect with community vendors, provide HSRM sign-up information and promote the advantages to utilizing HSRM.
- Direct contact with community vendors is a key element to a community provider's HSRM enrollment.
- Community Providers who utilize HSRM obtain all required referral details resulting in claims payment (reducing claim denials for missing referral information).
- Advantage to VA: VA community care staff receive records from the community providers (directly via HSRM); alleviates claims issues and allows appointment recording(s) from the community provider.
- Advantage to community provider or community facility: the community provider, in utilizing HSRM, will have access to all referral data including duration; start and end dates, and referral details for claims processing.
- Removes manual process from VA providing referral and encompassing documentation by means of fax, email, or other electronic communications outside of HSRM.
- Reinforces streamlined appointing between the VAMC, community provider office, and Veteran.

STEP	VA Actions to Advertise Provider Enrollment of HSRM
1	• VA community care offices should employ a dedicated VA provider support liaison and utilize community care administrative staff, as they speak with providers on a regular basis • VA community care offices should assign VA facility community care HSRM Subject Matter Experts (SMEs) to work with community providers
2	• VAMC ensures their HSRM POC information is up to date on the <u>HSRM Community Care Points of Contact List</u> -If updates/changes are required, coordinate the change with <u>VISN/Facility assigned Field Support</u>
3	• Utilizing the suggested resources provided within this procedure, build a HSRM advertisement packet for providers

PROCEDURES	
	and include <u>HSRM/ID.me</u> enrollment information in all outreach documents
5	• Include <u>advertisement</u> of utilizing HSRM within the referral document (via email or fax)
6	• Ensure the provider attends <u>HSRM and ID.me</u> Training via VHA TRAIN • Assist the provider in signing-up for training when indicated
7	• Create a <u>Letter Template</u> advertising HSRM, including resources for facility specific Webinars • These Webinars may occur bi-weekly or (at minimum) monthly, depending on facility personnel availability
8	• Work with local facility Public Affairs office to advertise HSRM with local area physicians/facilities. • Create standing virtual presentations every-other Friday (based on community provider interest) via platforms such as Facebook Live or WebEx. • Utilize a training deck such as what is provided within the embedded example here HSRM Presentation_Provid
9	Facility HSRM SME Provides follow-up support: • Send follow-up emails at least twice a month • Assist with any issues providers are having with initiating HSRM sign-up • Encourage usage of HSRM • Advertise first appointment recording, uploading of medical documentation, receipt of full referral details, etc.
10	• Review the listing of providers enrolled with HSRM and share with leadership periodically • You can retrieve a listing of providers utilizing HSRM via PPMS Report Build, located within the <u>PPMS Functionality Guide</u> on the <u>PPMS SharePoint</u>
11	• Utilize the <u>National Help Desk</u> to assist vendors with HSRM access issues and entering tickets for assistance with HSRM program issues

STEP	Locating Community Providers for Outreach
1	• In PPMS create a list of providers in the area, including emails; advertise HSRM via email or fax as provided in PPMS provider's profile contact information • Utilize the <u>PPMS User Functionality Guide</u> to assist with identifying providers enrolled in HSRM and extracting reports • Share email listing with your region's Provider Relations & Services POC for assistance in conducting HSRM advertisement and outreach throughout local community
2	• Weekly, search all hospital pages in the area • Reach out via the *contact us* pages on the Hospital's website • Sign up for secure messaging (where available) to connect with community providers • Obtain distribution listing of clinics (via clinics outlined within the community facility's website) and advertise directly through the hospital website, when available/secure access is obtained

STEP	Providing Outreach - Include standardized advertisement using various technologies
1	• Telephone; Conduct Cold Calls • Email: send advertisement document via email located in the provider's profile in PPMS • Secure Messaging (via community hospital website) • Fax advertisement with Referral Package • Facebook or LinkedIn: Work with local Public Affairs office to advertise HSRM with local area physicians/facilities. Utilize various platforms such as LinkedIn/Social Media per National Outreach Office POC materials approved by VA. • See the Social Media HSRM Advertisement <u>Example</u>

STEP	Selling Points VA May Utilize when Advertising HSRM to Community Providers
1	• VAMC community care staff support the community provider HSRM enrollment efforts, to include ensuring HSRM SMEs are available by phone, email, and by eliciting HSRM training/presentations

	• HSRM is Free to community providers • HSRM does not require software installation • VA Provides support and training • Providers receive notification via automation (e.g., email notification) once a referral has been processed • Provider may conduct acceptance/rejection of a referral via HSRM automation • Provider records appointment attendance in HSRM • Community clinic uploads medical documents electronically and directly into the HSRM referral • Request for Services (RFS) and Treatment Notes may be uploaded/recorded directly into the HSRM referral • Community providers may utilize the HSRM messaging tool (via the task option in HSRM) to communicate (to VA) general messages regarding patient referrals/care

STEP	Reduced VA Community Care Processes
1	• Referrals no longer need to be faxed or emailed to community providers; they may be obtained directly from HSRM • Community Provider usage of HSRM eliminates phone calls, emails and/or faxes: -VA schedules Veteran directly via HSRM platform -VA receives automated community provider acceptance -VA retrieves Veteran attendance of first appointment via community provider's record of attendance in HSRM • VA receives notification via task list in HSRM when medical documentation has been uploaded into HSRM from community provider • VA Receives RFS and Treatment Notes directly within the referral, via HSRM

Resources:
- FGB Chapter 6 Manager and Lead References
- Fact Sheet: HSRM Single Sign-on External (SSOE) Quick Reference Guide
- HSRM Account Creation Information Sheet
- HSRM Community Care Points of Contact List
- HSRM Community Provider User Guide
- HSRM Community Provider Quick Reference Guide
- HSRM End User Tracker Template
- HSRM Help Desk: (b)(6)

- HSRM Help Desk Support Information Guide
- HSRM Provider Information Sheet
- HSRM Support Email: (b)(6) @va.gov
- HSRM Support Points of Contact List
- ID.*me* Registration: https://id.me
- ID.me FAQs and Trouble Shooting Support
- Interactive Map of VISNs
- Letter Template advertising HSRM
- National Help Desk
- PPMS Functionality Guide
- PPMS SharePoint.
- Register for Virtual HSRM Training
- Referral Packet HSRM Advertisement
- Social Media HSRM Advertisement Example
- VISN/Facility assigned Field Support

For more information, reach out to the VHA Office of Community Care – Clinical Network Management: (b)(6) @va.gov

1.7 Community Care Consult Closure

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. More information, processes, and metrics are available in the Office of Community Care Field Guidebook Chapter 4.

Guidance from Health Information Management
Below are strong practices that have been identified by Health Information Management staff to assist in medical documentation retrieval and closure.

Health Information Management Office of Health Informatics Practice Brief March 2021: Community Care – VistA Imaging Capture Best Practice and Minimum Documentation Requirements.

Louisville VAMC HIMs has been completing scanning for all community care documentation except Request for Services (RFS) forms.   **Request for Services are addressed by Community Care.**   **Scanning of Medical Documents/Progress Notes is performed by HIMs.**
ACTIVITY
1. Community care nurse reviews received documents.   2. CC nurse writes the consult number in the top right hand corner of the physical document. For electronic documents, files are saved with consult number in the title of the document.   3. Document is sent to HIMs.   4. Document is saved by the consult number and attached to the consult.
Notes   - Important that HIMs receives the documents daily, there is no backlog.   - Encourage providers to send electronic documents so the documents can be important faster.   - Consolidated effort between local HIMs and CC to develop this process.

- **Tucson VAMC has decentralized their HIMs department.**

ACTIVITY
1. Community care department does all their own scanning of all consulted encounters.
2. HIMs and CC share a folder on the Z drive and HIMs receives paperwork, faxes, and digital records for CC and scan to the folder with the proper naming convention. CC does the same. This is faster than inter-office mail.
3. HIMs performs all the Q&A on the CC staff monthly.
4. HIMs ensures scanning TMS courses and proper training are completed by new CC staff.
5. HIMs completes all training and audits for CC staff.

- Many HIMs and community care departments have switched from land-line faxes to electronic-faxes.
- This allows staff to pull documents, review, change document names, assign, and upload into VistA imaging as needed.
- Benefits include ease of working documents, less delay in receiving faxes, and less paper waste.

- **Central Western Massachusetts VAMC** HIMs hired MSAs instead of File Clerks and responsibility for scanning is no longer in community care.
- MSAs can do a review of documents to determine which consults to connect the progress notes to. Most documents do not need to be routed through community care for review, which has lowered scanning and turn-around time.
- Crafted a local Scanning One Note that outlines almost every type of document that comes through scanning, which makes it easier for staff to remain consistent in how to index records.
- Created 15 additional buttons in the "configuration file" for VistA Imaging Capture, which speeds up the capture process and provides confidence in capturing the correct button.

- **San Diego VAMC HIMs has created local SOPs for proper indexing and uploading of documents for community care consults. (Please also perform clinical review as required.)**
- San Diego VAMC Indexing SOP:
- Includes list of all Community Care Consult titles in CPRS, and the corresponding CPRS notes to use when marrying consults to notes and the proper naming conventions.

ACTIVITY

San Diego VAMC Medical Document Upload process:

Medical Record Upload Process:

1. A community care consult is approved for care in the community, with a Standard Episode of Care (SEOC). The SEOC determines the number of authorized visits and specific parameters of care a patient will have in the community. Medical documentation should be uploaded to the approved community care consult.

a. Sorting: File Clerk Scanners will receive and review virtual faxes, with some faxes containing the information of multiple patients within the same batch. File Clerk Scanners will need to separate these medical documents to ensure that all care in the community is related to the same approved community care consult. Each PDF containing medical documents should only be related to the approved community care consult and the associated SEOC.

b. Unable to Locate Community Care Consult: File Clerk Scanners may receive medical documentation but be unable to locate a community care consult. There may also be occasions when medical records are received for a community care consult that was *discontinued*. In these cases, the Lead File Clerk Scanner should place the medical records in the *S Drive: Community Care Unresolved Medical Records*.

*Note: Based on the memorandum "Changes to Consult/Referral Management during COVID-19" published on September 15, 2020, discontinuing a consult is no longer to be utilized).

1. PDF Naming Convention is as follows:
i. LAST NAME, FIRST NAME, LAST FOUR, WHAT ISSUE IS
Example: DOE, JOHN, 0000, NO CONSULT FOUND
2. The VACC Supervisors will review and disposition these medical records.

c. Request for Service (RFS) or Secondary Authorization Request (SAR): This care is in addition to the initially approved community care consult and these documents will need to be securely emailed to the correct staff for review.

2. Medical records will be received by using Electronic Fax and by receiving direct mail.
A. **Electronic Fax:** The File Clerk Scanners will create one PDF document with all related medical documentation and upload the PDF to the appropriate community care consult. The medical records that were downloaded will then need to be deleted from the Electronic Fax. The File Clerk Scanner will then need to link the uploaded medical documentation to the consult, which will complete the consult.
b. **Direct Mail:** These records come from the Mailroom. The VACC will sort these parcels to ensure that only medical records are sent to HIMs. HIIMs will pick-up the medical records from the VACC When medical records are ready to be picked-up by HIMs staff, one of the below staff will notify the Lead File Clerk Scanner.

Audits and Reporting:
1. **Completed Consults**: Each Monday (or Tuesday if there is a Federal Holiday), VACC leadership will run a report to understand how many community care consults were completed the previous week by File Clerk Scanners. This information with will shared with HIMs.
2. **Quality Assurance:** Audits will be conducted by the Lead File Clerk Scanner on a weekly basis to ensure that medical documentation is sorted properly prior to being uploaded and linked to community care consults.

CPRS View Alerting:
1. All VA providers that initiate community care consults must have their CPRS setting adjusted to enable view alerts. View alerts are needed to enable VA providers to see important medical information that is uploaded to community care consults by File Clerks Scanners that complete community care consults.
2. Completed community care consults may require additional action by VA providers, such as community providers may make a recommendation to follow-up with VA provider or to a different specialty. This would require the VA provider to submit an in-house consult. If the VA is unable to provide the care needed, a community care consult should be submitted.

1.8 Natural Disasters Community Care Contingency Plans

Natural Disasters – Actions when a facility is affected by natural disasters.

Identified Need / Challenge	Process Implemented	Why is this a "strong practice?"	Resources/ References
Northern California VAMC facility community care office identified need with their Incident Command to support Veterans with Community Care needs during local wildfires and subsequent / preventative wide-spread power shutoffs.	Reliable process for management of Community Care tracking and management of consults/patients during natural disasters.	Process helps assist with safety and care coordination of vulnerable Veterans and staff during natural disasters.	

PROCEDURES
• Natural Disasters and Power Outages effect both Community Care Veterans and Employees.

Step	
1	Upon receiving notification of an emergency, the Incident Command Center POC activates the Community Care Response Team for emergency operations during adverse weather, fire and/or power outages. • Heads up Internal notification is sent to the Supervisors/Team Leads of the incident and potential impact to patients and/or employees. • Incident Comment Center will send notification to the ERT Leads (POCs) regarding areas impacted by threat of fire, floods, or power outages. • Communication is dispersed internally to the service supervisors/leads or designees.
2	Consult Manger or designee will pull consults within the calendar year for medically fragile patients to include high acuity categories of care: • Community Care GEC/CNH/ADHC • Community Care Dialysis/Hemodialysis • Community Care Hospice • Community Care Radiation Oncology

PROCEDURES		
	• Community Care Medical Oncology List is then shortened to include most recent consults for those categories of care within the affected zip codes/counties, and removal of consults for Veterans that have expired. Note: In the event of a mass emergency such as the Camp Fire of 2018, the list extends to all categories of care for Veterans within the affected zip codes and all appointments with providers within these zip codes.	
3	Workload is distributed for outreach by Category of Care/Employee assigned Supervisor. Sample email to staff: There is an SOP Call Script (attached) for contacting veterans with vulnerable categories of care needed. (Insert VAMC) has indicated community care needs to provide outreach to these veterans to ensure their safety. Please distribute these lists to have your staff contact the Veterans to ensure they are aware of the outages/emergency and are prepared, as well as provide them with important information in case they need services. I have provided a link to the lists as well as a link on the SOP that states "Patient Contact List here."	
4	Sample SOP/Script: Please follow the script below and make sure to record the calls on the spreadsheet to which you have been provided access. Please make sure to provide warm handoffs (wait on the line until a live person is reached) if calls need to be transferred. **Vulnerable Categories of Care for Outreach: CNH, Dialysis, Hematology, Hematology/Medical Oncology, and Radiation Oncology.** "Good morning/afternoon, my name is _____ and I am calling from the (insert VAMC) VA Health Care System on behalf of Community Care to check on your safety due to possible (natural disaster) in your area and to find out if we can assist you in any way from the VA. 1. Do you currently have power, or have you been advised that your power will be shut off? 2. Do you need any assistance with emergency housing, transportation, or other social services? 3. Are you experiencing any change in your health? Problems with breathing or other symptoms you would like to have evaluated? 4. Do you have your medications? Are you able to get your refills? In the event of a power outage, do your medication require refrigeration?	

PROCEDURES		
		5. Do you have any Community Care appointments during this time that you require rescheduling or coordination for? *If the person answers yes to any of these questions, please be sure to get a good call back number so that a staff member can contact them.* *Provide information on Urgent/Emergent Care, Pharmacy, and other hospital provided resources here.* All medication refill requests should be referred directly to Advice Pharmacy line. Medical symptoms during the day should be transferred to Advice Nurse.
5		Outreach updates are provided in intervals throughout the day to the assigned ERT Lead within the service at 10:00am, 2:00pm and 4:00pm. Staff will continue to follow up with outreach until all Veterans and needs are accounted for.
6		Status are reported back to Incident Comment with the below information:

CATEGORY OF CARE	COUNT	DISPOSITION	COMMENTS
Hospice		Pt. Safe/Family Contacted	
		No contact/Left VM w/CC phone #	
		Evacuated	
		Pending Evacuation	
Radiation Oncology		Pt. Safe/Family Contacted	
		No contact/Left VM w/CC phone #	
		Evacuated	
		Pending Evacuation	
Medical Oncology		Pt. Safe/Family Contacted	

PROCEDURES

		No contact/Left VM w/CC phone #	
		Evacuated	
		Pending Evacuation	
		Pt. Safe/Family Contacted	
GEC/ CNH/ ADHC		Pt. Safe/Family Contacted	
		No contact/Left VM w/CC phone #	
		Evacuated	
		Pending Evacuation	
		Pt. Safe/Family Contacted	
Dialysis/He modialysis		Pt. Safe/Family Contacted	
		No contact/Left VM w/CC phone #	
		Evacuated	
		Pending Evacuation	
		Pt. Safe/Family Contacted	
TOTAL AFFECTED			

7	Employee Considerations – Local Level.

If a telework employee is affected by the power outages, cannot connect to the network, etc., they must return to their duty station and/or take leave.
- All teleworking employees must agree that if the bandwidth of the VPN or CAG networks becomes problematic to the point that their productivity is adversely impacted, or if the employee is unable to connect remotely, the employee must return to their duty station (within the time parameters set in their telework agreement) or take leave.
- Outreach to all employees will include the following questions and affected staff will be reported forward to ERT to include:
  - Zip code
  - Employee Name
  - Incident Name
- Questions asked of employees:
  - Are you impacted by the power outage?

PROCEDURES	
	· Are you safe? · Do you have any special needs affected by the outage?
8	**Employee Considerations – VISN Level Cross-Coverage** • Community Care staff across the VISN have been given access to other stations' consults and HSRM, to provide coverage in the event one or more stations undergo significant catastrophic events which render Community Care staff unable to perform job functions.
9	**Provider Considerations** Reports are also run to determine: · Hospitals in the affected area that have inpatient Veterans. · CNH & Dialysis providers that are serving Contact is made with these providers to ensure that they have power (are generators operating as normal) and water, if they need to evacuate, if they have contingency plans, and if care coordination is needed for their Veteran patients.

1.9 Maximizing Appropriate Use of Emergency Departments in the Community

Recent data shows Veterans have increasingly been utilizing community EDs, leading to potentially undesirable health outcomes. To address the heavy reliance on community EDs, VHA established the Care Optimization in the Emergency Department (CO-ED) initiative. The CO-ED initiative strives to identify best practices that will help us meet the following goals: (1) Decrease Revisits/Excess Utilization of Resources Within EDs in the Community (2) Ensure Veterans are guided to and receive care at the appropriate level for potential emergent or urgent needs (3) Maximize the number of medically appropriate transfers back to the VA from the community (4) Increase Healthcare delivery with VA Direct care ED/UC telehealth services.

A new tool, the OCC Community Emergency Care Dashboard has been created to provide VISNs and VAMCs with data regarding community care ED utilization by Veterans and the community partners where those Veterans are seen. Each VAMC will complete the following actions to begin addressing the high utilization of community EDs for non-emergent care:

a. Review and outreach to the top 10 highest Veteran utilizers of community EDs to learn why the Veterans have been going to community EDs frequently and ensure appropriate support is provided to these Veterans within VAMCs and VA Clinics. If you have staff dedicated to review community care ED visits, please utilize and coordinate with your facility community care office. This review will be comprised of both a chart review and discussion with the Veterans. This is important in order to identify why community ED visits were deemed necessary by the Veteran, identify any barriers to VA care, as well as to provide education regarding VA available resources.

b. Review and outreach to the top 5 community EDs/hospitals that most frequently provided emergency care and emergency hospitalizations for Veterans. VAMCs will ensure that clear relationships and expectations are established between the local VAMCs and community hospitals in order for VAMCs to help coordinate potential transfers, discharge needs, and/or follow-up care. VAMCs will ensure processes are strengthened or developed to ensure prompt notice of the community ED visits.

c. Utilize the newly created Appropriate Community Emergency Department (ACED) Use Submission Tool (located on the bottom left of the ACED Use Homepage ACED) to document the top 10 highest Veteran utilizer analysis and the top 5 community ED outreach.

d. The data for the highest Veteran utilizers and community EDs is located in the ACED Data section (bottom right) of the ACED Use Homepage ACED. VISN Business Implementation Managers (BIMs) and facility community care managers have been granted access to the folders containing the ED data for their respective sites.

It is highly recommended that VISNs and VAMCs continue to routinely utilize the OCC Community Emergency Care Dashboard to efficiently provide care management and monitor the appropriate use of community EDs. To facilitate this continued review, training on the use of the OCC Community Emergency Care Dashboard and an FAQ document can be found on the ACED SharePoint site as well as the community care hub emergency care training page Emergency Care.

Information regarding obtaining SSN level access to the OCC Community Emergency Care Dashboard is located in the Restricted Emergency Care dashboard Data Restrictions - Power BI (powerbigov.us) and in the recorded training link provided above. Non-Restricted Emergency Care dashboard Emergency Care - Power BI (powerbigov.us).

When submitting responses in the ACED Power App, please follow the instructions below:

(1) Access the ACED Power App via the link: ACED

(2) When submitting your top 10 Veteran information select number 1 for each unique Veteran submission.

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

Appropriate Community Emergency Department (ACED) Use Submissions

1. Click here to submit a Community ED Highly Utilizing Veteran Information response

1. Please submit **10 unique entries** for each of your facility's top 10 high community ED utilizing Veterans by clicking the *Community ED Highly Utilizing Veteran Information* button to the left.

2. Click here to submit your Facility Community ED Relationship Responses

2. Once your facility has submitted a questionnaire for **each** of your 10 unique Veterans, please click the *Community ED Relationship Responses* button on the left (Button #2). Then submit **1 questionnaire** to document your facility's responses.

(3) The unique Community ED Highly Utilizing Veteran questions requiring completion for each unique Veteran submission are listed here for use in gathering information prior to submission.

1. What were the Veteran's diagnoses/chief complaints at the community ED?
2. Was the Veteran aware of available VA resources prior to self-presenting to a community ED? I.e. was the Veteran aware of Clinical Contact Center (C3) services (if available in their area)?
3. What percentage of the time did the Veteran contact telephone care?
4. What percentage of time did the Veteran contact the crisis hotline?
5. Was the Veteran aware of urgent care facilities near their home?
6. Was the Veteran in need of a Social Worker but did not have a relationship with VA Social Work Service?
7. If your organization offers Tele Urgent Care, did the Veteran contact the service?
   a. If so, were they then directed by the Telehealth Urgent Care to a community ED?
   b. Or did the Veteran not receive resolution of their health care need after the Tele Urgent Care visit and decided to present to a community ED?
8. Is the Veteran being seen at the VA for most of the same diagnoses they sought care for in a community ED?
9. Does the Veteran have a VA case manager or lead coordinator for this same diagnosis/chief complaint?
10. How many times in the last 6-12 months has the Veteran been seen in the community ED for this same diagnosis/chief complaint?
11. How many times has the Veteran been admitted to a community facility for the same diagnosis/chief complaint in the last 6-12 months?
12. For the ED visits provided in the data, what percentage of time did the VA staff complete a post ED/hospitalization follow-up call with the Veteran?

a. If a post ED/hospitalization follow-up call was completed, what percentage of the time was it completed within 2 days of discharge?

13. Does the Veteran have assigned Primary Care at VA?

   a. If no, does the Veteran have VA authorized Primary Care in the community?

14. Did the Veteran contact VA PACT/CC Primary Care, prior to seeking care in a community ED?

   a. If Yes, how many times did the Veteran contact their Primary Care?

15. If seen, was the diagnosis/chief complaint addressed during the last Primary Care encounter?

16. How many times per calendar year is the Veteran seen by their assigned PACT/CC Primary Care?

17. What PACT staff are involved in the Veteran's PC care management?

18. Is the Veteran established with VA specialty services in relation to the diagnosis/chief complaint seen for in the community ED?

   a. How many times per calendar year is the Veteran seen by their specialty care team for care related to the diagnosis/chief complaint seen for in the community ED?

19. Is the Veteran established with CC specialty services in relation to the diagnosis/chief complaint seen for in community ED?

20. How many times referrals per calendar year have been submitted to CC specialty care for care related to the diagnoses/chief complaints seen for in the community ED?

21. If the Veteran was seen for a mental health diagnosis/chief complaint, are they established with VA mental health?

   a. If yes, when was the last time the Veteran was seen by VA Mental Health?

22. Was their diagnosis/chief complaint addressed during the last VA Mental Health encounter?

23. How many times per calendar year is the Veteran seen by their Mental Health providers?

24. Is the Veteran established with CC Mental Health services in relation to the diagnoses/chief complaints seen for in the community ED?

(4) Please complete the questions for each unique Veteran submission within the ACED Power App.

New ACED Submission Screen

VISN

Station

Veteran Numerical Identifier

Find items

Veteran's Last Name

1. What was the Veteran's diagnosis/chief complaint at the community ED?

2. Was the Veteran aware of available VA resources prior to self-presenting to a community ED? I.e. was the Veteran aware of C3 services (if available in their area)?

Find items

2. Additional Information
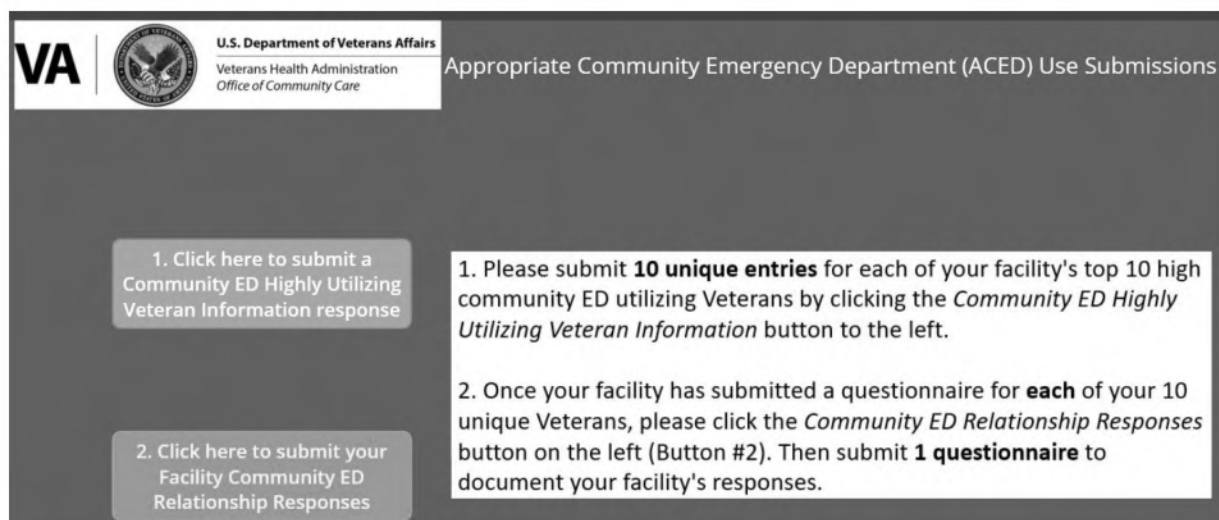
(5) Once you have completed responses, click the save icon for each unique Veteran submission.

Once all necessary fields have been completed, click the Save icon to the left to submit entry. At the next screen hit the Home button to return to the Start screen in order to create the rest of your individual Veteran responses.

Note: Please follow steps 1-5 for each of the 10 unique Veteran submissions.

(6) After each 10 unique Veteran responses have been completed, select number 2 to submit Community ED Relationship responses

(7) The unique Facility Community ED Relationship questions requiring completion for a one time submission are listed here for use in gathering information prior to submission.

1. Does your VA contact local community facilities on a daily basis to determine if Veterans have self-presented?
2. Do the local community EDs communicate on a daily basis with your facility regarding Veterans that have self-presented without prior authorization or are admitted to their facility?
3. Who at your VA is responsible for contacting the local community EDs on a daily basis?
4. Does your VA have adequate staffing (clinical and administrative) for care coordination activities? Care coordination activities include admission/continued stay reviews, discharge planning and VA transfer activities.
5. Does your facility have a dedicated contact method i.e. phone line or email address, established for Community EDs to use to communicate with your facility?

(8) Please complete the questions within the ACED Power App.

ACED Use Facility Community ED Relationship Response Questionairre

VISN (Required)

Station (Required)

1. Does your VA contact local community facilities on a daily basis to determine if Veterans have self-presented?

Find items

2. Do the local community EDs communicate on a daily basis with your facility regarding Veterans that have self presented without prior authorization or are admitted to their facility?

Find items

2. Additional Information

3. Who at your VA is responsible for contacting the local community EDs on a daily basis? (Leave blank if unknown)

Find items

3. Additional Information for the 'Other' option

(9) Once you have completed, click the save icon to submit.

Once all questions have been answered, click the Save icon to the left to submit your answers. At the next Screen, click the Home button if you need to submit any more highly utilized Veteran information for your Facility.

To aid facilities communication with Veterans and community ED facilities the emergency care fact sheets were updated to provide fillable spaces for facilities to add their specific contact information.

Community Emergency Treatment Reporting and Care Coordination Information for Veterans fact sheet
https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-43.pdf#

Centralized Community Emergency Treatment Reporting and Care Coordination fact sheet https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_27-04.pdf#

Department of Veterans Affairs

Veterans Health Administration

Referral Coordination Initiative Implementation Guidebook

Updated: October 28, 2021

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1 EXECUTIVE SUMMARY

1.1 Referral Coordination Initiative Objective

The Referral Coordination Initiative (RCI) is the Veterans Health Administration's (VHA's) revised process to streamline the referral process. This change shifts the work of multiple clinical staff members to dedicated Referral Coordination Teams (RCTs) of administrative and clinical staff dedicated to RCI.

VHA is committed to improving referral timeliness and empowering Veterans with understanding the full range of their care options. In response to the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act implementation and the ongoing COVID-19 pandemic response, VHA's change to its referral process will improve timely access to care and the overall Veteran experience.

Veteran feedback suggests many prefer to receive internal/direct VA care, regardless of eligibility for community care. The RCT provides every Veteran a complete picture of their care options so he/she can make the most informed care decisions.

Without an improved consult/referral process, the scheduling of referrals will take more time than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs. Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community or vice versa. The terms **consult** and **referral** are used interchangeably throughout the guidebook. The intent is to have RCTs review clinically appropriate care options and community care eligibility (if applicable) with Veterans – then move referrals from a pending/unscheduled status to a scheduled status in a timely manner.

Clinical RCTs will guide Veterans through their full range of care options including internal/direct care in VA and care in the community. All staff should discuss benefits of receiving internal/direct VA care with every Veteran. The ultimate decision regarding where eligible Veterans will receive their care remains with the Veteran. Administrative RCTs then schedule VA or community care appointments based on Veteran eligibility and preference in a timely manner. The aspirational goal is to move to scheduled status within three (3) days for internal/direct VA care and three (3) days for community care.

RCTs at each VA medical facility will ensure Veteran care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

- Access to RCT support and comprehensive information about care delivery options including face-to-face care, all available telehealth options and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects eligible Veteran's preference for internal/direct VA care or care in the community

9

1.2   Purpose of Referral Coordination Initiative Guidebook

The Referral Coordination Initiative Guidebook is a centralized source of information to support local deployment of RCI. Department of Veterans Affairs Medical Centers (VAMCs) and Veterans Integrated System Networks (VISN) are encouraged to utilize the guidance documents within to tailor strategies locally to improve timeliness and standardize Veteran education on care options both within VHA and in the community. This guide is intended to be used by VHA staff.

1.3   Future Updates to Referral Coordination Initiative Guidebook

The Referral Coordination Initiative Guidebook is a living document that will be updated as frequently as monthly as new guidance and tools are developed to support this work.

2 REFERRAL COORDINATION INITIATIVE INTRODUCTION

2.1 What is Changing and Why?

Understanding the what, why, what is not, benefits and risks of this initiative clarify the reason we are making this change. We developed a change management tool to address these important questions called the Six Essential Questions.

1) What is Changing?

The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

2) Why is it changing?

VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

3) Why is it changing now?

Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

4) What is not changing?

VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran's needs and life goals – whether that is internal/direct VA care or care in the community. Eligibility standards for community care are not changing.

5) What are the benefits of this change?

RCTs align with VHA's modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

6) What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs. Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community or vice versa.

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2.2 Future State

Veterans have more options than ever to receive the best, timely care. RCI's streamlined referral process will empower every Veteran to make more informed care decisions and prevent delays in scheduling critical, high quality care.

The future state process is illustrated in Figure 1: RCT Process for Referrals.

Veteran Experience *

| Veteran needs care/referred for care | → | Veteran offered the ability to schedule and RCT appointment prior to leaving | → | Veteran reviews all care options and eligibilities with clinical RCT | → | Veteran selects care options including same day appointment if available | → | Appointment Scheduled |

RCT Process Map *

Referring provider places SC Consult/ Order → Veteran selects to schedule an RCT appt prior to leaving → Consult triaged by RCT → Determine Eligibility → Call Veteran to discuss (1) eligibility, (2) value of choosing VA and (3) care options/modalities → Veteran chooses (when applicable) modality of VA or Community Care → Choose's VA → MSA schedules appointment → Internal VHA or CC appt scheduled

Referring provider MSA schedules RCT appointment → RCT initiates appointment

Figure 1: RCT Process for Referrals

Not all consults will result in a scheduled appointment. RCT to assess all care options including E-Consults, testing, medication refills, etc.

A more detailed process map is available for reference.

RCTs will work across Primary Care, Mental Health and Specialty Care Medicine/Surgery services. RCTs will:

- Provide each Veteran with information about all appropriate care options available, including in-person, virtual and telephone.
- Determine Community Care eligibility and secure Veteran appointments when appropriate.
- Coordinate with clinical and administrative staff who have training in both VA in-house and community care scheduling processes to eliminate unnecessary steps and people from the process – making it easier and quicker to schedule.

VHA aspires to achieve scheduling referrals on average within 3 days from time the referral is entered into the Electronic Health Record (File Entry Date) to first scheduled (1st scheduled) for both internal/direct care and community care. This is to assure that Veterans receive timely care regardless of where care is delivered. The Office of Community Care and the RCI team have developed a glidepath of scheduling timeliness milestones for community care that use

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multiple process improvement tools to support VAMC's journey to reach the ultimate aspirational goal of 3 days for both internal/direct and community care scheduling.

2.2.1   Team Composition

The RCT will include dedicated clinical and administrative staff with the capability of coordinating care for internal/direct VA care and community care needs for Veterans. The clinical staff within RCTs should be nurses. Sites may use Doctor of Medicine (MD), Doctor of Osteopathy (DO), nurse practitioner (NP) and/or physician assistant (PA) during the transition to RNs on this team. These team members should be cross-trained to triage internal/direct VA care. Additional responsibilities include:

- Conduct initial triage on all consults/referrals.
- Run the Decision Support Tool (DST) or determine Community Care eligibility through alternative means.
- Call Veteran to review all available care options including internal/direct VA and community care when eligible.
- Assign themselves the RCT User Role within CTB in order, which Simplifies and automates consult processes and allows for tracking of consult management actions by RCT members
- Introduce the Veteran to the administrative staff member of RCT to schedule the appointment.

The **administrative staff** members should be schedulers or the equivalent. The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. Cross-training of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility, services offered and timeliness of care in the community. The RCT must be able to speak to both internal VA and community care options and processes to get the patient scheduled in a timely manner.

2.3   VAMCs with Limited or No On-site Specialty Care

All VA Medical Centers (VAMC) are required to implement RCI. VAMCs with limited or no onsite specialty care should work with their VISN and VAMC leadership to develop a VISN-level inventory of available services that can be delivered either in person or virtually. VISN-level services may be organized within Clinical Resource Hubs or as Interfacility Consults. VAMCs must develop appropriate service-level agreements between VAMCs for appropriate E-Consult reviews and/or in-person/virtual care appointments for Veterans who choose this alternate care option within VA. Reference the VISN Referral Coordination section for more details.

2.3.1   Ideal Process for VAMCs with Limited or No On-site Specialty Care

Referring providers will inform the Veteran during his/her initial visit that the RCT will be contacting them within three (3) days to review their eligibilities and available care options,

including internal/direct care in VA and in Community Care using available modalities including in-person, virtual and telephone care.

VAMCs must decide whether the RCT will be located at the site originating the referral or at a partner site (either a remote location or another VAMC). If the RCT is at the originating site, the referring provider enters an E-Consult or internal/direct consult. If the RCT is located elsewhere, the referring provider enters an E-Consult or inter-facility consult as appropriate.

In either case, the Veteran will have the option to meet with the RCT or arrange a future meeting with the RCT prior to leaving the referring provider's office. The RCT, regardless of where it is located, follows the RCT Process for Referrals (please review Figure 1: RCT Process for Referrals).

While each facility may develop strategies to address referral coordination, key minimum required strategies include:

- Implement Referral Coordination Teams.
- Eliminate direct entry of community care referrals by referring providers.
- Work with VISNs to establish a network of interfacility consults between VAMCs to support facilities with limited or no on-site specialty care services.
- Offer Veterans the ability to schedule a Clinical RCT appointment at check-out.
- Identify scheduling preferences for all Veterans who choose community care.
- Utilize RCI Clinical and Administrative staff model recommendations to support a dedicated RCT.

2.3.2   What This Means for Veterans

Local RCTs help Veterans make more informed decisions about their care while ensuring their appointments are scheduled in a timely manner for the care they need. RCTs review and discuss all clinical care options, including potential community care eligibilities with Veterans. VA will continue provide an exceptional experience and deliver high-quality care and serviced – whether the Veteran chooses internal/direct care in VA or care in the community.

With RCI, every referred Veteran can expect:

- A warm handoff from their referring provider's office to an RCT member either in-person, via VA Video Connect, or telephone
- An RCT point of contact to guide them through the referral process and their full care options
- A referral to move from a pending/unscheduled status to a scheduled status within three days for VA care and three days for community care

2.3.3   What This Means for Staff

In addition to providing a better experience for Veterans, RCI helps VA staff prioritize responsibilities. RCI will unburden referring providers from specialty care specific discussions around referrals and will allow them to focus on internal/direct patient care, initiating the "Choose VA" conversation with Veterans, and identifying future care needs of the Veteran.

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Dedicated facility-level RCTs serve as an extension of Primary Care, Mental Health, and Specialty Care providers. They will review and triage referrals and discuss with the Veteran all available options for care locally, virtually, in other VA locations and community care based on eligibility.

RCT will allow Specialists to work at the top of their license, focusing on delivering internal/direct patient care for Veterans. In addition, all referrals going through the RCT/specialty care will eliminate the direct entry of community care consults from referring providers to provide a more streamlined, consistent and thorough approach to the referral process, ensuring Veterans are offered care modalities both within VA and in the community that best meet their needs.

RCI will help maintain funding of specialty care and subsequent resources that allow VA to deliver the highest quality care. RCI aligns with VHA's Modernization and High Reliability Organization efforts through commitment to good financial decisions that best serve Veterans, including value-based utilization of both direct care and community care.

2.4 Support

Trainings, scripts, communications materials, dashboards, change management tools, and field-developed strong practices will be deployed to support this initiative. Further guidance on these materials will be provided in future iterations of this guide, as well as RCT meetings.

This iteration of the guidebook includes guidance on How to Get Started, RCT operations, **Error! Reference source not found.**, Best Medical Interest (BMI) information, DST changes, community care scheduling and examples for strong practices.

The email group for the RCI is VHARCI@va.gov.

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3 ROLES AND RESPONSIBILITIES OF RCI

It takes a comprehensive and collaborative approach to implement RCTs at both the local and VISN level. We have outlined the general roles and responsibilities of various VISN and local facility staff to give you a better understanding of the RCI's collaborative nature. This list may not be exhaustive of all roles.

3.1 Executive Sponsors and Facility/VISN Leadership Support

Each VAMC and VISN will identify an Executive Sponsor to support the Referral Coordination Initiative. Executive Sponsors are responsible for ensuring their facility and VISN are fully supporting and moving RCI forward. Executive Sponsors remove barriers to improving processes identified by the project team as appropriate.

The Executive Sponsors should be a member of the Executive Leadership Team (ELT). We recommend the VISN Executive Sponsor be the Chief Medical Officer (CMO) (and the Chief Nursing Officer (CNO), if applicable, may also be appointed). We recommend the facility-level Executive Sponsor be the Associate Director for Patient Care Services (ADPCS), Chief of Staff (COS) or Deputy COS.

Process improvement is most effective when leaders:

- Demonstrate effectiveness in clarity of vision, decision making, relationship building, inclusion and conflict management.
- Enhance and cultivate leadership capabilities in project team.
- Empower the organization and teams to think, act, and move as a network.

From planning to post-implementation, the leadership will act as a network and utilize the six essential change management questions to establish accountability.

3.1.1 Facility Executive Sponsors and Leadership

Facility Executive Sponsors serve as the catalyst to promote RCI buy-in and implementation at the facility level. Executive Sponsors oversee the development of a multidisciplinary Implementation Team. Staffing model suggestions are available in the Staffing, Reallocation of Resources, and Productivity Goals Section.

Facility Executive Sponsors' responsibilities include:

- Establish RCT oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 compliance).
- Attend the facility's Referral Coordination recurring meetings.
- Ensure all relevant RCI matters (including progress, implementation updates, barriers, action plans to remove barriers, etc.) are recorded and routed through the facility's governance structure.
- Oversee and develop multidisciplinary RCTs.

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3.1.2 VISN Executive Sponsors and Leadership

VISN Executive Sponsors serve as the catalyst to promote RCI goals and expectations to facility executive leadership team, service chiefs and other leaders as needed to ensure RCI is successfully implemented within the VISN. The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and development of VISN level teams as appropriate.

VISN Executive Sponsors' responsibilities include:

- Establish VISN RCI oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 Compliance).
- Maximize VA resource utilization within VISN by overseeing resource capacity, efficiency and productivity.

Please review the Funding Referral Coordination Teams

Additional funding will not be provided for this initiative. We expect Executive Sponsors to develop the RCT by leveraging staff already supporting administrative and clinical areas that will benefit from the improved process to address (please review the Staffing, Reallocation of Resources, and Productivity Goals Section). Referral coordination is already being done at most sites, but it may not be coordinated based on the current process. Facilities and VISNs that do not have this staff on hand may need to add additional resources.

3.2 RCT Oversight

RCT oversight is critical to the success of Referral Coordination. Local facilities and VISNs need to oversee the RCI development, implementation and evaluation to ensure RCI progress is moving forward as expected. This can be accomplished through either establishing an RCT Oversight Committee *or* incorporating RCT oversight into an existing committee as a standing agenda/reporting item. Examples of existing committees include (Access Committee, OCC Oversight Council, Consult Steering Committee).

To meet the intent of RCT oversight, the following key stakeholders should be included in the development of a new committee or included in current committee structure:

- Executive Clinical Leadership
- Administrative Officer and/or Chief, Medical Service
- Administrative Officer and/or Chief, Surgical Service
- Administrative Officer and/or Chief, Primary Care Service
- Administrative Officer and/or Chief, Mental Health Service
- Administrative Officer and/or Chief Physical Medicine and Rehabilitation Service
- Administrative Officer and/or Chief, Neurology Service
- Administrative Officer and/or Chief, Strategic Planner
- Administrative Officer and/or Chief, Dental Service
- Administrative Officer and/or Chief, Healthcare Administration Service
- Administrative Officer and/or Chief of Staff or designee

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- Administrative Officer and/or Chief, Community Care
- Group Practice Manager (GPM)

RCT oversight ensures RCI implementation is staying on track. Below are key actions to include in the committee meeting.

- Review, customize, and update charter to include RCT oversight (please review the RCT Oversight Section for 508 compliance)
- Establish regular reporting cadence for RCT implementation/progress.
- Develop a mechanism to track action items and ensure follow-up as suitable to the facility/VISN needs.
- Review key indicators and metrics presented by the implementation team (please review the Data and Measuring Success Section).

3.3 RCI Champions

Referral Coordination Champions are key to the success of RCI. They will drive the development, implementation and evaluation of the RCT. An RCI Champion will be appointed at each facility and at the VISN. We recommend facility Champions be the GPM and the VISN Champion be an RCI Manager and/or Business Implementation Manager (BIM).

3.3.1 Facility Champion

Facility Champion responsibilities include:

- Identify and lead RCI Implementation Team.
- Disseminate information and communication materials to staff.
- Help operationalize the RCTs.
- Identify, address, and report barriers to the Executive Sponsors.
- Track implementation progress and metrics (please review the Data and Measuring Success Section).
- Provide feedback to the local RCI implementation team and VISN RCI Leadership on overall initiative progress and ways to improve implementation moving forward.

3.3.2 VISN Champion

The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and development of VISN level teams as appropriate.

VISN Champion responsibilities include:

- Ensure consistency of RCT functions and use of RCT tools across facilities.
- Disseminate appropriate RCI materials.
- Develop VISN-level triage tools as needed.
- Develop and manage VISN RCT as appropriate.

3.4 Clinicians Related to the Referral Coordination Process

3.4.1 Referring Provider

The referring clinician are the first step in the referral process.

The referring clinician will:

- Participate with Specialty Care and RCT in the development and/or updating of service agreements.
- Follow established pre-referral guidelines/clinical pathways outlined in the electronic health record prior to entering a consult/referral.
- Enter consults prior to concluding the appointment, where applicable.
- Communicate with patient about the basic referral coordination process.
  - Referring provider enters referral.
  - RCT will review/triage/gather additional information and determine care options available both at VA and in community.
  - RCT will communicate with patient care options and allow Veteran to decide regarding where to schedule.
  - Provide Veteran with the RCT Fact Sheet (coming soon).

3.4.2 Facility Clinical Specialty Care Service

Facility clinical specialty services are responsible for providing subject matter experts to support RCTs. During the early phase of forming RCTs, facility clinical specialty services will work collaboratively with and train the RCT team to understand specialty care needs and services offered. They will build a collaborative relationship so that the RCT is an extension of the specialty service. They maintain ongoing collaboration and manage quality control with RCT clinical staff in the triage/scheduling process.

Facility clinical specialty services responsibilities include:

- Collaborate with RCT and referring providers to develop pre-referral guidelines, clinical pathways, modifications of consult templates as needed, and service agreements.
- Develop clinical triage tool that encompasses the collaborative RCT process (pre-determined clinical and scheduling guidelines utilized by the RCT for consult review, triage, documentation and scheduling).
- Provide specialty service training to the RCT Triage/Scheduling Team on the triage and scheduling of referrals in the designated services (please review the How to Get Started Section).
- Retain the overall responsibility of designated triage and management of referrals that do not easily conform to guidelines.
- Facilitate ongoing collaboration with RCT by working on day-to-day communication regarding triage and scheduling.

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3.5 Referral Coordination Team

RCI establishes dedicated local and/or VISN RCTs to manage all consults/referrals. RCTs support the national standardization of how VHA addresses referrals and align with the future deployment of Cerner and efforts to standardize referral templates.

RCTs serve as the liaison between referring providers and specialty care services. They remove an administrative burden from clinicians, enabling them to spend more time focused on Veteran care by allowing non-Licensed Independent Practitioner (LIP) staff (Registered Nurses (RNs)) to clinically triage consults/referrals. RCTs improve timely access to care, empower Veterans to make more informed care decisions, and ensure Veterans receive their chosen modality and location of care either within VA or in the community.

3.5.1 Minimal RCT Composition

RCTs are required to be staffed with administrative and clinical support to quickly receive and manage Veteran referrals. The minimal composition will be a clinical team member and an administrative team member. RCT clinical staff guide every Veteran through all internal/direct VA and community care options, and RCT administrative staff then schedule appointments based on individual Veteran eligibility and preference.

Because of RCI's clinical nature, individuals who are licensed and qualified to assess patient's medical conditions either face to face, via telephone, by medical record review, etc., should be identified as the primary RCT coordinator. We highly recommended that an RN serves as the RCT clinical team member. Administrative support with Medical Support Assistant (MSA) staff is critical to the timely scheduling and coordination of appointments.

3.5.2 Clinical RCT Staff

The clinical RCT staff will receive and triage all referrals to the specialty service. This includes referrals both internal and those eligible for community care. **Consults/referrals need to go through the RCT first and should not go directly to community care.**

The RCT clinical staff should ideally be a RN. Sites may use MD/DO/NP/PA during the transition to RNs. They should be cross trained to triage both internal/direct VA and community care referrals.

Clinical RCT's responsibilities include:

- Perform initial triage on all consults, to include determining clinical appropriateness and clinical triage tool/method used for the review
- Run the DST or determine community care eligibility through alternative means.
- Call every Veteran to review possible options for care including internal/direct VA and community care if eligible.
- Assign themselves the RCT User Role within CTB in order, which Simplifies and automates consult processes and allows for tracking of consult management actions by RCT members Complete a warm hand-off (defined in RCI Operations) to the Administrative RCT to schedule the appointment.

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The RCT clinical staff uses a triage tool to guide decision making and determining all options of care available based on Veterans clinical need. Once the clinical triage is completed, the Clinical RCT guides the Veteran through their full range of care options based on recommendations from the triage tool. This can include a clinical conversation with the Veteran for complex care needs and options and/or an administrative conversation based on clear direction from the clinical triage note.

As previously mentioned, RCI's streamlined process is collaborative. The Clinical RCT collaborates with the following care team members as needed based on triage training protocols and training:

- Referring provider if additional information is needed
- Specialty providers during the daily triage process
- Veteran to present and discuss all appropriate care delivery options (e.g., telephone, VA Video Connect, traditional Clinical VA Telehealth (CVT), face-to-face, community care) based on referral triage
- Administrative RCT to schedule the Veteran referral appointment in a timely manner
- Community Care handoff when appropriate

Note: Communication and discussion with patients regarding VA care options can occur with both the clinical and Administrative RCT members. This is driven by the clinical nature of the specialty care request and considering the request's complexity or simplicity. To maintain an efficient RCT process, optimization of processes and having the right staff do the right task is essential in utilizing clinical and administrative staff to the full scope of their role. Depending on the specialty and complexity of care requested, it may not always require a Clinical RCT to communicate with patients their options for VA care. Please review the RCT Operations Section for more details.

The clinical review outcomes must be captured by the clinical RCT member using the CTB Consult Review Tab.

3.5.3   Administrative RCT Staff

The RCT administrative staff will share with Veterans all their options for care during the scheduling process. This is driven by the RCT clinical plan/instructions documented on the consult. Administrative RCT should be a scheduler, MSA or equivalent.

Administrative RCT responsibilities include:

- Call Veterans to discuss care options and schedule appointments as indicated by the RCT clinical team member documentation.
- Use of DST to determine community care eligibility as appropriate.
- Document scheduling efforts on the consult/referral using the CTB Patient Contact Tab.
- Document the discussion of VA wait times vs. community wait times when appropriate.

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- Record a Veteran's community preferences, including if a Veteran chooses to self-schedule their community care appointment per Community Care Scheduling Enhancement Memo.
- Analyze the travel distance to select the most appropriate clinic location.
- Send the Veteran's appointment letter.
- Verify the Veteran's contact information.
- Collaborate with RCT clinical team and with facility scheduling staff as needed.
- Ensure a warm and seamless handoff to Community Care when appropriate.
- Develop collaborative communication processes for the local facility RCT to reach out to VISN RCI or assistance.

Additional MSA guidance, including functional statement and competencies templates are linked below:

- MSA Functional Statement Template
- MSA Competencies Template

3.5.4   Clinical Pharmacy Staff

The RCT clinical pharmacy staff should be included in the RCT where possible and partner with the RCT clinician when appropriate to address patient needs.

- For service specific RCTs, the Clinical Pharmacy Services should be considered as a key member of the RCT for the specialty area they are aligned with.
- For centralized RCTs, the Associate Chief of Clinical Pharmacy Services should be considered as an integral member of the RCT specifically to ensure that processes are in place so the RCT clinical nurse is aware and can identify consults where a CPS would be the most appropriate provider to the Veteran.

The CPS should be involved in ensuring processes are in place so the RCT clinical nurse is aware and can identify consults where the CPS would be the most appropriate provider to the Veteran. Specific scenarios for involvement of CPS in RCT are outlined below.

   o **Veteran is referred from primary care for pain management services**. The Pain RCT clinical nurse reviews the chart and determines the Veteran is being referred for medication management of their opioid therapy. The RCT clinical team discusses the care needed involving the CPS and the RCT nurse calls and offers the Veteran an appointment with the CPS for medication optimization. Although this facility had wait times for the pain management physician, the RCT identified a patient where medication management was needed and guided the Veteran to the correct provider to evaluate that care rather than using his wait time eligibility for community care
   o **Veteran, after a recent HF exacerbation, is consulted to the Cardiology service for evaluation and management by their primary care provider**. The Cardiology RCT clinical nurse evaluates the consult and determines the Veterans medication regimen is not optimized. The RCT clinical team discusses

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the care needed involving the CPS and the RCT nurse calls and offers the Veteran an appointment with the CPS for medication of their heart failure medication regimen. Although this facility had wait times for a cardiologist, the RCT identified a patient where medication management was needed and guided the Veteran to the correct provider to evaluate that care rather than using his wait time eligibility for community care

Veteran requiring MH care is referred from primary care for management of depression. The mental health RCT clinical nurse evaluates the consult and determines the Veterans medication regimen is not optimized. The MH service has wait times for mental health due to a current psychiatrist shortage. However, the MH health CPS does have openings on her schedule for the Veteran to be seen. The MH RCT nurse speaks with the Veteran about the role of the CPS as part of the MH team and schedules the Veteran with the MH CPS for evaluation. The Veteran chooses to keep his care in the VA rather than using his wait time eligibility for community care.

3.6 Supplemental Role and Responsibilities Materials

- Example of Oversight Charter (Community Care)
- Example of Oversight Charter (Access and Consult Committee)
- MSA Functional Statement Template
- MSA Competencies Template

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4 HOW TO GET STARTED

Identifying and putting together Referral Coordination Teams at both the local VAMC and VISN takes coordination, collaboration and teamwork! Local facilities and VISNs will work with the National RCI Implementation Teams, using the tools and training that has been provided to date. The facilities use the guidebook in conjunction with the RCI Implementation Checklist to ensure appropriate RCI implementation.

This section will outline steps to get your RCT off the ground. In the event there is VISN RCT structure in place, the local executive sponsors/champions will work collaboratively with VISN RCT to develop consistency between local and VISN RCT (refer to VISN Referral Coordination section).

4.1 RCI Implementation Checklist

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. The checklist was created in collaboration with the Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) and subject matter experts (SMEs) from respective medical centers. The checklist will allow VAMCs to strategically implement RCTs while ensuring that required elements are completed to successfully implement, execute and have oversight of the initiative.

The RCI Implementation Checklist captures high level tasks and sub-tasks, which are broken down by implementation phases. Below is a breakdown of the phases and number of tasks associated with each phase.

Table 1: RCI Implementation Phases and Tasks

RCI Implementation Phase	Number of Tasks
Planning	20
Execution	50
Oversight	14

VAMCs will be tasked with updating their RCI Implementation Checklist bi-weekly on the following site, using the template within the site. Instructions on how to update the checklist can be found here. The VISN RCI Standards and Expectations for Fiscal Year (FY) 21 memo communicates this requirement. The Access Office will be using the information submitted by the VAMCs to track implementation progress.

Watch 'RCI Implementation Checklist Training' here

Additional training and resources to assist with completing the RCI Implementation Checklist can be found here

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4.2   Develop the RCI Implementation Team

4.2.1   Select Implementation Team Members

The RCI Champion will work with facility Executive Sponsors to establish an implementation team. This team is responsible for driving change at the facility in the development and implementation of RCT as outlined in this guidebook. This team meets routinely with an agenda and action items to progress implementation.

Recommended stakeholders are listed below:

- Chief of Staff/Deputy Chief of Staff
- Primary Care
- Mental Health
- Specialty Care
- Community Care
- Nursing
- Clinic Practice Management (CPM) Team
- GPM
- Health Administration Service (HAS)
- Administrative Leads
- Public Affairs Officer (PAO)
- Clinical Application Coordinator (CAC)'s (optional)
- Data Analytics Group (if applicable)

4.2.2   Develop Implementation Plan

The RCI implementation team will develop a facility implementation plan, utilizing the RCI Checklist, Guidebook and National RCI tools and guidance. Below are key actions to follow when developing the implementation plan:

- Review and compare current state at local site and recommended RCT process flow, roles and responsibilities. (Please review the Roles and Responsibilities of RCI
- Conduct a workload analysis and prioritize implementation by service line/specialty.
- Determine the best RCT model to implement for the facility.
- Develop a facility communication/change management plan for respective stakeholders.
- Develop a training plan for the key stakeholders (referring clinicians, RCT, specialty care service).
- Utilize transformational coaches and VISN RCI group at their facilities or VISNs.

4.2.3   Monitor and Communicate

The Champion or CPM team will support ongoing communication between all necessary groups, including facility leadership and VISN RCI leadership. This support includes the following:

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- Establish routine meetings with ELT to provide updates and feedback.
- Attend frequent huddles with RCTs and RCT Oversight Committee to discuss key findings or trends.
- Arrange meetings with Primary and Specialty Care leadership to discuss the collaborative nature of RCT, roles/responsibilities of each area, etc.
- Routine communication with VAMC/VISN RCT Executive Sponsors and Champions to report program progress, risks and issues.
- Collaborate with VISN RCI leadership for consistency throughout VISN, building bridges with other facilities for services not offered locally.

4.3   Conduct Workload Analysis

4.3.1   Workload Analysis

To perform a workload analysis, it is recommended that the implementation team review the recommended RCT process. A more detailed process map is available.

After reviewing the recommended process map, the implementation team reviews and compares the local processes with the recommended RCT process with subject matter experts. Following the review of local processes, the implementation team performs a gap analysis. The team assesses the differences to identify attributes that are needed to develop a successful RCT. Some questions to consider are listed below.

When evaluating the current state:

- What is happening (volume of referrals leaving VA, which specialties)
- What is the impact?
- What is the financial impact to the VA?

When developing a future state:

- What should happen at your facility
- When it should happen
- What changes need to be made for it to happen
- Why is it better than the current situation (timeliness of care, patient satisfaction)
- Who will benefit (quality of care, continuity of care, cost of care)

Share the findings with appropriate stakeholders, capture input and use the information to inform the next steps on the checklist.

4.4   Prioritize RCT Implementation by Service Line/Specialty

Evaluation of internal specialty care resources and workload will help the facility determine the prioritization of RCT implementation for specialty care. Facilities are expected to follow the national guidelines/timelines for implementation of services. However, it is important to review a few critical items to determine where the greatest need exists:

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1. Specialties with:
   a. Access issues/appointments with increased wait times (WT)
   b. The highest overall volume of referrals
   c. The highest community care demand
   d. The longer referral processing times
   e. Significant clinician time spent triaging
   f. Increased Veterans with drive time eligibility
   g. The highest volumes of community care referrals with Best Medical Interest (BMI) as the eligibility since beginning use of DST
   h. A strong clinical champion
   i. Strong academic affiliations
2. Modalities of care being offered (i.e., Telehealth, VA Video Connect (VVC), Face to Face, Telephone Clinics)
3. Time providers spend triaging consult (time that could otherwise be used to implement VVC, Telehealth, telephone appointments, procedures, etc.)
4. Specialty care services not offered by the local facility but potentially offered within VISN
5. Gap Analysis that includes staffing and clinical services offered at the facility and across the VISN
6. Patient Self-Referral Direct Schedule (PSDS) Clinics
   a. PSDS is a process where Veterans can call a Specialty Care clinic directly to schedule an appointment for routine care without needing a referral.
   b. If RCT leadership feels that PSDS is resulting in inappropriate referrals into the community and/or irresponsible utilization of care, it is appropriate to halt the direct scheduling and run through RCT.

4.4.1 Update CPRS Consult Menu

The local Computerized Patient Record System (CPRS)/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

1. Work with Specialties and Community Care, Consult Committees, etc., to determine what unavailable services can be offered at the VISN or other VAMCs/the Department of Defense (DoD).
   a. Establish a process for Inter-Facility Consults (IFCs) and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
   b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.
2. Use VISN menu of services to determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. Remove Community Care (CC) referral menu to drive the in-house referral option. There should be very limited referrals available to referring providers in order to promote use of RCT and available internal care options.
3. Establish order menu.

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4. Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the <u>CPRS Technical Guide</u>).
5. Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.
6. Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.
   a. Train providers *before* the menus are setup.

4.5 Staffing, Reallocation of Resources, and Productivity Goals

This section will provide guidance on appropriate staffing roles and productivity goals. This guidance provides sites the flexibility to determine the best way to reach these desired outcomes given the structure and staff currently available at one's site and VISN.

Staffing ratios are dependent on the service and how each service utilizes their nursing allocation may alter the ratio. Multiple tools are needed to ensure efficiency of the RCT and will be provided as the guidebook is developed. To be successful, the team needs to have the following information easily accessible: (1) clear triage directions, use of a clinical triage tool (2) internal and external options available and applicable to the Veteran, and (3) simple scheduling instructions.

The RCT will be triaging and dispositioning the referral; informing the Veteran of their internal and external modalities of care options; and scheduling care. The recommended initial RCT triaging productivity target is approximately 25-45 referrals per day per clinical staff member (almost 10,000 referrals per year). Productivity measures may vary depending on the specialty given complexity of some services. For example, clinical triage of Oncology or Cardiology may take longer than Podiatry or Optometry. It is important to take this into account when establishing productivity metrics. Please review the <u>Clinical Triage Recommendation Section</u> below for the formula used to calculate this target. This productivity target is subject to change based on field level data. Changes will be reflected in future guidebook releases.

VAMCs are required to create RCTs that will be responsible for integrating relevant information across specialty services, with an aim to provide Veterans with the best and most timely care options. RCTs at each VA medical facility will ensure Veteran health care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

- Access to RCT support and comprehensive information about care delivery options including face to face care, all available telehealth modalities and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects the Veteran's preference for internal/direct VA care or care in the community (if eligible)

4.5.1 Clinical Triage Recommendation

Strong Practice: Approximately 25-45 referrals per day per clinical staff member or almost 10,000 referrals per year

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Clinical staff can triage incoming referrals, provide scheduling guidance, discuss care options in the service, and be a resource within the service. We recommend looking at the volume of referrals that specialty service receives and assigning approximately 10-25 minutes per referral. Considering there are 510 minutes in an 8 ½ hour day, and 60 minutes are reserved for lunch and breaks throughout the day, there are truly 450 workable minutes throughout the day. This means that we could expect a nurse to handle up to 45 referrals per day or almost 10,000 referrals per year (when factoring in normal leave usage). This formula may be adjusted locally as needed but should be close to this target.

Ideal: 55-60 referrals per day as demonstrated by DoD Integrated Referral Management and Appointing Center (IRMAC) model

For more information on #RCT#, reference RCT Operations Section, subsection #RCT#.

4.5.2   Scheduling Recommendation

Forthcoming in future guidebook versions.

Preliminary information for some specialties is in the How to Get Started Supplemental Materials Section.

4.5.3   Staffing Structure Consideration

The RCT should be made up of administrative and clinical team members. The clinical Full Time Equivalent Employee (FTE) recommendations for RCT members are RNs, PAs, Social Workers (SWs), and/or Advanced Practice Registered Nurse (APRNs)/NPs. Ideally it would be an RN and MSA used to provide frontline care to Veterans (Please review the Minimal RCT Composition Section). The administrative FTE recommendations for RCT members are MSAs, Advanced Medical Support Assistants (AMSAs) and/or other clerical administrative roles such as Licensed Practicing Nurses (LPNs), Health care Technicians (HTs).

To source the RCT member, we highly recommended for facilities to examine FTE utilization and re-allocate staff members first before establishing new FTE if re-allocation examination is inconclusive. When re-allocating, the facility should:

- Evaluate Community Care FTE
- Evaluate current Staff & Specialty Care Case Managers
- Evaluate current Reasonable Accommodation Clinical Staff
- Evaluate RN Staff vs. Inpatient Bed Days of Care (BDOC)/length of stay (LOS)/Occupancy
- Evaluate current Clerical/Admin FTE & Productivity

4.5.4   Alignment / Supervision of the RCT

The alignment and supervision of the RCT will be based on how the facility operates day-to-day. Some recommendations for RCT alignment and supervision are with Specialty Care Services, Clinic Practice Management Team (supervision vs. strong working relationship), or any other existing Care Coordination programs/team.

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4.6   Identify Optimal RCT Model

The RCI implementation team should use their workload analysis and current process flows to determine the most appropriate RCT Model. Sites fall into three categories:

1. Category 1: They currently have the clinical support/nursing infrastructure in Specialty Care.
2. Category 2: They are a smaller site with limited Specialty Care, but often send much of their Specialty Care to another VA site.
3. Category 3: They are somewhere in in-between categories one and two, with limited clinical support/nursing infrastructure in place for Specialty Care they offer.

A description of the most common RCT models with pros and cons are listed in the following sections.

4.6.1   Centralized RCT Model

The Centralized RCT model houses the entire RCT team (administrative and clinical) under the same management structure, but they are built and function as an extension to the specialty care service. For the greatest success of this centralized model, the RCT management team works collaboratively with specialty care leadership team to ensure that the team is trained and functions as an extension of specialty care. This model builds a bridge between RCT and specialty care to ensure accountability and consistency in how VA services are utilized to the full extent.

Table 2: Pros and Cons of Centralized RCT Model

Pros	Cons
- Staff is co-located (physically or virtually), easing burdens on communication and messaging challenges - Consistency in training, processes and functions - Consistency in RCT practice due to singular focus consistent with RCI principles - Improved collaboration between the central team and specialty care services - Ease of determining best use of VISN resources for VISN RCI leadership	- Other services lose existing staff if no additional facility FTE added - Services outside the central team may not share extensive understanding of RCT model to the same extent as centralized RCT staff

If this model is selected, the implementation team should schedule a meeting with facility leadership, including the COS, nurse executive and Specialty care service chiefs to coordinate development, implementation and education of this centralized model. Alignment of RCT under the COS or ADPCS is recommended.

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4.6.2   Service Line/Specialty RCT Model

The Service Line/Specialty RCT model is when the RCT is embedded in the existing service line or specialty and duties are aligned with roles of RCT members.

If this model is chosen, the facility needs to determine who will provide oversight regarding the successful implementation of RCI, given the management structure potentially crosses multiple areas. The facility will need to bring together all key stakeholders to ensure each specialty service RCT is following the processes for admin/clinical functions as outlined in this guidebook. In addition, it is critical that the education of each RCT understand VISN resources available and how to connect with VISN RCI as appropriate.

Table 3: Pros and Cons of the Specialty Line/Specialty RCT Model

Pros	Cons
- Services do not lose any FTE - Minimal/no organizational differences from existing footprint though duties will change	- Additional duties added onto potentially already overburdened staff, RCT may not be the primary focus of the staff member - Potential for decentralized team members to see RCI as "just another duty" - Lack of consistency in practice due to different levels of understanding of the RCI goals - RCT functions under multiple management structures, which often silos teams and processes, making consistency difficult to manage - Difficult to educate every specialty service regarding VISN resource availability

4.7   Form Referral Coordination Team

This section describes how to identify and form the RCT. VAMCs and VISNs have autonomy to staff the RCT based on current staff and specialties available locally. However, facilities must dedicate sufficient staffing to ensure successful RCI implementation across required specialties at their facility.

The composition of this team should follow the minimum composition recommend in the Roles Supporting Referral Coordination Minimal RCT Composition Section. Suggested staffing models can be determined with analysis of your process (Please review the Conduct Workload Analysis Section). The facility implementation team will make recommendations regarding the model that best fits the facility's needs and communicate this to Executive Sponsor.

The RCT will begin supporting our Veterans by triaging referrals and determining the care options available to address their care needs.

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Please review the RCT Operations Section regarding the details of how the RCT will function. Below sections outline tools the RCT must use during the referral triage and scheduling process.

RCT Cross-Training

The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. "cross-training" of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility and services offered. The RCT must be able to speak to both internal VA and community care options and processes to get the patient scheduled in a timely manner.

4.7.1 Required RCT Tools: Consult Toolbox (CTB) and Consult Tracking Management (CTM/CTM+)

Consult Toolbox (CTB)

The Referral Coordination Team Member User Role was released in CTB on 10/25/21. This update will go live on October 25, 2021 as part of VHA's continuous improvements to optimize consult management processes and improve data quality.

Use of the RCT User Role within CTB **is mandatory** for all members of Referral Coordination Teams (RCTs) and its utilization will be incorporated in RCI outcome metrics. Reports are being updated in the RCI VSSC Dashboard to track utilization of the user role within CTB.

Staff can assign themselves the RCT User Role within "User Settings" in CTB. Additional guidance on the use of the RCT User Role within CTB can be found in Chapter 7.2.7.

Step 1

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

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Step 2

User Settings ✕

User Role
- ○ MSA/Clerk
- ◉ RN
- ○ Provider

☑ **Referral coordination team member**

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**

SAVE SETTINGS

Additionally, RCT members must use the CTB to forward a consult to community care (section 2.18 in the community care field guidebook). The following CTB 2.0 TMS Courses are available for CTB 2.0 process specific steps:

- Webinar: Consult Toolbox 2.0 Training Demo TMS Course 4567333
- What's New - Consult Toolbox 2.0 (CTB 2.0) TMS Course 4568812

 RCT must also be able to capture patient preferences for community care, including if a Veteran chooses to self-schedule the community appointment. Please review Community Care Scheduling Section and/or (section 2.19 in the community care field guidebook); TMS course ID: 45058 specifically focuses on how to capture preferences.

Please submit CTB process related questions to the OCC Consult Toolbox Office Hours - Power Apps. Additional information on the CTB can be found in the Consult Toolbox SharePoint site. This site contains CTB Fact Sheets, Q&As, user guide, consult factor data dictionary and much more)

Consult Tracking Management (CTM/CTM +)

Staff are required to use CTM/CTM + **when it is available**. CTM is being sunset in the beginning of 2022. The benefits of CTM+ include:

- Provides a department/service view of RTCs.
- Displays and updates consult information in real time for both direct/internal and community care consults.
- Integrates with other VistA packages to provide up-to-date information on the same page.
- Creates workflow efficiency by eliminating paper or duplicative systems.
- Provides worklist view ensure every team member had up to data work list for consults they need to process.
- Improves patient satisfaction by providing tools to help ensure timely completion of consults.
- Monitors user performance and view numerous metrics pertaining to consult aging and bottlenecks.
- Includes consult tracking unique to Community Care workflows.
- Provides efficient, automated tools for tracking and managing RTCs.
- Provides additional features for enhanced progress note management.
- Provides enhanced scheduling features that allow viewing appointments by clinic.

Steps the Implementation team should take to setup CTM+ at the site include:

- Work with DSS on scheduling facility training after CTM+ is approved by the Network Director or Facility director and contract is awarded.

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- Train staff on CTM+ and provide <u>information brochure</u> to impacted staff.
- Implement CTM+ in daily operations.

Find more <u>information on technical aspects of CTM and recommendations for procurement</u>. Additionally, any questions not addressed by the resources provided/linked to this guidebook should be directed to Alyssa Tsai (<u>atsai@dssinc.com</u>).

4.7.2   Local Facilitation of RCT Training

RCT training at the local level is crucial for RCT members to familiarize themselves with referring provider groups and more importantly, specialty care groups. The following steps should be followed to ensure the RCT is trained.

1. Identify local training point of contact, who will coordinate and report on training status of RCT to the implementation team.
2. Deploy training from the national RCT team.
    a. Clinical Training for RCT should follow the <u>RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live Section</u>. An example of and RN orientation checklist is linked here and in the <u>How to Get Started Supplemental Materials Section.</u>
    b. Administrative Training for RCT guidance can be found on the <u>National Standardized MSA Training SharePoint</u>.
3. Deploy training from locally developed SOPs to customize the training to your specific VAMC/VISN.
    a. The building of a triage tool for each specialty is a crucial part of RCT Operations <u>Section</u>, it is the tool which directs RCT clinical staff on how to consider a patient in accordance with a specialty. More information on how to build and operate the tool, along with examples, can be found in the RCT Operations <u>Section.</u>
    b. Remember to include education of RCT members on beneficiary travel, special mode travel, and Veteran Transportation Service availability (Disabled American Veterans (DAV), shuttle services, etc.). This can vary by site or VISN.

4.7.3   RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live

Each Specialty develops and arranges a comprehensive orientation for their designated RCT. If a centralized model is used, Specialty care and RCT management will work together to ensure all elements of RCT development are included. This should include the development of a clinical triage tool (Please review <u>RCT Operations Section</u> for details).

1. RCT reviews Specialty process and materials to thoroughly understand their Specialties and function as an extension or bridge to the Specialty.
    a. Suggested activities:
        i. Overview of the Specialty
            1. Development of clinical triage tool (Please review the <u>RCT Operations Section</u>. List all services, procedures or other care that the Specialty provides

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      2. Services work-up orientation (i.e., what needs to be done when certain referrals are received: labs, procedures, other RCT coordination)

   ii. Specialty Care Organizational Chart

   iii. List and define roles of all the Specialty staff (admin, clinical support, physician, etc.)

   iv. Current Clinic Staff schedules (i.e., How is the Specialty covered and operate?)

   v. Current Service Agreements

   vi. Current Referral Triage Process

   vii. Scripted quality talking points (i.e., Why should a Veteran consider this VA specialty care clinic?)

   viii. Note/Referral Templates

   ix. Documentation expectations for the RCT

   x. List of common errors in referrals, and how identify and properly re-disposition to correct Specialty

2. RCT shadows Specialty, developing a working relationship and building a cohesive team.

   a. Administrative and Clinical RCT (admin and clinical) observe current state including referral triage and scheduling process. Example activities include:

      i. Spending time in the specialty clinic with the team understanding clinic functions, services, etc.

      ii. Reviewing consults/referrals with the providers who have historically triaged consults. This provides the Clinical RCT clinical insight and training in how best to clinically triage and disposition referrals using the clinical triage tool.

      iii. Spending time with scheduling team members as appropriate to better understand scheduling and review coordination issues.

3. Specialty, National Program Office, and VISN leadership provide detailed "buffet" Menu of services the VA/VISN offers. The RCT uses this menu to determine the comprehensive range of services the VA offers both locally and at the VISN. RCT is completely aware of all options available to Veteran, within VA health care system and community. These options will be offered to the Veteran during the referral process.

   a. Options for care include:

      i. E-Consults

      ii. Local tele-specialty options

      iii. Telephone visits

      iv. VVC

      v. Face to face

      vi. Group visits

      vii. VISN referral options (i.e., VISN menu of services)

      viii. Other regional VA referral options (geographically close, but different VISN)

      ix. National tele-specialty options

      x. Community options

      xi. Other Options

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4.8   Socialize and Educate Facilities

Socialization and education of RCI and the newly formed RCTs are critical steps in the implementation process. Ensuring the facility staff understand the critical role that RCT plays in the referral process is central to successful implementation. The RCT serves as a liaison between primary and specialty care, yet they are also an extension of the specialty care service designed to ensure patients are well prepared for their specialty care visit, at VA or in the community. VA is moving to operate more like multispecialty practices, with open lines of communication between different clinics to ensure our Veterans are receiving timely coordinated care. When appropriate, this care can be delivered by VA. When our Veterans will be better served in our communities, we will support that care. Further guidance will be developed to support this change management effort, but initially it is important to make sure these groups understand their roles and the future benefits of this process change.

Ideally facility socialization and education start before the RCT is formed and functioning. The facility Executive Sponsors/Champions and implementation team should lead this effort. Tools to use in the socialization/education process include:

- Please review the Internal/Staff factsheet and Scripts for Discussing Care Options Section, that are available in this guidebook.
- Executive Sponsors are encouraged to hold town halls or leadership sessions to communicate the importance of this initiative to all staff.

4.9   How to Get Started Supplemental Materials

- RCI Implementation Checklist Training
- Limited Specialties Webinar Recording
- How to Build a Triage Tool
- Service Agreement SOP (coming soon)
- Administrative RCT Training
- NEJM Catalyst Article: The Referral Coordination Team: A Redesign of Specialty Care to Enhance Service Delivery and Value in Sleep Medicine

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5 OPTIMIZING REFERRALS

5.1 Consult Directive 1232

The consult directive 1232(2) published August 24, 2016 and associated SOPs (located in the supplemental materials) outline the requirements for the implementation and maintenance of the CPRS Consult application in VHA. Specifically, responsibilities for consult status timeliness, responsibilities for sending and receiving services, business rules for consult set up and usage and oversight responsibilities are defined. The policy for the disposition and scheduling of consults for both Mental Health and Non-Mental Health services including provider review and minimal scheduling efforts are defined. The processes for disposition of low-risk consults are also outlined.

5.2 Developing Care Coordination/Service Agreements

A Care Coordination/Service Agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the workflow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; and reviewed or updated as changes are needed or as set forth by local medical center policy. Refer to the Care Coordination/Service Agreement SOP (coming soon).

The assumption should be made that the Chief of Staff has fully endorsed the use of Service Agreements and has relayed that endorsement and expectation of involvement to Service Chiefs. Additionally, GPM and Associate GPMs would be the ideal owners of this process.

The following checklist may be used to assist facilities in the implementation of Care Coordination/Service Agreements:

1. Utilize a standard template including the following elements:
   a. Service Overview
   b. Services Provided
   c. Staffing & Availability
   d. Services Not Provided
   e. Referral Process & Expected Timeliness
   f. Required Referral Information
   g. Criteria for Discharge
   h. Review & Renew Dates
   i. Signatures from Service Chief and Primary Care Chief
   j. Contact Information for Service
   k. Appendices (items the service wants included, but do not fit into the above categories)
2. Assess the current state of Service Agreements.
3. Existing Service Agreements should be:
   a. Transitioned to the standardized template.
   b. Reviewed for accuracy by current Service Chief and/or designee.

4. Prioritize Services without Service Agreements based on volume, complexity and costs.
5. Meet and/or communicate with Service Chief regarding potential stakeholders for the service.
6. Organize a kick-off meeting with stakeholders to:
    a. Provide objective of Service Agreements.
    b. Develop relationships.
    c. Create an understanding of consensus decision-making with involvement from Primary Care stakeholders.
    d. Assign responsibilities for sections within the Service Agreement.
7. Coordinate follow-up meetings with stakeholders with an identified deadline for the completion of the initial draft.
8. Meet and/or communicate with Primary Care Chief regarding potential Primary Care Providers for review of Service Agreements.
    a. Coordinate with assigned Primary Care Providers regarding input required and timeline of review of Service Agreements. A reasonable deadline must be established.
9. Follow-up with Specialty Service stakeholders on feedback provided from Primary Care.
10. Coordinate any additional meetings between Specialty Care and Primary Care stakeholders, if needed to come to consensus on Service Agreement.
11. Obtain signatures on Service Agreement from Service Chief and Primary Care Chief.
12. Publish Service Agreements to SharePoint.
13. Educate staff on availability, location and expectations of use of Service Agreements. Consider adding link to Service Agreement within Consult Template.

Refer to examples of Care Coordination/Service Agreements.

5.3   What Makes a Good Consult?

5.3.1   Referring Perspective

A consult template should be developed with the initiating provider, the receiving service, and the patient in mind to promote ease of entry, accuracy of clinical content, and timeliness of completion to ensure that the patient gets the right care at the right time in the right place.

A consult template should reflect a negotiated and mutually agreed-upon understanding of appropriate conditions for referral and necessary work-up prior to referral entry as embodied in the Care Coordination/Service Agreement.

A simple and streamlined consult template enhances communication within patient care teams. The contents of the consult template should be tested for usability to assure efficiency and ease of data entry while minimizing response burden.

The clinician will:

1. Choose the consult in the CPRS orders tab.
2. Within the consult, select STAT (within 24 hours) or Routine.

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3. If appropriate, select a specific procedure or diagnosis within that consult so the specialty knows how to best route it.
4. Ensure adherence to Care Coordination/Service agreements, ordering any tests required for comprehensive specialty care. A consult template may or may not automatically prompt the clinician to place necessary orders.
5. The consult template should be uncluttered and easy to navigate. Basic requirements for triage and coordination of a consult are:
   a. Indication/clinical history
   b. Reason for request
   c. Does the patient agree to this referral and has patient been told that a member of the Referral Coordination Team will contact him/her?
   d. Indication of patient preferred modality of care (i.e., Video telehealth, E-Consult, Face-to-Face)

5.3.2   Example Consults

The following consult template was developed by Gastroenterology (GI)/OVAC and sent out nationally for a Screening Colonoscopy. It is very simple for the referring provider to fill out, contains information on the patient's other diagnoses and whether the patient has issues with sedation.

Figure 2: Screening Colonoscopy Consult Template

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Cardiology Echocardiogram (ECHO) consult which:

- Contains the reason for ordering the ECHO
- Has a data object to pull in the most recent ECHO / Catherization
- Asks for the reason the patient had a previous ECHO

Figure 3: Cardiology ECHO Consult Template

5.4 Update Consult Menu

The local CPRS/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

1. Work with Specialties, Community Care, Consult Committees, or other oversight committees, to determine what unavailable services can be offered at the VISN or other VAMCs/DoD.
   a. Establish a process for IFC and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
   b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.
2. Determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. (More scripting information can be found in the Scripts for Discussing Care Options Section.
   a. Remove referrals from the Community Care (CC) referral menu to drive the in-house referral option so those clinics can have a chance to meet the Veteran's clinical needs and only forward to CC if a Veteran is CC eligible and opts-in
3. Establish order menu
4. Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the CPRS Technical Guide).
5. Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.
6. Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.
   a. Train providers *before* the menus are setup.

5.5 Optimizing Referrals Supplemental Material

- Consult Processes and Procedures Directive 1232 (2)
- Consult Tips of the Week
- Consult FAQs
- Unable to Schedule SOP
- Minimal Scheduling Effort SOP
- Consult Timeliness SOP (coming soon)
- Consult Business Requirements (coming soon)
- Care Coordination Service Agreement SOP (coming soon)
- Consult Use for Established Patients SOP (coming soon)
- Gastroenterology Colonoscopy Procedures SOP(coming soon)

6 VISN REFERRAL COORDINATION

6.1 VISN Referral Coordination Program

This section will outline the key strategies to fully engage VISNs in RCI development implementation. VISN Referral Coordination has two elements to consider:

1. VISN RCI oversight, guidance and assistance to local facilities that offer limited specialty care
2. VISN RCT Operations

6.2 VISN Oversight and Offering Limited Specialty Care Support

VISN RCI oversight, guidance and assistance to facilities offering limited Specialty Care are key to the overall success of referral coordination. VISN RCI leadership should provide a clear understanding and expectation for facilities to incorporate use of VISN resources prior to sending patients to community care. In addition, they will establish consistent standards and processes that will assist and support the local RCT in fully utilizing VISN resources.

VAMCs that do not offer a wide array of Specialty Care services to address Veteran's health needs will require additional coordination. In such situations, the RCT (local or VISN) must look for all VA care options across the VISN to ensure that the patient is offered all internal/direct VA care and community care options available prior to making a decision. VA offers a variety of face to face, telehealth, VA Video options, all of which must be considered and offered to Veterans during the referral coordination process. Ensuring that local facility RCTs have access to a **Error! Reference source not found.** Section and the ability to connect with VISN R CT (if available) to assist in offering the wide array of VA services available will provide Veterans with the best possible options to meet their healthcare needs.

VISN RCI Leadership will:

- Ensure streamlined processes for inter-facility consults (IFCs) and handoffs between facility. Consider use of a "Business Rules" within the VISN to communicate VISN processes and expectations. An example of this is provided (VISN20 Care Routing Business Rules).
- Establish VISN RCT as a hub for the local RCT to assist in the knowledge and use of specialty care resources across the VISN. This will assist in building collaborative relationships between local RCT and VISN resources.
- Collaborate with VISN ICC, CRH and OCC is needed in the development activities of IFC process, Menu of Services, Service Agreements, etc.
- Develop service agreements between primary care, RCT and specialty care services that outline the roles/responsibilities to ensure smooth handoffs across the VISN. Examples of these are in the How to Get Started Supplemental Materials Section.
- Support increased use of Telehealth Options, VA Video Connect (VVC) – offer this to all VISN facilities for services with limited specialists.
- Evaluate the current IFC process and determine how to improve this. Consider future state with Cerner implementation.

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Local and VISN
Collaborative Structure

VISN Referral
Coordination

VISN General
Referral
Coordination

VISN Referral
Coordination Team

Business Rules
Service Agreements
IFC Process

Specialty Service (ie.
Sleep Med)

Local VAMC Referral Coordination Teams

Figure 4: VISN RCI Collaborative Relationship with Local RCT

6.2.1 How to Use VISN Resources

Ways to utilize VISN resources include:

- RCTs can use of VISN Menu of Services to ensure all options of care are presented to patients.
- RCTs can use a VISN Access Dashboard to help facilities determine wait times across the VISN. This will need to be modified in the transition to Cerner.

6.2.2 How to Hand-off Referrals (IFCs) Between Facilities

VISNs should ensure there are clear processes around IFC use (in business rules) between facilities. Include the local RCT in the IFC process to promote collaboration and timely handoffs.

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6.3   VISN RCT

The VISN RCT model centralizes specialty referral triage and scheduling, for a particular specialty. The model allows VISN RCT to search all facilities within the VISN for timely care that best fits the Veteran's needs. This model can be used for specialty services that are scarce or limited within the VISN and/or are complex and require a good working knowledge of VISN-level resources.

A specially trained team of nurses and administrative AMSAs work closely with the Veterans, each other, and the clinical services at each facility to meet the Veteran's needs. This model is a great example of how to provide referral coordination and internal/direct VA services to those facilities who do not provide specialty care service(s) at their local facility. This model has a strong interdisciplinary approach, working daily with providers at the local facilities as an extension of the local facility specialty service. The team uses a VISN Clinical Triage Tool that guides the decision making of the nurse and provides pertinent information for the admin/scheduler regarding what services are offered at each facility.

VISN RCT goals include:

- Optimize the number of Veterans receiving specialty care within the VA network.
- Maximize opportunities for care through alternative care modalities, including VA Video Connect, Telehealth, Phone Clinic and traditional face to face.
- Maximize utilization of existing clinical resources across a VISN.
- Optimize referral triage and appointment schedule process.
- Provide consistency across the VISN utilizing established tools.
- Decrease provider time spent triaging referrals.
- Ensuring patients have accurate information regarding VA and community resources.

When VISN RCT is established for a specialty across the VISN, local RCT is not needed for that specialty, as the VISN has chosen to provide a VISN approach to referral coordination. VISNs can use this approach for complex specialties and specialties where there are limited resources in the VISN. VISN Referral Coordination acts as the hub while the local facility RCT act as the spoke. The VISN Referral Coordination Hub should establish a routine meeting with the local RCTs to promote and provide open communication, continuity of care, consistency across VISN, collaboration, bridge building and open sharing of services. This will ensure VA is offering Veterans quality and timely care within VA.

6.4   Strong Practice/Brief History VISN Care Routing/Referral Coordination

VISN Care Routing was launched in VISN20 in 2014 in response to managing waitlist challenges. The VISN Care Routing Team serves as a central hub to assist facilities in the coordination of complex patients and scarce specialty resource needs, providing consistent communication regarding services available within the VISN. VISN Care Routing Business Rules were developed to ensure all facilities were functioning as an integrated network and to promote seamless and timely transitions of care from facility to facility. Multiple tools have

been developed to assist in the Care Routing process, including: Access Dashboard, Care Routing Inquiry Process, Cancer Care Interdisciplinary Team and Change in Services Process.

In 2018, VISN20 Care Routing worked with OVAC to pilot the Specialty Care Routing Triage & Scheduling Model, which resulted in the VISN20 Sleep Medicine pilot, based on the DoD Integrated Referral Management & Appointing Center (IRMAC) model.

What started as Care Routing in 2014 has now transitioned as the national Referral Coordination Initiative that can be implemented at local facilities as well as VISN. VISN Referral Coordination is critical to support the local RCT to maximize utilization of specialty care resources across the VISN when local facilities cannot provide the service. This includes utilizing all care modalities (e.g., face to face, Telehealth (CVT and VVC), telephone clinic and E-Consult). VISN RCT can look across the VISN and schedule patients at any facility within the VISN, per patients request. RCI promotes providing Veterans with options for internal/direct care within VA as well as in the community. RCT provides patients with VISN level resources so they can make the best-informed decision for care.

Referral Coordination Division Organizational Chart

```
┌─────────────────────────────┐
│ Chief Medical Officer/ Chief │
│      Nurse Executive        │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│  VISN Referral Coordination │
│         Leadership          │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────┐
│ VISN Referral Coordination  │
│         Team Clinical       │
│        Administrative       │
└─────────────────────────────┘
```

Figure 5: Referral Coordination Division Organization Chart

6.4.1 VISN Referral Coordination Roles and Responsibilities

VISN RCT roles and responsibilities mirror those listed in Roles and Responsibilities of RCI Section. However, there are a few slight differences when a VISN RCT is established, which requires coordination and collaboration across multiple facilities.

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VISN Referral Coordination Leadership

Responsible for oversight of RCT triage and scheduling functions for designated services and facilities within VISN, including but not limited to:

- Manage and supervise VISN RCT, ensuring adequate staffing, space, and equipment to meet VHA referral triage timelines.
- Coordinate with local specialty services to implement processes, using a phased approach, in the designated services and facilities.
- Collaborate with local RCT in development of hand offs when appropriate to VISN RCT.
- Collaborate with facility leadership to maintain RCI consistency throughout VISN.

Facility Leadership

Responsible for collaborating with VISN Referral Coordination Leadership.

Facility Clinical Services

Responsible for collaborating and training the RCT in their specialty clinical services, including:

- Develop pre-referral guidelines/clinical pathways and the RCT triage tool in the designated specialty.
- Provide specialty training to the RCT team to develop them as extension of the service
- Collaborate with VISN Referral Coordination MD and Program Manager providing guidance and oversight when provider input is required.

Designated clinical services retain overall responsibility of triage and management of referrals that do not easily conform to triage guidelines.

VISN Clinical RCT

Responsibilities are the same as local Clinical RCT. However, the VISN Clinical RCT routinely communicates/collaborates with local facility specialty service and other RCT teams as needed to identify VISN resources/services available.

VISN Administrative RCT

Responsibilities and recommended staff (typically an AMSA) are the same as local RCT. However, the VISN Administrative RCT can schedule across multiple VISN facilities to offer and schedule internal/direct care within VA whenever possible. They collaborate with community care when the Veteran chooses this VISN option to ensure timely transition and handoff for scheduling.

6.5   How to Get Started

This section is like the VAMC in the How to Get Started Section. However, there are a few things to consider when building a VISN RCT. The following steps will help you systematically walk through how to identify and create a VISN RCT.

6.5.1 Assess Need – What Makes Sense at VISN and What Can Stay Local

RCI success relies on identifying the appropriate specialty service to launch VISN Referral Coordination Triage/Scheduling. This requires a "current state" assessment across the VISN of specialty care services.

6.5.2 Identify Key Stakeholders

Stakeholders are responsible for strategic planning, reviewing specialty data, decision making and identification of leadership team, steering committee and workgroups.

VISN Level Stakeholders:

- VISN CMO
- VISN BIM
- VISN Primary Care Committee
- VISN Specialty Care Access Team/ICC/Clinical Resource Hub
- VISN Telehealth Coordinator
- VISN Chief Nurse
- VISN Health Administrative Service (HAS) Leadership
- VISN CAC
- VISN Project Manager

Facility Level Stakeholders:

- Facility Chiefs of Staff
- Facility Specialty Care Leadership
- Facility HAS
- Facility Telehealth Coordinator
- Facility Chief Nurse
- Veteran
- Veteran Experience Office (VEO)
- Union Leadership

6.5.3 Complete Current State Assessment

Assess the current state by reviewing the following topics:

- What specialty care services are scarce across the VISN?
- What local RCT's currently exist?
- Where is there a large volume going into community care?
- How much time do providers spend triaging referrals?
- What types of modalities is the service currently using (e.g., telehealth)?
- Data gathering (community care volume, clinic timeliness, provider time triaging)
- Current/upcoming initiatives
- Cerner/electronic health record (EHR)
- MISSION Act

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- On-Demand Appointments
- VA Online Scheduling
  - New Scheduling Software

6.5.4 Develop Business Case

Develop a business case by considering the following:

- What might Referral Coordination do for my VISN?
- How will my VISN support expansion of RCT at the VISN?
- What resources are needed for planning?
- What needs will be met by implementing VISN Referral Coordination?
- How will local RCT and VISN RCT team work together?
- Create a presentation to VISN Clinical Services and Resource Management.

6.6 Develop and Plan

Once VISN RCT concept is approved, we recommend holding a face-to-face Strategic Planning Kickoff Meeting with key stakeholders from VISN and local facilities. A kick-off will not increase buy-in, but it also develops and cultivates working relationships with the team invested in VISN RCT.

6.6.1 Identify VISN Leadership Team

The Leadership Team is responsible for oversight of launching VISN RCT and should include VISN and local facility team members and have no more than 10 individuals. Team should meet weekly initially to discuss implementation timeline, progress of workgroups, identification of barriers and decision making.

6.6.2 Identify VISN Steering Committee or Overseeing Body

The Steering Committee is responsible for guiding decisions related to what specialties are implemented VISN-wide and for the overall guidance on VISN level decision making. This committee can include a larger number of individuals, with everyone ideally involved in the initial planning sessions. This meeting group should come together monthly to review progress, problem solve barriers and ensure VISN RCT is moving forward.

6.6.3 Identify Individual Workgroups

Individual workgroups are needed to manage the large-scale change and implementation of RCT at the VISN level. These groups should be multi-disciplinary with an identified lead and clear workgroup charter with timelines. There is a considerable amount of "pre-work" that must be done prior to launching the VISN RCT. This "pre-work" is assigned to the workgroups listed below. The number of workgroups can be adjusted based on the identified need in your VISN.

6.7 Workgroups

Develop clear and concise Workgroup Charters for each group.

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Example of Referral Guidelines Workgroup Charter: Develop clinical pre-referral guidelines and referral templates that clearly communicate to the referring provider what is expected prior to referral. Guidelines will be consistent across the VISN, providing uniformity and consistency for the referral coordination team triaging from site to site.

List of workgroups:

- **Referral Guidelines/Pre-Work Team:** Develop guidelines, referral templates, and clinical triage tool.
- **RCT – Triage and Scheduling Workgroup**: Assemble the VISN RCT team, role of Clinical RCT member, role of Administrative RCT member, documentation of triage, SOPs, etc.
- **Care Delivery/Telehealth Workgroup** (CVT, VVC, Telephone, and Store and Forward): Develop VISN Telehealth Service Agreement (TSA) and support expansion of VVC across facilities.
- **Communications Workgroup:** Identify and develop training tools for local/VISN staff, and market and promote the VISN RCT.
- **Clinical Applications Coordinator (CAC) Workgroup**: CACs are key stakeholders in strategic planning and are part of the workgroups. They must partake in the initial strategic planning and early assessment of what systems/processes are already in place and what needs to be built. Tools requiring CAC involvement include: Referral Guideline Menus, CPRS/EHR Templates, Note Titles, and assigning VISN referral coordination staff as recipients to alerts and Interfacility Consults.
- **Data Workgroup**: Conduct baseline data gathering; ensure metrics are in line with RCI; perform ongoing data management/validation, patient/provider satisfaction, and data quality validation.

6.7.1 Pre-Work

Prework consists of:

- **Pre-referral Guidelines/Clinical Pathways:** The referring provider must follow these guidelines to patient information and required studies/tests *prior* to entering referral. These guidelines are specific to the specialty service that are developed by the Referral Guidelines team and then embedded in the EHR. Consistent guidelines across the VISN for a given specialty provide consistency for the referring providers, referral coordination staff and the receiving specialty service. Depending on where your VISN is with Cerner implementation, you must collaborate with Cerner/EHR team during this phase. Clinical staff receiving consults must document whether the pre-work provided for the referral is acceptable within the CTB Consult Review tab.
- **Electronic Health Record Referral Templates:** EHR referral templates include auto-populated patient information as well as templated questions prompting the input of pertinent clinical information needed by the triaging clinical team. The Referral Guidelines team developed these templates, which are embedded in CPRS/Cerner. Consistent templates across the VISN ensure consistency for referring providers, referral coordination staff and the receiving specialty service. They should be clear and

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simple but provide enough clinical information for the both the triaging and receiving team. (Note that these will change with Cerner Implementation.)

- **Clinical Triage Tool:** The Clinical Triage Tool contains pre-determined clinical guidelines and scheduling guidelines for clinical and Administrative RCT to use for referral review, triage, documentation and scheduling of care. This is a specialty-specific tool that the Triage Team and Referral Guidelines team build collaboratively. This is a decision-making tool for both the clinical and administrative staff, providing consistency from facility to facility in the triage/scheduling process. This tool takes time to build and can be a "living document" that is edited as the program evolves. Specialty providers throughout the VISN must provide input into this clinically based decision-making tool. RCI has/will provide basic triage tool templates and a "how to build a triage tool." It is important to note, the clinical review method/tool must be documented using the Consult Review tab in CTB.

- MCG Guidelines: An evidence-based clinical review tool focusing on the severity of illness and diagnosis to determine clinical appropriateness for requested outpatient health care services.
- InterQual Criteria: An evidence based clinical review tool focusing on a set of measurable, clinical indicators, as well as diagnostic and therapeutic services reflecting the need for acute hospitalizations
- Chief of Staff Approved Protocol/Local RCT Triage Tool: A Medical Center specific framework developed to provide predetermined criteria to guide care and/or referral (i.e. RCT Triage Tool, Service Agreements, Sharing Agreements and approved SOPs).
- Other: Select this option upon facilities discretion based on local process.

- **VISN Service Agreement:** This document outlines the expectations of the referring provider, VISN referral coordination team and specialty providers as patients are shared across the continuum of care. The Referral Guidelines team develops the VISN Service Agreement, which provides a common understanding of roles, responsibilities and expectations for sharing patients within a VISN.

- **VISN Telehealth Service Agreement (TSA):** This document is required to initiate Telehealth Services. A VISN-level TSA can be developed for a specialty for consistency across the VISN.

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6.8   Develop Performance Monitoring Plan in Line with RCI Expectations

Monitoring the progress of VISN Referral Coordination triage/scheduling is integral to understanding the overall impact that RCT has on the VISN and local facility specialty care programs. RCI success depends on monitoring timeliness of VA care, community care demand and quality of nurse triages. Leadership must identify VISN level data management for the VISN RCT in collaboration and support of the local facility RCT metrics.

Examples of performance monitors include:

- Quality
  - Accuracy of Nurse Triage
  - % Provider Agreement with Nurse Triage
  - % Order/Plan change
  - % Order/Plan deferred to provider
  - Quality should be assessed in two periods: 1) initial training, and 2) continuing review.
    - Initial Training: Initial training may include a higher level of provider oversight in the early phases, which likely includes provider co-signature on triage notes until the providers feel nurses competent to triage independently, per triage tool.
      - Continuing Review: After the initial training period ends, nurses no longer co-sign specialists for review, unless the triage tool requires it based on patient complexity, but ongoing audit and feedback is essential to maintain triage accuracy and quality.
- Timeliness and Access
  - Time to scheduling contact
  - Time to appointment
- Community Care Demand
  - Community Care Referral volume pre/post VISN RCT
- Provider Time
  - % provider spent triaging referrals
- Patient/Provider Satisfaction
  - Patient perception of timeliness to care
  - Patient perception of knowing next steps in care
  - Patient perception of being treated with respect
  - Provider perception of VISN RCT impact on provider time

6.9   Implement and Monitor

Once the workgroups have completed the pre-work, VISN RCT training should begin. The Communications Workgroup will have identified key stakeholders for training and created training slides for the following example audiences:

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- Referring Providers - VISN Primary Care Committee
- Specialty Providers – VISN Specialty Team Committee
- Facility Scheduling
- Community Care
- VISN RCT

VISN RCT functions are very similar to the local RCT. However, the VISN RCT can look across the VISN for specialty care resources that are not available locally and provide patient's with expanded VA options for care. The VISN Clinical RCT has easy access to the specialists within the VISN for clinical inquires and triaging who are readily available to assist local RCT when local services are not offered. The VISN Administrative RCT can schedule at local facilities across the VISN, offering VVC or other appropriate modalities.

VISN RCI implementation includes routine VISN Referral Coordination meetings, which are led by the VISN RCT manager and include the VISN Referral Coordination representative and Local RCT representative for each facility. These meetings provide a consistent forum for questions, identification of barriers, problem resolution, team building and refining processes across VISN.

6.10 Monitor and Improve

Ongoing evaluation of the VISN RCT is critical to the success of this program. The VISN Leadership Team and/or Steering Committee meet regularly to assess VISN RCT's overall impact. This includes routine evaluation of the baseline data as well as ongoing data. The routine VISN RCT and local RCT team meetings will provide valuable input on the day-to-day operations of the VISN and local RCT interactions and handoffs of care.

- VISN leadership should identify changes needed to meet goals and objectives.
  - VISN and Local RCTs will likely recommend updates to the triage tool; updates to standard operating procedures; and workflow process improvement.
- Collect data and generate performance reporting.
  - As VISN referral coordination expands, continue to use the RCI Data Portal to publicly guide timeliness of care and community care utilization.

VISN leadership, facility leadership and national RCI leadership communication and reporting is critical to the ongoing success of RCI. There needs to be appropriate overseeing bodies that tie together VISN and local RCT's.

6.11 VISN Menu of Services

6.11.1 Definition and Education

A VISN Menu of Services is defined as a document that outlines clinical services available at each facility within the VISN. This includes the specialty (e.g., Cardiology), the subspecialty (e.g., Interventional Cardiology), and the modalities offered (e.g., F2F, VVC, telehealth, or phone). All facilities can use a clear and consistent VISN Menu of Services document during

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the referral coordination process to ensure VISN resources are offered and used to the fullest extent when the RCT is offering all care options to Veterans.

VISN/facility education about the menu of services is important to ensure the RCT can leverage the full array of services in the VISN for Veteran care. The following slide deck may be used to educate RCTs, specialty care providers, referring providers and facility leadership.

- What is VISN Menu of Services?
- How to use VISN Menu of Services?
- Who can use this tool?
- Where is it located?
- How is it updated? (see feedback loop)
- Who to contact for questions?

Menu of services education presentation is linked here.

6.11.2   How to Build VISN Menu of Services

Developing this tool will require collaboration between the VISN and facilities. Establish a team to lead and develop the VISN Menu of Services. We recommend that you include: VISN ICC Leads (e.g., MH, Specialty, Surgery, and Rehab), VISN/Facility GPMs, VISN Connected Care Lead, VISN CRH, VISN/Facility RCI Leads/Champions, VISN OCC Chief, Clinical Applications Coordinator (CAC), and Data Analysts. VISN ICC leads are a good choice to lead this effort in bringing together medical/surgery specialty care as well as all the other clinical services.

If individual facilities have a Menu of Services for their site only, this can be used to populate the VISN Menu of services utilizing the VISN Menu of Services template. The goal is to have ONE Menu of Services for the entire VISN.

A VISN may currently have a preferred template to capture the Menu of Services which can be used if it meets the intent described in the section above. If there is no template currently available, the RCI team has provided a template which can be used to build and review the VISN Menu of Services.

The following steps should be followed on how to build a VISN Menu of Services, outlined below:

Step 1: Ask and gather from facilities any Menu of Services documents they currently use. Work with clinicians/facilities to develop a list of subspecialities and detailed clinical offerings for each specialty (e.g. instead of ophthalmologist, determine if you have cornea specialists, retina specialists, glaucoma specialists, etc.)
*The following care routing tool can be used to determine what clinics are available for your VISN. Care Routing - Summary - Power BI Report Server (va.gov)

Step 2: VISN Menu of Services workgroup lead will populate Menu of Services worksheet with each specialty and subspecialty and facility name based on any facility specific current Menu of Services document.
    *Recommended template for VISN Menu of Services is linked here.

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Step 3: Educate GPMs across the VISN about the intent of what is needed, why it is needed, and when it should be returned to the VISN.

Step 4: Send ExtraView (EV)/Suspense to each facility within the VISN and allow 3 weeks to complete. Instruct each facility to complete their list of specialties, subspecialties, and modalities offered for these services. The following language was used on the VISN 7 EV:

As discussed during the VISN7 GPM Bi-Monthly call, 2/24/2021, as part of the National Referral Coordination Initiative, Network Offices are required to develop an inventory of clinical services within their VISN.

Attached to this EV is a spreadsheet with two tabs (one for surgical services and one for medicine services). VISN7 network office is requesting that each site completes all services on each tab. Facilities should respond either "yes" or "no" to whether you offer these services and then which modalities you offer them in (e.g. F2F, VVC, TELE). An example of a response would be like this "Yes – F2F/VVC/TELE".

This request is due back to the network office by 3/12/2021.

For any questions related to this EV, please contact {insert POC email} or via phone at {insert POC telephone number}.

Step 5: VISN Menu of Services workgroup lead will compile all information submitted by facilities into a single spreadsheet and make corrections as needed.

Step 6: Post the VISN Menu of Services to a common location easily accessible to front line staff and RCT. Ensure staff have appropriate access to the document. Send completed Menu of Services spreadsheet to (b)(6) @va.gov.

6.11.3   Updating Menu of Services

The VISN Menu of Services will be a living document. The VISN Menu of Services development team will be responsible for updating and making sure the content is current. When a facility has a change in services, it impacts the supply and demand balance across the VISN, thus accurate reporting and tracking of services is critical.

The feedback process for the RCT/Facility to communicate change of services to the VISN is outlined below:

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Change in Services Process

Preferably the facility with the change in service should provide the feedback. However, the referring site or specialty care can submit the change in service form.

The form should be stored on the local VISN SharePoint. We recommend the form includes the following fields for change in service request:

- Site of change
    - Name, Role of RCT member, E-mail
    - VISN/Site
    - Specialty/Service
    - Date
- Receiving Site:
    - Who reported the change in service?
        - Name, Role, E-mail
    - Date
    - Detail:
        - Service
        - Subspecialty
        - i.e. Provider for x subspecialty resigned 2 weeks ago. No replacement available.

An example of the form is linked here.

The local supervisor should be notified of the change in service.

The VISN RCI Champion and Oversight committee will:

- receive and review the submission for accuracy

- update the Menu of Services as required

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- evaluate other potential options for care in the VISN

- communicate changes to local facility leadership and RCTs throughout the VISN

We recommend the Menu of Services to be reviewed and updated quarterly (four times a year) at a minimum while making it a standing agenda item (e.g. RCI Oversight Committee, Specialty ICC Health Care Delivery Committee Meeting, Executive Leadership Committee). Additionally, teams should update services offered on an ad hoc and/or rolling basis if it is determined between reporting periods that specialty availability has changed.

6.12 VISN Referral Coordination Supplemental Materials

- Example of VISN Service Line Agreement
- Example of VISN Telehealth Service Agreement
- How to Build a VISN Triage Tool
- Example of Referral Coordination Business Rules – V20

7 RCT OPERATIONS

RCT operates within the RCI framework and provides resources for a standardized approach to receive, triage, review and gather clinical information in the health record; to identify barriers to scheduling the referral; and talking to Veteran's about their care options.

The process map below depicts the recommended RCT operations process from RCT receipt of consult/referral all the way through RCT conversation and scheduling decision with the Veteran.

Figure 6: RCT Operations Process Map

7.1 Receive/Review Consult/Referral

The Clinical RCT initially receives the consult/referral to determine the urgency/appropriateness of the referral and potential care options.

Initial assessment of the consult/referral includes:

- Referral reason clearly stated and was routed to the correct specialty.
- Referral is not a duplicate.
- Referral contains appropriate pre-work.

It the referral is not appropriate for the RCT based on the above elements, the RCT may disposition the referral in various ways. Each way should be documented in the referral for tracking purposes. The most common ways are listed below.

- Convert referral to E-Consult.
- Provide a return to clinic order if patient already established in specialty.
- Forward the referral to the correct specialty service, documenting the reason for forwarding.
- Reach out to referring provider for clarifying information needed.
- Cancel referral clearly documenting reason for cancellation.

7.2 Clinical Triage

7.2.1 Overview

RCT's clinical triage of the consult/referral ensures that all clinical information is clear and available in the medical record when the patient is seen in VA's specialty care or in the community. RCT promotes efficiency by ensuring Veteran health care is accessible, convenient, and delivered in a timely manner. Part of this work includes ensuring proper pre-work and clinical information is available once the referral appointment is made.

When triaging specialty care referrals, RCTs conduct a medical chart review to gather clinical information and determine the most appropriate level of care for the Veteran. First, the EHR will alert RCT clinical team members to the specialty care consult. Work with your local CAC on how to setup automatic alerts for CPRS. For alerts in the Cerner platform, the RCT will need to create their worklist such that they will be the first to receive all referrals for their specialty. The Clinical RCT uses an approved triage tool for consistency in the clinical triage and scheduling process. Instructions how to create and use the triage tool are in the Clinical Triage Tool Section.

The Clinical RCT members must continue to follow the guidance outlined in the May 13, 2021 Memorandum titled "Use of COVID-19 Priority Designations for Consults" for the use the COVID-19 CTB priority options to capture the appropriate referral priority for scheduling purposes. Also refer to Prioritization for Consultations Procedures and Appointments.

Specialty care services often require medical testing prior to a medical visit. Since each facility and specialty has unique testing requirements and availability, it will be up to each specialty service to determine which tests are essential to complete prior to a medical visit. In addition, each specialty service will determine how recent the testing should be and whether the Veteran would need new testing prior to an appointment. This information should be listed in the triage tool. The RCT will document the triage actions on the consult/referral utilizing a template and/or CTB that will provide a clear and consistent summary of the triage, conversation with the Veteran and the plan/next steps for the patient.

As a reminder, all RCT members must assign themselves the RCT user role within CTB. Additional guidance on the use of the RCT User Role within CTB can be found in Chapter 7.2.7.

7.2.2   Medical Record Review

The Clinical RCT uses the clinical triage tool in the medical record review process to track what clinical information is needed during the triage process. Upon receipt of the referral, the Clinical RCT first determines the urgency of the consult/referral and if testing has been completed in the EHR. If testing is not indicated as complete in CPRS/Cerner, the RCT should search in Vista imaging, Radnet or in the Joint Longitudinal Viewer (JLV) to see if the Veteran had testing in the community or at another VA/DoD location. If there is incomplete information on the consult/referral, the Clinical RCT may need to reach out to the referring provider for additional information.

During the review of medical records, the Clinical RCT can determine complex coordination needs, barriers to care coordination and community care eligibility to understand the Veteran's best available care options.

7.2.3   High Risk and Complex Veteran Considerations

High Risk Veterans can be defined in a multitude of ways, including having one or more of the following characteristics: high intensity medical management, suicide risk, homelessness, frequent ER user, polypharmacy, frequent PCP visits, frequent admissions, and medication non-adherence. Find further information regarding the CAN Score and the Patient Care

Assessment System (PCAS) with the <u>supplemental material on High Risk and Complex Patients.</u>

7.2.4   Eligibility

Veteran Community Care eligibility criteria became effective June 6th, 2019 under the VA MISSION Act of 2018. Find key aspects of community care eligibility and the six eligibility criteria can be found in the <u>MISSION Act factsheet</u>. All Veterans should be offered VA care options and should be informed of their community care eligibilities to ensure they have a choice in where they receive care.

7.2.5   Tools to Use (Required and Optional)

The Referral Coordination Team Member User Role was released in CTB on 10/25/21. This update will go live on October 25, 2021 as part of VHA's continuous improvements to optimize consult management processes and improve data quality.

Use of the RCT User Role within CTB is mandatory for all members of Referral Coordination Teams (RCTs) and its utilization will be incorporated in RCI outcome metrics. Reports are being updated in the RCI VSSC Dashboard to track utilization of the user role within CTB.

- RCT members should use the Consult Toolbox (CTB) for the following actions:
- **Clinical members of the RCT must capture the consult triage/review process using the Consult Review Tab**
- **Document the appropriate appointment modality options for the requested care**
- **Document if the clinical pre-work provided was complete**
- **Document if the care requested can be completed as e-consult**
- **Capture if the CC appointment was scheduled at the RCT level**
- **Capture that all available care modality options were discussed with the Veteran**
- **Capture Minimum Scheduling Efforts**
- **Capture Consult cancellation reasons**
- Forward consults to community care
- Capture Veterans community care scheduling preferences. Refer to <u>Community Care field guidebook</u> for instructions on how to use CTB.
- Additional guidance on the use of the RCT User Role within CTB can be found in Chapter 7.2.7
- The Consult Tracking Manager (CTM/CTM +) must be included in daily RCT operations when it is available. Refer to the <u>How to Get Started Section to</u> determine if your VISN has CTM and review information on how to setup CTM locally.

7.2.6   Documentation

Documentation of the clinical RCT member of the consult review process will be completed within CTB using the Consult Review Tab.

Using the Consult Review tab in CTB, the clinical end users will be able to document the following:

1. Whether the care requested is clinically appropriate

2. Clinical Review method/tool used

3. If pre-work completed is acceptable for consult triage

4. If the request can be completed as an e-consult

5. Appropriate care modality options

6. Minimum Scheduling Guidance

7. COVID-19 scheduling priorities(if applicable)

By documenting this information on the consult, it will keep all the information related to the car requested in one place, so when the patient/referral arrives to their appointment, all the information is on the referral string. Documentation of clinical triage provides transparency in the medical record as outlined above. Documentation occurs in the consult/referral itself to promote clarity and ease of finding information relative to the consult/referral

The consult should be dispositioned (scheduled, forwarded, cancelled or completed) within three business days (excludes weekends but not holidays). The Consult Timeliness SOP is coming soon.

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Additional information that can be captured in Additional Comments section in CTB:

- Patient referred for X (reason for referral):
- Pre-work and/or diagnostic studies completed and/or available in CPRS/JLV/Vista Imaging:
- Special Considerations:
- Patient discussion:
- Plan:

Find more information on general guidance on why to disposition a referral can be viewed.

7.2.7   Referral Coordination Team Member User Role Within CTB

The Referral Coordination Team (RCT) User Role within CTB was released on 10/25/21.

The ability to designate this use role within CTB add the following benefits to the consult management process at the RCT level:

- Removes need to manually add the #RCT# comment on consults

- Simplifies and automates consult processes

    o Creates a comprehensive and intuitive workflow for receiving clinicians in "Consult Review" tab

    o Streamlines and standardizes documentation process

    o Provides transparency across team into who is taking which actions

Additionally, at an organization level ability to designate the RCT user role within CTB allows for:

- Increased and improved understanding of RCI's impact across enterprise

    o Improved tracking of RCI implementation, including which clinical services have RCTs across VHA

    o Increased insight into RCT review outcomes

    o Provides awareness into type of staff assigned to RCTs and actions they are taking on each consult

        ▪ Provider

        ▪ Nurse

        ▪ Administrative

Use of the RCT User Role within CTB **is mandatory** for all members of Referral Coordination Teams (RCTs) and its utilization will be incorporated in RCI outcome metrics. Reports are being updated in the RCI VSSC Dashboard to track utilization of the user role within CTB.

Staff can assign themselves the RCT User Role within "User Settings."

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

User Settings   ✕

User Role
○ MSA/Clerk
◉ RN
○ Provider
☑ **Referral coordination team member**   ⬅

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**

SAVE SETTINGS

Clinical RCT members will need to use the consult review tab to determine provide clinical triage and scheduling guidance. The consult review tab will allow the clinical end user to document the following:

1. Clinical appropriateness and triage tool/method used
2. Whether the pre-work provided is acceptable for consult triage
3. Whether the referral can be completed as an e-consult
4. Appropriate appointment modality options
5. Scheduling Triage guidance
6. Consult Cancellation authorization guidance

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

Please note, the questions in the consult review tab will populate based on the response to the previous question.

Please review the RCI FAQs for questions and answers related to the RCT User Role.

RCT User Role Just in Time Training is now available and will be available in TMS soon

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7.2.8   Clinical Triage Tool

A clinical triage tool is a pre-determined clinical and scheduling guideline used by RCT for consult review, triage, documentation and scheduling. It is built collaboratively with specialty providers, referral coordination nurses and administrative team and provides a clinical algorithm for nurse decision making in determining appropriate care routing modalities. This triage tool also includes scheduling guidelines and scripting for administrative staff when scheduling appointments. This tool is not part of the EHR; RCT uses this tool for decision making and routing of care.

Reasons to use a triage tool include:

- Allows nurses to clinically triage consults/referrals based on an approved MD algorithm (triage tool).
- Allows specialty providers to re-direct their time to things only a provider can do (e.g., clinic visits, procedures, and VVC).

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- Provides consistency in the referral and scheduling process – everyone using the same document.
- Provides clear expectation of documentation in the record summarizing referral triage, plan and scheduling.

Creating a triage tool is a collaborative process that includes physicians, nurses and admin staff. Details about how to build a triage tool "how to slides" and a "base triage tool" examples are linked here and in the Supplemental Materials Section.

Example triage tools by specialty:

- Cardiology VA
- Gastroenterology IRMAC
- Sleep Medicine VA
- General Surgery IRMAC
- Cancer IRMAC
- Cancer/Oncology VA
- Hem-Oncology IRMAC
- Pulmonary IRMAC
- Dermatology VA

As a reminder, the clinical triage tool/method used must be documented by the receiving clinician using the CTB Consult Review Tab.

- MCG Guidelines: An evidence-based clinical review tool focusing on the severity of illness and diagnosis to determine clinical appropriateness for requested outpatient health care services.
- InterQual Criteria: An evidence based clinical review tool focusing on a set of measurable, clinical indicators, as well as diagnostic and therapeutic services reflecting the need for acute hospitalizations
- Chief of Staff Approved Protocol/Local RCT Triage Tool: A Medical Center specific framework developed to provide predetermined criteria to guide care and/or referral (i.e. RCT Triage Tool, Service Agreements, Sharing Agreements and approved SOPs) Local RCT: Refers to a document either created locally or adapted from a national specialty template on how to triage patients based on the clinical question being asked.
Other: Select this option upon facilities discretion based on local process.

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7.3 Contact Veteran

Once the clinical triage of the consult is completed, Clinical RCT can **hand it off to the Administrative RCT to call** the Veteran and schedule. The conversation with the Veteran to discuss VA options for care can happen both with the clinical and Administrative RCT. Each facility determines the workflow and who best to have the conversations. Regardless of who has the conversation, it must happen; patients must be given an option for internal/direct VA care vs. Community Care (when eligible); and staff clearly documents the discussion in the EHR.

Contacting the Veteran and offering internal/direct VA care options is critical. We need to ensure that patients have all care options available to them whether internal/directly in VA or community care, and ultimately, they have a choice. If they are eligible for community care, we cannot assume they will choose that based on distance or wait time measures. They make the final choice once all options presented to them.

If a facility does not offer a specialty, the local RCT needs to discuss internal/direct VA care options within the VISN, as the service may be offered via Telehealth or VVC. A Menu of Services Example can be found in the Virtual Care Supplemental Materials Section.

We have provided scripting to help facilities with Veteran conversations to ensure the right conversations are happening and documented clearly in the EHR. Please review Scripts for Discussing Care Options Section to guide you through the process.

Staff must use the CTB Contact Attempts tab to document Minimum Scheduling Efforts (MSE) on Consults. Additional guidance on the MSE process can be found in the MSE SOP.

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7.3.1 Determining Who Should Contact the Veteran

If the Clinical RCT contacts the Veteran

During the clinical triage of the consult/referral, Clinical RCT may need to call patient to gather additional clinical information and discuss care options for the high risk and more complex specialties. This allows the Clinical RCT to address any clinical questions the patient may have as well as thoroughly explain VA resources both locally and across the VISN that would best meet the patient's needs. The Clinical RCT will then hand off the scheduling activities to the MSA once the patient has decided on VA or community care. Examples of high-risk specialties that would likely require a phone call from the Clinical RCT include Oncology, Neurosurgery, complex Cardiology, etc.

If the Administrative RCT Contacts the Veteran

The Administrative RCT will call patient to offer VA and community care options This should be documented by the Clinical RCT on the consult/referral triage summary directing the MSA to call patient. This process will decrease the number of phone calls the patient receives as they will get one phone call from MSA providing both VA/Community Care Options AND the ability to schedule during the same phone call. Example of this could be a referral for some of the lower risk specialties such as Podiatry, Optometry, Audiology, Physical Therapy, Primary Care.

Handoffs between Clinical and Administrative RCT

There are multiple options for handoffs between the clinical and administrative RCT to begin the scheduling process. A warm handoff is considered to be an immediate handoff between two parties via phone or IM. Warm handoffs are is considered to be ideal, however, depending on local processes, smooth and timely handoffs can be accomplished in the following ways:

- Alert system in the EHR consult/referral system (i.e., via CTB).
- Transfer call to MSA while patient is on the phone.
- Enter or forward consult/referral to community care when this option is selected.
- STAT Referrals (internal/community care) requires a telephone conversation to for handoff and disposition.

Teams/Skype and other messaging systems can be used for informal hand-offs in addition to formal hand-offs listed above.

During the discussion with the patient, the RCT needs to communicate VA resources that patients may need with scheduling their appointments, such as transportation options. See below for guidance relative to transportation services.

7.3.2 Solutions for Transportation

RCTs identify their local and VISN opportunities for transportation needs of Veterans when seeking to keep this care within VA's health care system and mitigate and/or reduce travel expenses.

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RCTs collaborate with their local Beneficiary Travel point of contact(s) to pinpoint what modes of transportation are available to your VAMCs.

Several national programs within the Veterans Transportation Program (VTP) offer transportation assistance to Veterans obtaining health care at VAMCs or an outpatient clinic across the country. When a Veteran does not have any other means of transportation, they are eligible for VTS transportation.

RCTs should check with their local Beneficiary Travel Office for additional guidance regarding Veteran's eligibility requirement (see below) and other travel benefits that may be available within their respective VISN and/or Network.

Administrative Eligibility for Beneficiary Travel

Description	Travel for SC Care Only	Travel for Any Care
Veterans rated 30% or more service-connected		●
Veterans rated less than 30% service-connected	●	
Veterans who receive a VA pension		●
Veterans whose income does not exceed the maximum annual VA pension rate		●
Veterans traveling in relation to a Compensation and Pension (C&P) Examination	<C&P Exam only>	
Veterans in certain emergency situations		●
Certain non-veterans when related to care of a 30% or more SC Veteran (caregivers, attendants, donors, and other claimants subject to current regulatory guidelines)		●
Certain non-veterans when related to care of a less than 30% SC Veteran	●	

Figure 7: Administrative Eligibility for Beneficiary Travel

Veterans Transportation Program

VA's VTP offers Veterans many travel solutions to and from their VA health care facilities. This program offers these services at little or no costs to eligible Veterans through the following services:

1. Beneficiary Travel (BT)
2. Veterans Transportation Service (VTS)
3. Highly Rural Transportation Grants (HRTG)

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7.3.2.1.1   Veterans Transportation Service

VTS provides safe and reliable transportation to Veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments. VTS also partners with service providers in local communities to serve Veterans' transportation needs. Partners include:

1. Veteran Service Organizations (VSOs)
2. Local and national non-profit groups
3. Federal, state and local transportation services

Find a VTS location near you. (Find a VTS location near you.)

7.3.2.1.2   Beneficiary Travel

The BT program reimburses eligible Veterans for costs incurred while traveling to and from VA health care facilities. The BT program may also provide pre-approved transportation solutions and arrange special mode transportation (SMT) at the request of VA. Veterans may be eligible for common carrier transportation (such as bus, taxi, airline or train) under certain conditions. All BeneTravel eligible veterans must have a referral confirming a Medical need for wheelchair or common carrier transports.

7.3.2.1.3   Highly Rural Transportation Grants

HRTGs provide grants to VSOs and State Veteran Service Agencies. The grantees provide transportation services to Veterans seeking VA and non-VA approved care in highly rural areas. These grants are available in counties that have fewer than seven people per square mile. HRTGs are specific to VISNs if needed.

Learn more about the HRTG program and VA's grants program. (Learn more about the HRTG program and VA's grants program.)

7.4   Coordinate/Schedule

Once internal/direct VA care and Community Care options have been discussed with the patient and they have decided, it is time to begin coordination of scheduling. There will be documentation on the consult/referral from the Clinical RCT providing direction to the Administrative RCT regarding scheduling.

There are basically three options for scheduling:

1. Local VA facility
   a. Administrative RCT will review the scheduling instructions documented by the Clinical RCT to determine the next steps in scheduling.
   b. Administrative RCT reviews/establishes appointment modality (face to face (F2F), VVC, etc.) per triage tool and/or Clinical RCT documentation/direction.
      i. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note

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requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    c. Administrative RCT reviews/establishes Veteran scheduling preferences for internal/direct VA care (provider, date, time, location).

    d. Administrative RCT calls to schedule appointment (refer to contact Veteran and scripting sections).

2. Administrative RCT documents all scheduling activities on the consult/referral via CTB. Another facility within the VISN.

    a. Clinical RCT forwards the consult to the preferred VA facility/service via the IFC process.

    b. Receiving VA facility/service Clinical RCT reviews the consult, annotates consult priority and applies scheduling process listed in the Local VA facility section.

3. Community Care – If a patient has opted to use their community care eligibility after being presented all options, the RCT must gather and document the following information during the patient discussion in order to streamline community care scheduling. MEMO Community Care Scheduling Enhancements.

    a. RCT must also capture patient preferences using the CTB for community care, reference Veteran Community Care Scheduling Preferences Section and/or (section 2.9-2.12 in the community care field guidebook).

        1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    b. RCT members should forward a consult to community care (section 2.18 in the community care field guidebook) using CTB.

    c. Document using the CTB, if the Administrative RCT member is scheduling for community care at the RCT level

RECEIVE VA CONSULT	Patient Preferences
Consult Review	**Veteran Contacted**
CC Eligibility (DST)	☐ Veteran informed of eligibility, referral and approval
Contact Attempts	☐ Mailing address confirmed
Patient Preferences	☐ OK to leave appointment details on voicemail
View Consult History	**OK to leave appointment details with:**
Go to CC Workflow	-- Select --
User Settings	**Veteran's Scheduling Preference**
	◉ VA schedules
	○ Veteran self-schedules
	○ Community provider schedules
	☐ CC appointment was scheduled by RCT member

    d.

7.5 RCT Promising Practices

Strong practices have emerged over the past two years for RCT development and implementation. We have local and VISN level strong practices that you can refer to as you

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implement RCT at your facility/VISN. Please refer to <u>Promising Practices Section</u> on the RCI SharePoint details.

7.6 RCT Operations Supplemental Material

- <u>Eligibility Factsheet</u>
- <u>Referral Disposition Instructions</u>
- <u>Care Assessment Need Information</u>
- <u>Special Consideration Solutions Table</u>
- <u>Veterans Transportation Service Information</u>
- <u>**HRTG Program and Grants Information**</u>
- <u>Referral Triage Tools</u>

8 SCRIPTS FOR DISCUSSING CARE OPTIONS

The scripting provided is a reference for RCTs to discuss referral care options with Veterans. These scripts will be revised and expanded based on user feedback. The scripts are guidelines. Veterans should know their options include appointment slots across the VISN. VAMCs/VISNs have authority to standardize messaging based on services available and care modalities that meet their Veterans' care needs.

8.1 Referring Provider Scripting

8.1.1 Veteran Has No Specific Questions

The referring provider needs to inform the Veteran on what to expect for referral coordination next steps.

Referring provider script: "Mr./Ms. (*Veteran's name*), I will place a referral for (*specialty*) service and a member of the Specialty Referral Coordination Team will contact (*add facility specifics on who/how the Veteran will be reached*) you to discuss options available to you in the VA and in the community. You can then decide what option is best for you. Your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

8.1.2 Veteran Requests Community Care Referral Based on Eligibility

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care. Our goal is to inform you of all your health care options. I will place a referral for your specialty care and a member of our Referral Coordination Team will contact you to discuss all options available to you in the VA and in the community. This allows you to decide what option is best for you. In my opinion, your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, keep that in mind when making your appointment. Can I answer any more questions for you at this time?"

8.1.3 Veteran Requests Community Care Referral Based on Best Medical Interest

Referring provider script: "Best medical interest takes into consideration several eligibility criteria that examines medical hardship. This will determine if you are eligible to receive community care. Based on these criteria, I see that you (*do/do not*) meet the best medical interest eligibility criteria." (*State reason based upon nature or simplicity of service; frequency of service; need for an attendant; potential improved continuity of services; or travel difficulty*).

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care based upon best medical interest criteria. I will place a referral for (*specialty*) service. We have a member of the Specialty Referral Coordination Team here at (*facility name*) who will review your referral and determine what testing or level of care you may need. The Referral Coordinator {*add facility specifics on who/how the Veteran will be reached*) will contact you to

discuss options available to you in the VA and in the community. Then you can decide what is best for you. Your appointment (*is/is not*) urgent, and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

8.2 Referral Coordination Team: Administrative and Clinical Scripting Framework

1. Greet and deliver individualized script to Veteran.
2. Inform Veteran of all options available to the Veteran.
   a. Recommendation(s) from Provider
      i. Clinically appropriate modality
      ii. Clinically appropriate timeline
      iii. Recommendation to receive care in VA vs Community
   b. Availability of VA appointments (in local or VISN)
      i. Telehealth at a VA clinic, community telehealth access point or at home, IFC, DoD
      ii. Travel: Bene-Travel, VTS, DAV etc.
   c. If Veteran is eligible for Community Care
      i. Expectation of Wait Times
      ii. Possible locations and associated drive times
      iii. Veteran scheduling preferences (location, time, date, provider) including if the Veteran chooses to self-schedule
3. Capture Veteran input of available options.
4. Veteran and RCT agree upon disposition.

8.3 Referral Coordination Team: Administrative and Clinical Scripting

Prior to contacting Veteran, team member runs DST to check eligibilities.

8.3.1 Administrative RCT or Staff with Scheduling Keys – Veteran Engagement

1. "Good Morning/Afternoon, my name is (*staff member name)* and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"
2. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We reviewed the request and want to schedule you for an appointment. We have a variety of options for this appointment including (*offer modalities identified in the consult*), and you (*are/are not*) eligible to be seen in the community. The dates and times we have available are (*dates/times for the modality*)."
3. **If Veteran elects to schedule with VA:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name, date/time, via face-to-face visit/Telehealth*). I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you? Thank you for choosing VA for your health care provider. Have a great day!"
4. **Scripts for Community Care Eligibility for Community Care with Veteran**

a. **Veteran is not eligible to be seen in the community**: "I am sorry Mr./Mrs. (*name*), but at this time you do not meet the eligibility requirements (*state requirement*) for community care. However, we are happy to schedule an appointment for you at the VA and can do this right away. Once the appointment is made, I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you?

b. **Veteran is eligible to be seen in the community**: "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*). However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our number one priority, and we can assist with either option you choose. How would you like to proceed today?"

    i. **Veteran elects to schedule VA Face to Face appointment:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. Thank you for choosing VA for your health care. Have a great day!"

    ii. **Veteran elects to schedule VA telehealth appointment:** "Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."

        1. **Into the home:** [Administrative RCT obtains/updates email field] "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. For your video visit, you will choose a private location such as home or work to meet over video with your VA Provider using secure, encrypted technology on your internet-connected smartphone, tablet or computer. A member from the specialty or a telehealth coordinator will contact you for a test call before your (*specialty*) appointment."

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2. **Into a community telehealth access point:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit in the private room at (*Walmart/VFW/other*) an attendant will be on site to securely connect you to a virtual provider."

3. **Into the virtual clinic:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit, a VA technician will use modern technology to do an exam or connect you to a virtual provider."

iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file and will then send your information to the Community Care staff. They will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.3.2   Clinical RCT or Administrative RCT Do Not Have Scheduling Keys – Veteran Engagement

1. "Good Morning/Afternoon, my name is (*staff member name*), and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"

2. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We have reviewed the request and want to schedule you for an appointment. We can see you at the VA Medical Center as soon as (*date, time, via F2F visit/Telehealth*), and you (*are/are not*) eligible to be seen in the community."

3. **If Veteran opts to schedule with VA:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. Thank you for choosing VA for your health care. Have a great day!"

   a. **Veteran is eligible to be seen in the community**: "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*) date. However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our

number one priority, and we can assist with either option you choose. How would you like to proceed today?"

    i. **Veteran elects to schedule VA Face to Face appointment:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. After the appointment is made, a letter will be mailed to you as a reminder of your appointment date and time. Thank you for choosing VA for your health care."

    ii. **Veteran elects to schedule VA Telehealth appointment:** "Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have a smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."

        1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file. I will then send your information to the Community Care staff who will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.4   Referring Provider or RCT Team: Veteran Needs Can Be Addressed via E-Consult

Referring Provider/Referral Coordinator Script: "Mr./Ms. (*Veteran's name*). This is (*Provider name, or Referral Coordinator calling for Provider name*). A referral for (*specialty*) service was placed and (*specialty provider*) contacted me. After review of your information, we feel we can treat you without you having to visit the specialty clinic. We recommend the following (*treatment plan*)."

Remember to document using CTB Consult Review tab if the care can be addressed via an e-consult.

> **Consult should be completed via e-consult?** (*required*)
>
> ◯ Yes ◯ No

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8.5   MISSION Act Information

Current Mission Act Information and Scripting:

- Mission Act General Information
- Eligibility FAQs
- Call Handling and Documentation

8.6   Veteran Does Not Answer the Phone

Scripts for answering machine messages will be included in future releases of the guide. VAMCs and VISNs will need to identify how Veterans can best reach the RCT. It is recommended the Veteran's PACT be the initial point of contact provided if a telephone number is needed so as not to add another phone to monitor.

9 DATA AND MEASURING SUCCESS

9.1 Impact Measures

Initial anecdotal feedback from RCTs, Patient Advocates and providers should be collected by the Executive Sponsors to assess immediate impact. The purpose of the initiative is to improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.

To measure success, VHA will be monitoring the following RCI outcome measures:

Table 4: RCI Key Performance Indicators

Focus Area	Measure	Goal
Decrease consult scheduling time	Consult Scheduling Timeliness - Average days from File Entry Date (FED) to first scheduled by first scheduled date	▪ Aspirational goal of 3 days for both Internal/Direct Care and Community Care
Improve Veteran satisfaction	VSignals (Community Care survey)	Increase percentage of respondents with "agreement" score
Ensuring Veterans understand their full range of care options	Percent of Veterans engaging with RCT (metric in development)	90% of referrals reviewed by RCT
Maintain VA's ability to fund internal/direct VA specialty care services	▪ Referral Volumes for internal/direct VA vs community care ▪ Understanding population of Veterans who Choose VA (metric in development)	Intended to be used for VISN/VAMC leadership to identify possible resources

9.2 Analyzing Data to Monitor Progress

Data that can be used to monitor progress includes those listed under How to Get Started and Operational Measures.

How to Get Started:

- VA and Community Care Referral Trends (see example in next section about how to use this data to choose which specialties to start with)
- Understanding Changes in CC Volume (by Consult title)
- Understanding Changes in VA Volume (by Stop Code)

Operational Measures:

- Community Care Eligibility Distribution

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- Improving Timeliness: Referral Cycle Time
- Increasing Care Options: Face-to-face, E-Consults, Virtual, Telephone, Interfacility, etc.

The RCI Data Portal provides links to reports that support management of RCI access principles by providing a consolidated view of internal and Community Care measures in the same visuals. The Implementation Team should thoroughly analyze report results to determine the effectiveness and efficiency of current operations and reporting reliability. The implementation team should also analyze trends to observe reporting result changes over time and to determine the root causes behind inadequate performance.

Supplement detailed reports are currently available for both internal/direct and community care referral management individually. This data portal will evolve as new data measures become available. RCI Data Supplement is in development to provide data definitions and additional training. For guidance on Community Care specific reports, review Chapter 6 of the OCC Field Guidebook.

Each facility should take a multi-disciplinary approach to selecting which specialties to incorporate into the RCT first. Considerations include specialties with highest overall volume of consults, highest community care demand and longer consult processing times. Additionally, facilities can consider specialties that may already be operating with an RCT-like process, specialties with a strong clinical champion, or specialties with strong academic affiliations.

Below is an example of how to look at the data if you would like to focus on specialties that have the highest community care demand.

How to Determine Specialties with the Highest Demand

4. **Step 1:** Identify yearly referral volume by specialty (Internal & Community Care)
   a. Access the RCI Data Portal
      i. Select Volume by Specialty
      ii. Filter data for latest Fiscal Year and facility
      iii. Sort data largest to smallest
         1. All Internal VA Referral Volume by Service/Stop Code
         2. All Community Care Referrals volume by consult title
      iv. Use the Data to develop Staffing Plans
         1. Prioritize specialty services by Referral Volume (Community Care, Internal, or Community + Internal)
         2. Identify Total Referral Volume (Community Care + Internal) and divide annual volume by 10,000 to identify approximate FTE required to timely and appropriate address referrals.
            a. Example: 17,000 VA Cardiology Referrals + 3,000 Community Care Referrals = 20,000 divided by 10,000, which shows 2.0 FTE required
5. **Step 2:** Prioritize specialties that have the highest rate of referral to community care
6. **Step 3:** Using audience from How to Get Started Section to identify appropriate staffing

9.3 Data and Measuring Success Supplemental Material

- RCI-Power BI-Dashboard
- RCI Data Portal
- Data Portal Supplement
- OCC Field Guidebook - Chapter 6
- Recording: VSSC Office Hours 030221 RCI Dashboard Presentation

10 APPROPRIATE USE OF DECISION SUPPORT TOOL (DST)

NOTE: *Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web-based tool integrated within CPRS. The equivalent of the DST is built directly into the CTB Version 2.0 and the below still applies using the CC Eligibility (DST) tab in the workflows.*

In the new process, the referring provider is not required to use DST but may choose to render a Veteran Community Care eligible under MISSION ACT authority of Best Medical Interest (BMI) eligibility and document the reason if they feel there is a strong clinical indication. Specialty clinics or RCT utilize this tool when determining where the Veteran is eligible to seek care. The RCT will take more ownership of making this determination if the DST was not previously run by the referring provider. The primary care team must still determine primary care community care eligibility before including provider, nurse and scheduler when scheduling primary care appointments.

DST will allow the RCT to view relevant data within the existing CPRS consult order workflow. This helps guide the conversation with the Veteran to decide if a consult should be referred to the local VA facility, a near-by VA facility via Inter-Facility Consults (IFC), or to a community provider by providing information about the following:

1. Veteran's static community care eligibility (hardship, living in a state without a full-service VA or grandfathered into community care from the legacy Choice program) for accessing care in the community
2. Drive time standards and drive time eligibility associated with the requested consult service.
3. Average wait times for the requested clinical service at VA facilities near the Veteran's place of residence and average wait times for community care appointments (note that average wait times may not be used to determine wait time eligibility)
4. Veteran's stated preference for community care (Opt-in/Out or To Be Determined/Deferred)

It is important to note, with CTB 2.0 a consult cannot be forwarded to community care without community care eligibility captured using CTB.

10.1 DST Checklist for RCT

1. The RCT must be familiar with E-Consult and Telehealth protocols as well as access to the face-to-face clinic grids and Telehealth schedules to discuss the appropriate options available when having a conversation with the Veteran about his/her care choices.
2. Community Care Eligibility
   a. If none exists, consider what the best method is to meet the Veteran's needs based on local protocols.
   b. Ensure to review the specific clinic where the patient is to be scheduled using VSE or VistA appointment packet in order to determine the next available appointment and to consider community care wait time eligibility. If the Veteran

is eligible for community care based on wait time, the consult must be forwarded to community care using the CTB.

3. Best Medical Interest (BMI)
    a. If the referring provider entered a referral and used DST to render the veteran community care eligible based on best medical interest, the RCT should still review with the veteran ways in which the veterans care needs might be met within the VA including an E- consult, telehealth or face-to-face visit. If the veteran chooses to receive his/her care within VA, the appointment is made and #COO # is placed in the comment section of the appointment.
    b. If the veteran opts into community care, scheduling preferences are obtained and documented using the CTB. Offer the Veteran the opportunity to self-schedule and to select a specific provider using the community provider locator (CPL). Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.
    c. If the referring provider entered a referral and placed considerations for BMI in the body of the referral but did NOT use the DST to render the Veteran CC eligible based on BMI, RCT determines if the care requested can meet the Veteran's needs via either a Community Care consult or an E-Consult, Telehealth, or a face-to-face visit.. Supporting documentation should be available in the body of the consult to support the need for the episodic medical hardship/BMI.
        i. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult and inform the Veteran of the pending recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document. If the Veteran's care needs can be addressed by a face to face visit within the wait time standard, the appointment is made.
        ii. If care cannot be addressed via E-Consult or Telehealth, review the referral with the Veteran, discussing the available care options within VA as well as care in the community. If the clinician reviewing the consult agrees that based on the considerations for BMI noted by the referring/ordering provider in the body of the consult and their own judgement that it is in the Veteran's best medical interest to seek care in the community, the Veteran is given the option for community care. The Veteran's decision is captured on the consult along with the Veteran's community care scheduling preferences. The Veteran is informed that these preferences will be used to schedule the community appointment. Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.

4. Drive Time – Can the care need be addressed via an E-Consult or is Telehealth a viable option?
    a. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending

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recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document opt-in/out decision in the Consult Toolbox (CTB). If the Veteran opts out, schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.

    i. If care cannot be addressed via E-Consult or Telehealth, discuss transportation options to receive internal/direct VA care.

    ii. If none are acceptable, capture the Veteran's scheduling preferences in CTB and forward to community care using CTB and choose Drive Time as the forwarding reason.

5. Wait Time – Is there local guidance for the scheduler to consider an overbook?

    a. If yes, scheduler should book the Veteran in clinic according to the local overbook guidance within the wait time standard. If the overbook request is denied or is for after the wait time standard, the Veteran is still eligible for community care.

6. Wait Time – Can the Veteran/referring provider's needs be met via an E-Consult or Telehealth?

    a. If yes, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending recommendations from the specialist. For telehealth options, discuss with the Veteran and document opt-in/out decision in the CTB. Schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.

    b. If no, capture the Veteran's scheduling preferences in the CTB and forward to Community Care using CTB and choose Wait Time as the forwarding reason.

10.2 Best Medical Interest General Information

It is important to keep the following information regarding BMI in mind while making the BMI determination:

- BMI is **not** required and should only be recommended when there is a true medical hardship for the requested episode of care rendering the Veteran eligible to receive care in the community.
- BMI is **not** to be used for Veteran or provider preference or convenience.
- BMI is a MISSION Act eligibility.

If a referring provider believes that BMI should be utilized for a true medical hardship and documents this in the DST, it does **not** mean the Veteran must receive their care in the community. Once RCT reviews the referral, the Veteran should make an informed choice to either remain with VA for his/her care or utilize community care based on his/her BMI eligibility as well as other factors such as other modality options or appointment availability.

10.3 Types of BMI

There are two types of BMI: Episodic Medical Hardship and General Hardship.

1. Episodic Medical Hardship (labelled "BMI-Per Episode of Care" in CTB) is only for a single, specific episode of care.

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a. The referring or primary care provider is not required to run DST unless he or she has determined BMI is clinically appropriate for a true medical hardship. The referral would then be routed to the RCT to review the referral with the Veteran including the BMI request. The referring or primary care provider can only capture BMI using DST (CC Eligibility (DST) tab in CTB 2.0) at the time of entering the referral. DST will not allow end users to capture the BMI eligibility on a signed referral.

b. When the referring or primary care provider recommends BMI be considered without running DST, he or she should document this in the body of the referral with justification. **This is not considered a true BMI eligibility** but rather a suggestion that the RCT or specialty provider would consider when discussing care options with the Veteran.

2. General Hardship (labelled "BMI-Hardship" in CTB) can be either for six months or one year, depending on the Veteran need, for all care referred to the community.

a. General Hardship BMI is determined via a Community Care-Hardship Determination referral placed by VA provider and reviewed by the facility Chief of Staff or designee. If hardship determination is approved, community care or VA referrals must be placed as appropriate for all subsequent care needs for the approved length of time.

b. Just because a Veteran has an approved hardship eligibility, it does **not** mean the Veteran must have all their care in the community. The Veteran has the option to have some (or all) of their care at the VA for each referral placed. If the DST has **not** been run to place BMI or there are no BMI considerations within the body of the referral from the referring provider, the Clinical RCT can discuss with the Veteran if there is a reason for BMI. The Clinical RCT would need to document the justification via added comment on the referral. Once that is done, the LIP from the RCT team, if applicable, or VA provider, would need to provide their concurrence as an added comment on the referral that BMI is appropriate. Once that has occurred, the RCT can forward the referral to Community Care, using the appropriate community care eligibility reason using the CTB, at the time of forwarding the consult to community care.

10.4 BMI Definitions

Within the DST, there is a **required** explanation box under each BMI option for referring provider to document the justification for choosing the specific BMI option. This should be documented upon the referral entry.

Please note that BMI eligibility cannot be determined/captured by an administrative staff member. The following process must be followed to capture BMI eligibility using the CTB.

• A consult entered directly to community care must have the BMI eligibility reason captured by the ordering provider. The nurse would not be responsible for capturing the BMI eligibility determination, if not captured by the ordering provider. In this scenario the team would need to work with the ordering provider to capture the recommendation using CTB.

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- If the consult is forwarded from an internal consult service, the nurse can only indicate BMI if the ordering provider has this documented in the consult, and only while forwarding the consult to community care. This process is outlined in the Office of Community Care Field Guidebook, chapter 2.

In CTB 2.0, the end user making the BMI eligibility determination can use the pre-populated drop down to capture the specific BMI eligibility reason.

- **Nature or simplicity of service:** To be considered if the requested medical services can more easily and safely be provided in the community and would be medically burdensome for the Veteran to receive the care in the nearest VA. Examples include routine optometry exam or hearing evaluation.
- **Frequency of Service:** To be considered if the frequency of the requested care is often enough to be a medical or clinical burden to the Veteran to have to travel to the nearest VA to receive. Examples include physical therapy, chemotherapy, and radiation therapy.
- **Need for an Attendant:** To be considered when an attendant is required for a specific episode of care. An attendant is any person who provides required aid and/or physical assistance to the Veteran, for a Veteran to travel to a VA medical facility for hospital care or medical services. The provider must consider the care/procedure being requested and/or the Veteran's medical condition when determining the need for an attendant. This definition is consistent with the definition of this term in VA's beneficiary travel regulation (see 38 CFR 70.2.), but that definition at § 70.2 is dependent on separate eligibility under the Beneficiary Travel program.
- **Potential for Improved Continuity of Care:** To be considered if the requested service were to occur in VA it would disrupt an established treatment plan with a community provider who delivers stable, consistent care to the Veteran during a specific episode of care. Examples could be: Recent surgery or active chemotherapy. A Veteran who had a knee replacement two years ago or who is previously established with a community provider and wants follow-up with their community provider would require a new referral with a new determination of BMI eligibility for a new episode of care if medically indicated.
- **Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 mins for PC and MH and 60 mins for SC) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (e.g., Social Work Service (SWS) referral) when making this determination.

10.5 Supplemental Materials

- Office of Community Care Field Guidebook (FGB)
- Consult Forwarding Procedures, FGB Chapter 2, subsection 2.18

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11   COMMUNITY CARE SCHEDULING

When the RCT determines that the Veteran is eligible for and opts in for community care, the RCT *must* ensure the information listed in this section is documented in the consult before the consult is forwarded to community care. For consults/ that are directly ordered to community care (for services not offered in the VA facility), the PACT or RCT front-line staff will ensure that Veteran preferences identified below are documented at the time the Veteran checks out of the internal, VA appointment. Ensuring this information is documented will support expedited scheduling of the community appointment for the Veteran and avoid unnecessary Veteran contacts.

11.1 Community Care Referral Checklist

Prior to the consult being forwarded to community care, the RCT will review the consult for completeness and document the following information in the consult:

1. Capture clear documentation of the community care eligibility either using the DST or using CTB and selecting the correct forwarding reason.
2. Ensure a clinical review was completed and documented by either an MD, NP, PA or DO or RCT/Specialty Care RN under direction of one of the above.
3. Consider a standard episode of care (SEOC) and, if appropriate, select using CTB's "authorizations tab." The CC Eligibility (DST) tab is used in CTB 2.0. (This step can be delegated to the facility community care office.)
4. Capture clear documentation of the clinical need by the referring provider.
5. Capture the Veteran's community care appointment scheduling preferences to include preferred provider or "no preferred provider", day of the week or "any", and time of day or "any" using CTB unless the Veteran decides to self-schedule. If so, only preferred provider is needed.
6. Inform the Veteran that these preferences will be used to schedule his/her community appointment.
7. Capture if the community care appointment was scheduled at the RCT level using the CTB Patient Preferences Tab (only if applicable)
8. Provide Veterans choosing to self-schedule for community care, with the community provider information, and document the action using the CTB Patient Preference Tab.

11.2 Veteran Community Care Scheduling Preferences

Capturing a Veteran's community care scheduling preferences is mandated to expedite appointment coordination. Multiple attempts to contact the Veteran delay community care scheduling. Capturing preferences prior to check-out or before the consult is forwarded to community care minimizes delays and ensures the Veteran receives timely care in the community.

Capturing Veterans preferences for community care scheduling occurs after the Veteran's eligibility has been verified and the Veteran has opted-in for community care services.

Capturing scheduling preferences will be completed for all community care consults regardless of who is doing the scheduling (VA or Contractor) or how the Veteran prefers to be scheduled. When an eligible Veteran opts into community care, scheduling staff *must* capture the Veteran's scheduling preferences as shown in CTB. Additional guidance can be found in the OCC Field Guidebook, Chapter 2, subsection 2.19.

Staff members who are responsible for consult management such as the RCT will document the Veteran's community care scheduling preferences in the following scenarios:

- When the Veteran is eligible and opts into community care after discussing the options offered internal/directly within VA, the RCT will capture Veteran community care scheduling preferences for the following scenarios 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

When a Veteran is eligible for community care due to wait time and opts in, the VAMC staff member who forwards the internal consult to community care should place the date of the next available internal VA appointment on the consult/referral prior to forwarding to community care.

11.2.1   Types of Preference Information to Capture

Scheduling staff *must* capture the following information for Veteran preferences for scheduling community care appointments (the minimum information required is bolded unless the Veteran chooses to self-schedule in which case only the community provider preference (or "no preferred provider") is required):

1. **Community Provider Preference (or "no preferred provider")**
2. **Day of the Week (or "any")**
3. **Time of Day (or "any")**
4. **Scheduling Preference (VA or Veteran self-scheduling)**
5. Communication Preference (text, phone, email, standard mail, MHV Secure Messaging)
6. Mileage Veteran is willing to travel

Each Veteran *must* be informed that this information will be used to schedule the appointment with the preferences provided this information *must* be documented and agreed upon by the patient to not be considered blind scheduling.

11.2.2   Accessing the Consult Toolbox to Capture Scheduling Preferences

Frontline staff and RCT *must* use the VA Community Provider Locator (CPL) tool must be used to identify the preferred provider.

Facility community care staff *must* continue to use Provider Profile Management System (PPMS). For contingency purposes, staff (not including facility community care staff) may use the VA.gov Facility Locator to identify the preferred provider. If the Veteran does not have a preferred provider, the staff must select "no preferred provider" using the CTB.

Staff can capture Veteran community care scheduling preferences using the CTB Patient Preferences tab.

The staff member will need to speak to the Veteran prior to entering the scheduling preferences in the CTB. The staff member will need to know the method in which the patient will be scheduled to complete the preference. Methods include VA scheduling, or Veteran self-scheduling (VSS).

It is important to note that community care scheduling preferences must be captured prior to forwarding the consult to community care. The following report can be used to monitor compliance of this process: Power BI (powerbigov.us)

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

(CTB Version 1.9.0078)

(CTB Version 2.0)

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

Figure 8: Community Care Workflow Provider Preferences

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

Figure 9: Scheduler Options for Patient Preferences Add Comment / Receive Consult Workflows

Figure 10: Scheduler Options for Patient Preferences Forward Consult Workflow

Figure 11: Scheduler Options for Patient Preferences Forward Consult Workflow

11.2.3 Entering Veteran Preferences

(CTB Version 1.9.0078)

(CTB Version 2.0)

Select the "Patient Preferences tab" tab and complete the Patient Preferences and the "Veterans Preferred Provider" section using the available options and the CPL. If a Veteran chooses to self-schedule the day/time preferences are not required.

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

Figure 12: Scheduler Options for Patient Preferences Add Comment / Receive Consult Workflows

11.3   Options for Community Care Scheduling

Veterans will have the two options to determine how their community care appointment will be scheduled: VA Scheduling and Veteran Self-Scheduling. Veteran preference for scheduling will be documented using the guidance identified in the OCC Field Guidebook, Chapter 2, subsection 2.19.

11.3.1   VA Scheduling

VA will schedule the community appointment on behalf of the Veteran using the community care scheduling preferences documented by RCT.

Additionally, the RCT member must capture if the community care appointment was scheduled at the RCT level using the CTB Patient Preferences Tab (only if applicable).

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11.3.2 Veteran Self-Scheduling

The Veteran may elect to self-schedule his/her own appointment.

VSS begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider. The Veteran can provide this preference to self-schedule to the clinic Medical Support Assistant (MSA), RCT or the facility community care staff. The community care VSS 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 the CTB Consult Review Tab.

Additionally, RCT *must* use the VA Community Provider Locator (CPL) in CPRS to identify Veteran's preferred provider and to ensure the preferred provider is in network. Upon identifying a preferred provider or possible options for community providers, ensure to provide with the community provider information, and document the action using the CTB Patient Preference Tab.

It is important to note for care that is available within VA, the Veteran's preference to self-schedule for community care should be captured after an RCT member 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

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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. If the preferred in-network provider is known, the Veteran may also elect to wait three days to call the provider to schedule prior to receiving the letter in the mail.

In addition, the front-line staff or RCT *must* clearly communicate to the Veteran that he/she *must* contact the facility community care office to inform them of the appointment date/time for documentation purposes in a timely manner. More information is in the OCC Field Guidebook, Chapter 3, subsection 3.16.

Note that self-scheduling may not be appropriate for some Veterans with active Behavioral Patient Disruptive Flag (BPDF), based on the Veteran's individual needs. If the Veteran has an active BBDF, elevate the request 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 a community provider. DBC Chair contact information can be found at: Workplace Violence Prevention Program (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 OCC Field Guidebook, Chapter 3, subsection 3.15. "How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran."

11.4 Community Care Scheduling Supplemental Material

- The Office of Community Care Field Guidebook (FGB)
- Policy Appendix

12 USE OF ELECTRONIC CONSULTS (E-CONSULTS)

Recently updated reimbursement rules have expanded payment for non-synchronous care such as Electronic Consults (E-Consult). While some Veterans prefer in-person visits and some types of services will require in-person visits, the availability of electronic records supports wider access to specialists' expertise without the necessity of a face-to-face patient visit. Electronic record review and consultation can spare Veterans unnecessary travel and provide them convenient access to specialty care.

The Office of Specialty Care Transformation developed the E-Consult initiative to improve access to specialty care for Veterans and their primary care providers. E-Consults allows referring providers to request review of the record, obtain interpretation of the information, and receive recommendations. They also allow the specialist to receive workload credit for non-face-to-face visits done by chart review.

12.1 What is an E-Consult?

E-Consults are referrals designed for Veteran/provider questions about advice for diagnostic and therapeutic issues. They can also be used to better prepare a Veteran for a face-to-face visit by arranging for the completion of necessary tests in advance of the visit with a specialist.

E-Consults should be completed within three business days (excluding weekends but not holidays) of the File Entry Date. Learn more about the process in the E-Consult Guidebook Version 3.

E-Consults are a kind of asynchronous care sometimes referred to as "chart only consult" or "virtual consult." Within VA, an E-Consult does not require direct communication (phone or written) with the referring provider and can be completed just through a review of the chart and a written note. E-Consults are also considered one subset of asynchronous care.

12.2 All Sites Should Promote E-Consults as an Avenue of Care

To optimize Veteran choice and improve access to care, all specialties should provide E-Consults. This requires the local site to develop a referral process in CPRS with note titles and encounter locations that include "E-Consult" to be tracked appropriately. Veterans are not billed for copay. Workload is tracked as described below. We strongly encourage specialty care services to consider active consult management, identifying face-to-face requests that can be completed as an E-Consult and vice versa.

All services within the medical center should receive communication about any new E-Consult opportunity. Staff should promote E-Consults as a rapid, efficient way to obtain documented diagnostic or management recommendations without a face-to-face visit. Examples of good outcomes should be marketed to all services to promote use of E consults. Staff should promote E-Consults in Care Coordination agreements between Primary and Specialty Care Services.

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12.3 Advantages of E-Consults

A consultant's review of the records can take place without structured scheduling, allowing the consultant flexibility to complete tasks at a convenient time. Because the Veteran does not need to travel, the inconvenience and costs of scheduling and arranging transportation are eliminated. While support staff may, at times, expedite requests from the referring provider or the specialist, when compared to a traditional consultation, the burden on support staff is generally reduced. Consults can be completed without the delay of scheduling and the response time to the consultation can be much less than in a traditional consultation. Consultants whose expertise is highly specialized may be accessible from long distances for those Veterans who cannot travel to/from medical centers.

12.4 E-Consults Take Time to Perform

Providers who perform E consults should have time to perform referrals using the most efficient approach that limits impact on face-to-face clinic time. Section Chiefs and Service Chiefs are responsible for assessing productivity and assigning the appropriate amount of allocated time for all asynchronous care, including E-Consults. Data on individual productivity will continue to guide those individuals in accomplishing their goals. Section productivity can be assessed based on total clinical workload: clinic, ward or inpatient referral coverage, procedures, test interpretation (electrocardiograms (EKGs), pulmonary function tests (PFTs), telephone or tele-video visits and E-Consults. Clinical care in any form should be used to maximize access based upon the need of the Veteran. Clinicians should be reassured that productivity for completing E-Consults is comparable to performing face-to-face visits and is based on the time spent completing the consultation as opposed to care complexity with office-based Evaluation and Management (E&M) codes. Please refer to the Electronic Consult Implementation Guide for additional information and implementation guidance.

12.5 Use of E-Consult Supplemental Materials

- E-Consult Guidebook Version 3

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13 TELEHEATH / VIRTUAL CARE

13.1 MISSION Act and Telehealth

The MISSION Act established "Anywhere to Anywhere" telehealth across state lines and from off-site locations to a Veteran's home or community. Through Telehealth, VA has an unprecedented opportunity to grow and to meet Veterans where they are with continuity, convenience, and excellence. Providers should invite Veterans to consider care by Telehealth for several reasons, including its ability to provide overall continuity of care, a Veteran-centric option within VA, and a more convenient option for care, often with reduced travel requirements.

Per the MISSION Act, the below verbiage from the preamble applies when determining community care eligibility when the appointment being offered is considered Telehealth. "The proposed rule stated that if the VA is able to furnish a covered veteran with care or services through telehealth, and the veteran accepts the use of this modality for care, VA would determine that is was able to furnish such care or services in a manner that complies with designated access standards. We received one comment that urged VA to ensure that the option for the Veteran to have face-to-face care would be maintained if the Veteran did not choose the telehealth modality. We do not make changes based on this comment. As stated in the preamble of the proposed rule, VA will not require a veteran to accept the use of telehealth for the purpose of meeting VA's designated access standards." Review specific guidance from the law. Select the Final Rule document and search the word telehealth. Review the Office of Community Care Field Guidebook for additional guidance about eligibility requirements for unique scenarios such as a Veteran who choosing telehealth and then requires an in-person visit.

13.2 What Kinds of Telehealth Appointments Exist at VA?

Synchronous (Clinical Video Telehealth or VA Video Connect into the home/non-VA site), Asynchronous (Store and Forward Telehealth) and Remote Patient Monitoring (Home Telehealth) are telehealth services offered at VA.

VA leads the Nation in telehealth, with options in more than 50 specialties. Service lines consider what care is appropriately delivered by Telehealth by clinical judgement and via guidance from Specialty Telehealth Operational Manuals. Specialty expert consultation by telehealth for select conditions is available through a network of National and VISN based Telehealth Hubs. Inpatient telehealth services include tele-hospitalist, tele-ICU, tele-stroke, and other programs.

Telehealth clinics must be set up in VistA to correctly capture workload. At this time, telehealth services into the home are not associated with a patient co-pay.

Increasingly, VA providers will have the skills to offer Veterans clinical care by telehealth. Video telehealth expansion into the home and non-VA sites of care began in 2018 for Primary Care and Mental Health and expanded to Specialty Care in 2019. All VHA ambulatory healthcare

professionals are expected to have completed at least one video visit into the home or non-VA site, by end of FY2021. Expansion of asynchronous care in eye care, dermatology and sleep is underway. VISN Clinical Resource Hubs offer services in Primary Care, Mental Health and increasingly Specialty Care.

13.3 Advantages of Telehealth

Telehealth, and virtual care in general (mobile applications, secure messaging, remote patient monitoring) should be promoted as an option for Veterans to choose VA, decrease travel time or travel cost, and increase convenience and comfort (for Veterans not wishing to receive care in a medical facility). There is high Veteran satisfaction with Telehealth Services at VA on par with in-person care. To date, the literature on Telehealth suggests equivalence in clinical outcomes, experiences and improved continuity of care.

In the management of rare/specialized clinical conditions, telehealth may be the best option for Veterans who have few (or no) options for care in the community. During disasters or emergencies when facilities experience closures and appointment cancellations resulting in a potential surge of increased eligibility for community care, prioritizing appointment rescheduling to include virtual care supported by facility based, VISN based or national providers can mitigate access challenges during the period of the disaster/emergency.

Since the location of the remote provider is flexible, VA can optimize capacity by recruiting providers in areas where it is relatively easy to do so and match this available capacity to demand elsewhere in the VISN. Clinical capacity for Telehealth may be available through Telehealth providers located in front-line clinics within the healthcare system, or within the VISN Clinical Resource Hub. Facility leadership is encouraged to identify underutilized FTEE for telehealth (Productivity and Staffing Guidance for Specialty Provider Group Practice VHA 1065(1) linked here) Services from providers outside the VISN may be arranged by an MOU and/or cost-transfer.

13.4 Applicable National Data Sources

- VSSC Connected Care Reports
- Appointment Data Cube now includes wait time and encounters for telehealth appointments in addition to in-person appointments. VSSC Appointment Cube
- CVT SFT Data cubes for information on Telehealth Data or historical usage, who/what CBOCs currently use. VSSC CVT SFT Cube
- Provider productivity cubes for evaluation of who may have capacity at your site to start or expand provider side offering of telehealth in your specialty VSSC Provider Productivity Cube
- Community Care data to review what services are being provided in the community. VSSC Community Care Cube
- Virtual Care Scorecards

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13.5 How to Increase Awareness with Veterans and Staff

A key to increasing use of virtual care throughout the health care system is to make both Veterans and staff aware of how it works, when it is appropriate to use and that the Veteran will still be receiving the top quality of care that they receive throughout other modalities. Using tools such as VEText, Secure Messaging, and social media for outreach efforts are recommended.

Promising practices and data to support their process. A summary of these practice may be viewed on the Connected Care Messaging Blog.

13.6 Scheduling with Virtual Care

In VA, there are multiple options for scheduling telehealth. The Telehealth Scheduling Tool Matrix outlines all scheduling platforms and when they are appropriate to use for scheduling. The Office of Connected Care is continuing to work on making the scheduling process streamlined with in person visits. Currently the main platform for scheduling VVC is Virtual Care Manager. Review additional information about Virtual Care Manager and scheduling specific information on VA Video Connect for Schedulers.

13.6.1 Scheduling Training Requirements

All schedulers need to follow OVAC Scheduler Requirements as laid out in VHA Directive 1230 including virtual care scheduling requirements. A Specialty Care Department of Veterans Affairs Video Connect Expansion Memo (VIEWS# 03400841) from August 25, 2020 was sent to the field requiring schedulers mastering the most recent VVC Scheduler training and schedulers are required to have scheduled VVC appointment. The trainings and can be found on TMS, training module #41309.

13.6.2 Understanding Where Virtual Care Is Available in VA Network

To optimally inform the Veteran, the RCT needs to know where virtual care is available across the network. Currently the VHA is in progress of creating an efficient national database however there are ways to gather the applicable information. Below are examples of how sites are sharing this information across their healthcare systems in the interim. Consider using the following practices to understand where virtual care is available across their VISN.

- Create a VISN SharePoint were all information is been posted and shared
- Grant Access to local SharePoint for staff and leadership
- Hold Telehealth Leadership weekly meetings
- Hold a VISN while Telehealth Strategic Planning call
- Hold weekly meetings with Leadership including front office and ACOS
- Connect with the SAIL workgroup, NDPP, Nursing Executive council and Medical Executive Council
- Participate in PACT Huddles and departmental staff meetings
- Distribute local flyer across the facility with all the Telehealth modalities and services offered.

- Work in collaboration with patient advocate team, patient centered care team and Wholehealth team to share Telehealth information across the facility
- Create a spreadsheet by site to show who is offering what about Telehealth at each facility.

13.7 Specialty Specific Guidance on How to Start and Expand

Through virtual care Telehealth is well suited to provide care for the majority of outpatient clinic visits through Synchronous Telehealth/Clinical Video telehealth (CVT), CVT to home (VVC), and other Virtual Care options including Asynchronous Store and Forward Telehealth (SFT) or E- Referrals. Expansion of Virtual Care offerings is the appropriate step for many services and for patients to bring the right care to the right place at the right time. This following seven specialty sprint focus areas gives recommendations on evaluation and expansion of Virtual Care offerings to be implemented in conjunction with the Referral Coordination Teams (RCT). Each specialty focus area includes the following sections specific to that specialty

- Services to consider for E-Consults
- Services to consider for telehealth
- What the Veteran & Provider can expect when using telehealth
- Recommended care pathways
- Staffing recommendations for telehealth
- FY2020 Usage facts
- Current promising practices
- Resources & innovative approaches needed to continue to expand virtual care

In the Field Guides, you will also find a Telehealth Supplement if one exists. The supplement includes use cases and set up for telehealth. Select and view guidance specific to your specialty on the Telehealth website.

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Figure 13: Telehealth Specialty Menu

13.7.1   Steps to Start Expansion

1. Review telehealth utilization, wait time and Community Care data to determine best specialty in which to expand.
2. Contact your Facility Telehealth Coordinator (FTC) and RCT review telehealth data and community care cost data, see where telehealth is offered at CBOCs see where you can expand, consider VISN CRH level approach.
3. See what the highest community care utilization is for your service(s) and plan how to include virtual health offering, prioritize where to start and with what service based on data.
4. Include RCI team at local facilities to make aware of current telehealth options for service(s) and expansion of service(s)/offering let it be known *which* CBOCs offer Telehealth currently.
5. Discuss pathway with RCI team for offering patients telehealth, (e.g., what does that look), use of telehealth admin scheduling referrals, how does RCT involve telehealth option up front and aware to offer this first to patients.
    a. Examples:
        i. Identify CBOCs in your VISN that do not offer TeleDermatology or face to face Dermatology care.
        ii. Evaluate the staffing at the CBOCs and if there is a TCT trained in TeleDermatology, if not have the FTC take steps to have the TCT at the CBOC trained in TeleDermatology.
        iii. Assess that the CBOC has the equipment for TeleDermatology, a hand-held point and shoot camera with dermascopy attachment is recommended, cost is around $2000.00 per unit.

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   iv. Follow telehealth specialty supplement for referral and clinic set up for go live of new TeleDermatology service offering.

6. Market to patients and providers.

13.8 Virtual Care Supplemental Materials

- Telehealth Website
- Telehealth Expansion - VHA Telehealth Services Intranet (va.gov)
- Specialty VA Video Connect Expansion VSSC Report
- Inclusion for Specialty Care Service Lines
- Facility Executive Leadership VA Video Connect Checklist
- Example of VISN Menu of Services
- Example of VISN Telehealth Service Agreement

14   CHANGE MANAGEMENT

This section of the guidebook will reference Prosci® tools and techniques to support RCI. Prosci® Change Management focuses on managing the people side of change with research-based processes, tools and techniques to achieve the required business results. Every organizational change ultimately has individual impacts—the tens, hundreds or thousands of employees who have to do their jobs differently when they adopt the solution. This is the role of change management.

On October 22nd, 2019, VHA approved an Executive Decision Memo that recognized Prosci® as VHA's current methodology for Change Management. Organizations that integrate Change Management into their project management delivery are six times more likely to successfully reach their program/project objectives. Change management is the use of an organized framework that helps to guide individuals through the change process. According to Prosci research, "the results and outcomes of changes are tied to individual employees doing their jobs differently. A perfectly designed process cannot improve performance until employees follow it. A perfectly designed technology adds no value to the organization until employees use it. Perfectly defined job roles won't deliver results until employees fulfill them. Employee adoption and usage are the bridge between a great solution and ultimate results" (Top Contributors to Change Management Success, Prosci®, 2016).

14.1 Three States of Change

Change is about moving to a future state while change management is about supporting individual employees impacted by the change during their transitions—from their current state to their future state.

There are three states of change: current state, transition state, and future state. The current state is how things are done today. The transition state is how to move from current to future. The future state is how things will be done tomorrow.

14.1.1   Why is Change Management Important?

It is important to understand VHA's future state is actually the collection of many individual future states.
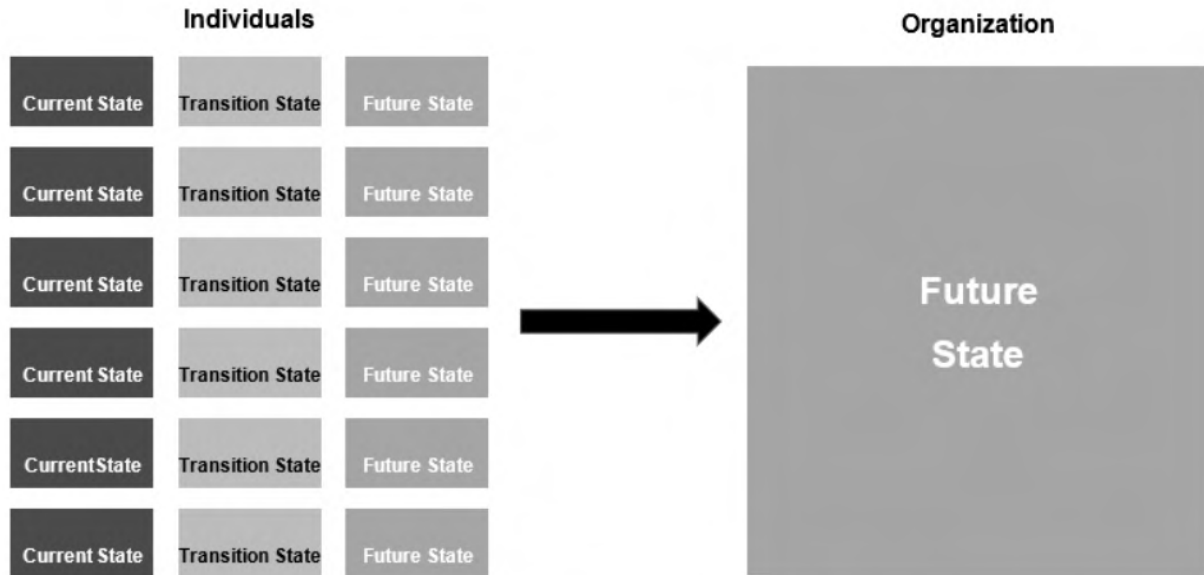
Figure 14: Change Management States of Change

Change management increases organizational outcomes to achieve desired results by driving individual adoption and usage. In order to drive individual adoption and usage, facilities must enable success by supporting each individual through his/her personal change journey. With excellent change management, employees:

- Adopt changes faster, more completely and more proficiently.
- Stay engaged in the organization during disruptive change.
- Understand why the change is happening.
- Have the time and tools to get on board and feel heard and supported.

14.2 Change Management Framework

ADKAR is a change management framework for understanding change at an individual level (Hiatt, Jeffrey. ADKAR. A Model for Change in Business, Government and our Community, 2006). Every change that occurs in a system is dependent on individuals making individual changes. Applying ADKAR framework can assist organizations in successful change by understanding the elements necessary for change results to be recognized. ADKAR presents in five stages that individuals go through when making a change.

- A in ADKAR stands for Awareness. For change to occur, the individual needs to have awareness of the need for change and the nature of the change.
- D stands for Desire. The individual must have the desire to support the change, participate, and engage in the change.
- K stands for Knowledge. The individual should have knowledge on how to change and on how to implement the new skills and behaviors.
- A stands for Ability. The individual should have the ability to implement the change and demonstrate performance.

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- R stands for Reinforcement. The individual needs reinforcement to sustain the change and build a culture and competence around change.

For sustainable change to occur in a system or organization, individuals must reach the level of Ability. The elements of ADKAR are sequential, requiring individuals to move through each stage successfully.

14.3 SmartChange Toolkit

VHA's National Center for Organizational Development SmartChange Toolkit provides simple, powerful tools to make change easier at all levels of the organization. This toolkit consists of 6 steps to help organizations think through and support the 'people side' of change. You can access the SmartChange Toolkit to gain a better understanding and best practices for each step. This guidebook provides a summary of all six steps with an intended focus on Step 1.

14.3.1 Step 1 – Define Success

In any change scenario, organizations should be able to answer the basics – starting with what's changing, why a change is needed, and what happens if we don't change. When you start with the Six Essential Questions, you'll get clear on what's changing, why, and what success looks like. The process of answering the Six Essential Questions gets people on the same page. Once the answers are in place, you have the cornerstone for key change messages.

Beyond informing communications, Six Essential Questions can:

- Help a leader decide if it is the right change to implement.
- Help a leader understand the change more fully so they can better lead others.
- Help a leadership coalition or project group come to consensus on the key reasons for the change and facilitate buy-in.
- Identify when you need to seek out more information to better understand the change.
- Initiate discussions with key leaders to discuss alternatives to the change and/or fully understand implementation options.

14.3.2 Step 2 – Strengthen Your Foundation

Once the reasons for change and expected benefits are clear, it's time to examine and strengthen your foundation. Change success depends on a balance of technical decisions and actions that help people adopt and use the solution as intended. By measuring the Foundations for Change, you'll get a snapshot of your project's health, and a good sense of which elements need the most attention.

14.3.3 Step 3 – Prepare Sponsors

Benchmarking studies repeatedly show the number one predictor of change success is active and visible sponsorship. Using the Preparing Sponsors tool, you'll identify the coalition needed to support your change, and discover how best to facilitate their success in these critical roles.

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14.3.4 Step 4 – Understand Individual Change

When you understand individual change, you can decode the mystery (and relieve the frustration) of organizational change. By applying Prosci's ADKAR® model, you can easily see where to focus your efforts, avoiding the common change management error of scheduling the "right" tactic at the wrong time.

14.3.5 Step 5 – Engage Impacted Groups

You know how change happens at an individual level (that's ADKAR!) – now it's time to shift your focus to engage groups affected by change. Resistance to change is normal and should be expected. Managing that resistance, however, depends on knowing several things: how the change impacts different groups, their readiness for change and their context for change. By using the Engaging Groups tool, you'll gain insight into what support is needed by whom and when.

14.3.6 Step 6 – Pull it Together: Your Change Strategy

You've assessed your change from several key perspectives, and now it's time to put it all together to make sense of the bigger picture. Whether you are a team of one leading a change in your workgroup, or responsible for a much larger change in your organization, this SmartChange Snapshot is a great way to capture the next actions to best drive the people side of change for the results you want and need.

14.4 Change Management Resources

There are many VHA change management resources available to assist with change success. We encourage all levels of the organization to become familiar with the following resources:

- VHA NCOD SmartChange Toolkit
- Best Practice Tip Sheet for Communications
- Best Practice Tip Sheet for Engaging Managers
- Sponsorship Roles
- Actions that drive ADKAR – Senior Leaders, Mid Managers/Supervisors, Individual level
- Plan for Sustainment: 3 Key Sustainment Elements
- Prosci Portal – VHA employees can create a Prosci account by using their VA email to register.

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15 ACRONYMS AND GLOSSARY

Table 5: Acronym List

Abbreviations	Meaning
ADPCS	Associate Director for Patient Care Services
AMSA	Advanced Medical Support Assistant
APRN	Advanced Practice Registered Nurse
BDOC	Bed Days of Care
BIM	Business Implementation Manager
BMI	Best Medical Interest
BPDF	Behavioral Patient Disruptive Flag
BT	Beneficiary Travel
CAC	Clinical Applications Coordinator
CC	Community Care
CITC	Care in the Community
CMO	Chief Medical Officer
COO	Community Opt-Out
COR	Contracting Officer's Representative
COS	Chief of Staff
CPL	Community Provider Locator
CPM	Clinic Practice Management
CPRS	Computerized Patient Record System
CRH	Clinical Resource Hub
CTB	Consult Toolbox
CTM	Consult Tracking Manager
CVT	Clinical VA Telehealth
DAV	Disabled American Veterans
DBC	Disruptive Behavior Committee
DO	Doctor of Osteopathy
DoD	Department of Defense
DSS	Decision Support System
DST	Decision Support Tool
E-Consult	E-Consult Electronic Consultation
ECHO	Echocardiogram
EHR	Electronic Health Record
EKG	Electrocardiogram
ELT	Executive Leadership Team
FBG	Field Guidebook
FTC	Facility Telehealth Coordinator
FTE	Full Time Equivalent Employee

F2F	Face to face
GEC	Geriatrics and Extended Care
GI	Gastroenterology
GPM	Group Practice Manager
HAS	Health Administrative Services
HCS	Health Care System
HOC	Health care Operations Center
HRTG	Highly Rural Transportation Grants
HT	Health care Technicians
ICC	Integrated Clinical Community
IFC	Inter-Facility Consult
IRMAC	Integrated Referral Management and Appointing Center
JOC	Joint Operations Center
JLV	Joint Longitudinal Viewer
LIP	Licensed Independent Practitioner
LOS	Length of Stay
LPN	Licensed Practicing Nurses
MD	Doctor of Medicine
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
MSA	Medical Support Assistant
NP	Nurse Practitioner
OCC	Office of Community Care
OCC	Office of Connected Care
OVAC	Office of Veterans Access to Care
PA	Physician Assistant
PACT	Patient Aligned Care Team
PAO	Public Affairs Officer
PFTs	Pulmonary Function Tests
PPMS	Provider Profile Management System
PSDS	Patient Self-Referral Direct Scheduling
RCI	Referral Coordination Initiative
RCT	Referral Coordination Team
RN	Registered Nurse
SFT	Asynchronous Store and Forward Telehealth
SMT	Special Mode Transportation
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SW	Social Worker
SWS	Social Work Service

TH	Telehealth
TPA	Third Party Administrator
VA	Department of Veterans Affairs
VAMC	Veteran Affairs Medical Center
VCCPE	Veterans Community Care Program Eligibility
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
VEO	Veteran Experience Office
VSO	Veteran Service Organization
VSS	Veteran Self-Scheduling
VSSC	Veterans Health Administration Support Service Center
VTP	Veterans Transportation Program
VTS	Veterans Transportation Service
VVC	VA Video Connect
WT	Wait time
WVPP	Workplace Violence Prevention Program

16 DOCUMENT HISTORY LOG

The Referral Coordination Initiative (RCI) Guidebook is a living document that will be updated to reflect new solutions and strategies. Below is the Document History Log of changes.

Document Type (Baseline/Revision)	Document Revision	Effective Date	Description
Baseline	V3.0	03/10/2021	Version 3 release of the Referral Coordination Initiative Guidebook.
Revision	V3.1	7/23/2021	Revision including addition of Consult Toolbox (CTB) 2.0 guidance. 4.7 – update to existing content 7.2 - update to existing content 10 - update to existing content 10.1- update to existing content 10.3 - update to existing content 10.4 - update to existing content 11.1 - update to existing content 11.2 - update to existing content
Revision	V3.2	9/21/2021	Revision including addition of Clinical Pharmacy Role on RCT, Menu of Services, and MSA Guidance 3.5.3 –update to existing content 3.5.4 – new content 3.6 – update to existing content 6.11 – new content 6.12 – update to existing content
Revision	V3.3	10/21/2021	Guidance added regarding updates with CTB 2.0 and how to utilize RCT User Role: 2.2.1; 3.5.2; 3.5.3; 4.7.1; 5.3.1; 5.5; 6.7.1; 7.2.1; 7.2.5; 7.2.6; 7.2.7; 7.3; 7.4; 8.4; 10, 10.4; 11.1; 11.2.2; 11.3.3; 11.3.1; 11.3.2; Guidance on how to best engage Clinical Pharmacy Specialists as part of RCI: 3.5.4; RCT MSA competencies and functional statement added: 3.5; VISN Menu of Services guidance and resources added: 6.11; RCT RN role guidance added: 3.5 and 3.6

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17   APPENDIX A – RCT SIX ESSENTIAL QUESTIONS

17.1 What is changing?

The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

17.2 Why is it changing?

VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

17.3 Why is it changing now?

Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

17.4 What is not changing?

VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran's needs and life goals – whether that is in-house VA care or care in the community. Eligibility standards for community care are not changing.

17.5 What are the benefits of this change?

RCTs align with VHA's modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

17.6 What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive in-house VA care may instead be referred to care in the community.

18   APPENDIX B – COMMUNICATION MATERIALS

Table 6: Communication Materials

Communication Material	SharePoint Link
Veteran Fact Sheet	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/RCI%20External%20Communications%20Documents/External%20Veteran%20Fact%20Sheet%20Final%20022321.pdf
Internal Staff Fact Sheet	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/RCI%20Internal%20Communications%20Documents/RCI%20Internal%20Fact%20Sheet%20Final.pdf

19 APPENDIX C – POLICY MATERIALS

Table 7: Policy Materials

Policy Material	Link	Issue Date	End Date
Community Care Scheduling Enhancements Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Community%20Care/Scheduling/Community%20Care%20Scheduling%20Enhancements%20VIEWS%20%2303771730.pdf?csf=1&web=1&e=tcWdTA	10/28/2020	10/31/2022
National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065 – COVID-19 Upgrades Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Announcements/National%20Deployment%20of%20Consult%20Toolbox%201.9.0063%20and%201.9.0065%E2%80%93%20COVID-19%20Upgrades%20(VIEWS%23%2002748457)%20signed.pdf?csf=1&web=1&e=MF6jcA	05/18/2020	
Changes to Consult/Referral Management during COVID-19 Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Conditions%20-%20Flu%20%20etc/COVID19/Changes%20to%20Consult%20Referral%20Management%20during%20COVID-19%20.pdf?csf=1&web=1&e=PNHS3P	09/13/2020	
RCI Memo: Veterans Integrated Service Network (VISN) Referral Coordination Initiative (RCI) Standards and Expectations for Fiscal Year (FY) 21	https://dvagov.sharepoint.com/:b:/r/sites/ReferralCoordinationInit/RCI%20Resource%20Documents/03122021%20--%204723515%20%20S%26D%20Memo%20%20031221%20--%20Veterans%20Integratedg%20Service%20Network%20(VISN)%20Referral%20Coordination%20Initiative%20(RCI)%20Standards%20and%20Expectations%20for%20Fiscal%20Year%20(FY)%202021_.pdf?csf=1&web=1&e=7KHoE2		
Prioritization for Consultations Procedures and Appointments	https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NA/ACAO/ConsultManagement/SitePages/Consult%20Toolbox.aspx	N/A	N/A
Consult Processes and Procedures Directive 1232 (2)	https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3230	06/28/2019	N/A
CPRS Technical Guide	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/Guidebook%20Supporting%20Documents/RCI%20Technical%20Guide%202%202%202021%20RW%20%202%205%202021%20cp%20v1.pdf	N/A	N/A

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E-Consult Guidebook Version 3	https://dvagov.sharepoint.com/:b:/r/sites/vhaovac/cpm/Shared%20Documents/Guidebooks/E-Consult%20Guide%20Book%20V%203.0.pdf?csf=1&web=1&e=WbAagT	N/A	N/A
Office of Community Care Field Guidebook (FGB)	https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx	N/A	N/A
Service Agreement SOP	Coming Soon	N/A	N/A
Unable to Schedule SOP	Coming Soon	N/A	N/A
Minimal Scheduling Effort SOP	Coming Soon	N/A	N/A

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VETERANS HEALTH ADMINISTRATION

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

IA-20-P001 | Performance Audit Report
November 2020

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

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VCCP Care Coordination Final Audit Report

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VCCP Care Coordination Final Audit Report

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VCCP Care Coordination Final Audit Report

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VCCP Care Coordination Final Audit Report

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VCCP Care Coordination Final Audit Report

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

VA | U.S. Department of Veterans Affairs

CONCURRENCE AND SUMMARY SHEET

SUBJECT FY20 Internal Audits: Veteran's Community Care Program (VCCP) Care Coordination for Breast Cancer Screening Audit Report and Veterans Affairs (VA) Care Coordination for Breast Cancer Screening Audit Report (VIEWS # 03911518)

NAME OF ADDRESSEE *(For Correspondence Only)*

TO BE COMPLETED BY EXECUTIVE SECRETARIAT (001B)

REMARKS
Memo included for EIC signature.

CONTROL NO.

NAME OF REVIEWER

CONCURRENCES - TO BE DETERMINED BY THE ORIGINATING OFFICE

CONCUR-RENCE REQUIRED	TITLE OR ORGANIZATIONAL ELEMENT	MAIL ROUTING SYMBOL	DATE IN	SIGNATURES		DATE OUT
				CONCURRENCE	NONCONCURRENCE	
X	VETERANS HEALTH ADMINISTRATION	10				
	VETERANS BENEFITS ADMINISTRATION	20				
	VETERANS EXPERIENCE OFFICE	30				
	NATIONAL CEMETERY ADMINISTRATION	40				
	OFFICE OF INSPECTOR GENERAL	50				
	OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION	70				
	OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS	002				
	OFFICE OF ACQUISITION, LOGISTICS & CONSTRUCTION	003				
	OFFICE OF MANAGEMENT	004				
	OFFICE OF INFORMATION AND TECHNOLOGY	005				
	OFFICE OF HUMAN RESOURCES AND ADMINISTRATION	006				
	OFFICE OF OPERATIONS SECURITY AND PREPAREDNESS	007				
	OFFICE OF ENTERPRISE INTEGRATION	008				
	OFFICE OF CONGRESSIONAL AND LEGISLATIVE AFFAIRS	009				
	BOARD OF VETERANS' APPEALS	01				
	OFFICE OF THE GENERAL COUNSEL	02				
	VETERANS SERVICE ORGANIZATION LIAISON	00C				
	OFFICE OF SMALL & DISADVANTAGED BUSINESS UTILIZATION	00SB				
	WHITE HOUSE LIAISON	WHL				
X	**ADUSH for Risk Management**	**10ORE**		David B. Chiesa 1779243 Digitally signed by David B. Chiesa 1779243 Date: 2020.11.19 08:27:29 -05'00'		

NAME OF AUTHORIZED SIGNER

SIGNATURE OF INITIATING KEY OFFICIAL OR AUTHORIZED SIGNER

DATE

VA FORM JAN 2019 **4265**

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

CONCURRENCE AND SUMMARY SHEET
(Continued)

PURPOSE - DISCUSSION - IMPLICATIONS

Purpose

To obtain the EIC's signature on the report memos herein in order to direct and implement needed change.

Request the EIC to review the Internal Audit (IA) reports attached herein. Upon review and concurrence of the IA reports and recommendations, request the EIC to sign the prepared memos, charging the Audit Risk and Compliance Committee (ARCC) with oversight of the recommendations and the corrective actions to ensure progress is made and the solutions deliver the desired outcomes.

Discussion

In accordance with the Fiscal Year (FY) 2020 Veterans Health Administration (VHA) Internal Audit Plan signed by the EIC on November 12, 2019 and revised November 9, 2020 (VIEWS 02673448), Internal Audit (IA) conducted a Veterans Community Care Program (VCCP) Care Coordination for Breast Cancer Screening audit and a Veterans Affairs (VA) Care Coordination for Breast Cancer Screening audit.

The objective of the VCCP Care Coordination for Breast Cancer Screening audit was to determine whether VA is coordinating Veterans' next stage in care following community care appointments. We conducted remote reviews of medical documentation from March 2020 through May 2020, finding that overall Veterans received well-coordinated care for breast cancer screenings occurring in the community. We identified seven findings and make ten recommendations.

The objective of the VA Care Coordination for Breast Cancer Screening audit was determine whether VA is coordinating Veteran's next stage in care following a breast cancer screening at a VA medical facility. We conducted remote reviews of medical documentation from May 2020 through August 2020, finding that overall Veterans received well-coordinated care for breast cancer screenings occurring in the VA and received the recommended next step in care, as indicated. We identified four findings and make six recommendations.

Implications

Opportunities for VHA to improve the VCCP and VA care coordination processes and ensure patients receive timely and appropriate care would be hindered.

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

FOR INTERNAL VA USE ONLY
EXECUTIVE SUMMARY

VIEWS Number 03911518
Internal Audit (IA): VA Care Coordination Audit
November 18, 2020

<u>BOTTOM LINE UP FRONT</u>: In accordance with the Fiscal Year (FY) 2020 Veterans Health Administration (VHA) Internal Audit Plan (VIEWS 02673448), Internal Audit (IA) audited Veterans Affairs (VA) Care Coordination for Breast Cancer Screening to determine whether VA is coordinating Veteran's next stage in care following a breast cancer screening. We conducted remote reviews of medical documentation from May 2020 through August 2020, finding (b)(3):38 U.S.C. 5705

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

We make two recommendations to the field and four recommendations to VHA program offices.

<u>EXECUTIVE SUMMARY</u>:

Recommendations to Veterans Integrated Service Network (VISN) Directors, VISN Chief Medical Officers, VA Medical Facility Directors and Medical Facility Chiefs of Staff:

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

2.

Recommendations to VHA's Women's Health Services and the National Radiology Program:

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

4.

5.

6.

<u>ACTION REQUIRED</u>: The Executive in Charge (1) Review the audit report and accept, reject or defer the report recommendations; (2) For each accepted recommendation, task the accountable VHA senior leader with implementing corrective action plans; and (3) Task the Audit, Risk and Compliance Committee with oversight for the corrective actions to ensure progress is made and the solutions deliver the desired outcomes.

(b)(6)

Office of Internal Audit
(b)(6)
(b)(6) @va.gov
APPROVED BY: David B. Chiesa, D.D.S.
Assistant Deputy Under Secretary for Risk Management

Enclosure IA-20-P002 – VA Care Coordination for Breast Cancer Screening Performance Audit Report

FOR INTERNAL VA USE ONLY
EXECUTIVE SUMMARY

VIEWS Number 03911518
Internal Audit (IA): Veterans Community Care Program Care Coordination Audit
November 18, 2020

<u>BOTTOM LINE UP FRONT</u>: In accordance with the Fiscal Year (FY) 2020 Veterans Health Administration (VHA) Internal Audit Plan (VIEWS 02673448), Internal Audit (IA) audited Veterans Community Care Program (VCCP) Care Coordination for Breast Cancer Screening to determine whether VA is coordinating Veterans' next stage in care following community care appointments. We conducted remote reviews of medical documentation from March 2020 through May 2020. We found (b)(3):38 U.S.C. 5705; (b)(5)
(b)(3):38 U.S.C. 5705; (b)(5)

<u>EXECUTIVE SUMMARY</u>:
Recommendations to VHA's Office of Community Care:
1. (b)(5); (b)(3):38 U.S.C. 5705

2.

3.

4.

5.

Recommendation to VHA's Women's Health Services and the National Radiology Program:
6. (b)(5); (b)(3):38 U.S.C. 5705

Recommendation to VISN Directors and Chief Medical Officers:
7. (b)(5); (b)(3):38 U.S.C. 5705

Recommendations to VA Medical Facility Directors and Medical Facility Chiefs of Staff:
8. (b)(5); (b)(3):38 U.S.C. 5705

9.

10.

<u>ACTION REQUIRED</u>: (b)(5); (b)(3):38 U.S.C. 5705
(b)(5); (b)(3):38 U.S.C. 5705

(b)(6)

Office of Internal Audit
(b)(6)
(b)(6)   @va.gov
APPROVED BY: David B. Chiesa, D.D.S.
Assistant Deputy Under Secretary for Risk Management

Enclosure IA-20-P001 – Veterans Community Care Program Care Coordination for Breast Cancer Screening Performance Audit Report

FOR INTERNAL VA USE ONLY

**Department of
Veterans Affairs**

Memorandum

Date: December 8, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Veteran's Community Care Program (VCCP) Care Coordination for Breast Cancer
Screening Audit (IA-20-P001) (VIEWS #03911518)

To: Audit, Risk and Compliance Committee (ARCC)

1. I accept Internal Audit's (IA) recommendations (defined below) to improve the
VCCP breast cancer screening care coordination process and ensure patients
receive timely and appropriate care.

    a. Five recommendations to VHA Office of Community Care (OCC):

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

1)

2)

3)

4)

Page 2

Subject: Veteran's Community Care Program (VCCP) Care Coordination for Breast Cancer Screening Audit (IA-20-P001) (VIEWS #03911518)

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

5)

b. One recommendation to VHA's Women's Health Services and the National Radiology Program:

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

6)

c. One recommendation to Veterans Integrated Service Network (VISN) Directors and VISN Chief Medical Officers:

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

7)

d. Three recommendations to VA Medical Facility Directors and Medical Facility Chiefs of Staff:

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

8)

9)

10)

Page 3

Subject: Veteran's Community Care Program (VCCP) Care Coordination for Breast Cancer Screening Audit (IA-20-P001) (VIEWS #03911518)

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

2. I charge ARCC with oversight of the corrective actions to ensure progress and solutions deliver the desired outcomes. ARCC is authorized to task owners for each recommendation to develop and implement corrective action plans and report their progress to ARCC on a schedule you determine. ARCC is authorized to task other VHA components, as necessary, to assist the owners for each recommendation.

3. IA will evaluate tasked owners' requests for recommendation closure and report to ARCC on their status annually, and to me as appropriate.

Richard A. Stone, M.D.

cc:

David Chiesa, DDS, Assistant Deputy Under Secretary for Health for Risk Management
Kameron Matthews, MD, JD, Assistant Under Secretary for Health for Clinical Services
Renee Oshinski, MPA, Assistant Under Secretary for Health for Operations
Mark Upton, MD, Acting Assistant Under Secretary for Health for Community Care
Patricia Hayes, PhD, Chief Officer, Women's Health Services
Beth Taylor, DHA, RN, Assistant Under Secretary for Health for Patient Care Services
(b)(6) Enterprise Risk Management
(b)(6) Internal Audit

Department of
Veterans Affairs

Memorandum

Date   **MAY 0 8 2019**

From   Acting Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Stop Codes Used for 20 Day Wait Time Access Standard (VIEWS 00241436)

To: Veterans Integrated Service Network (VISN) Directors (10N1–23)
Medical Center Directors (00)

1. The purpose of this memorandum is to announce the stop codes that will be used when measuring the wait times for Primary Care and Mental Health to meet MISSION Act access standards on June 6, 2019.

2. MISSION Act access standards stipulate that a Veteran is eligible for Community Care in Primary Care and Mental Health if wait times are greater than 20 days for new patients and/or drive time is greater than 30 minutes.

3. The Primary Care and Mental Health stop codes included in the 20 day wait time standard are listed below and included in Attachment A:
    a. Primary Care: 322 and 323
    b. Mental Health: 502, 513, 516, 523, 533, 534, 539, 550, 560, 562, 565, 566, 576, and 577

4. In all other stop codes, MISSION Act access standards stipulate that a Veteran is eligible for Community Care if wait times are greater than 28 days for new patients and/or drive time is greater than 60 minutes.

5. Should you have any questions, please contact (b)(6) Office of Primary Care, by email at (b)(6) @va.gov or Clifford Smith, Deputy Field Support and Analytics, Office of Mental Health and Suicide Prevention, by email at (b)(6) @va.gov.

(b)(6)

Renee Oshinsky

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

1. The Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) have partnered to provide the below consult and appointment scheduling guidance that is to be followed as VA Medical Centers (VAMCs) expand in-person care delivery. Each VAMC must have a documented plan for the clinical review and scheduling/rescheduling of Veterans in each Service/Specialty. This plan is to be developed by Service/Section Chiefs and is to be shared with all clinical, scheduling and administrative staff involved in the care of Veterans within the Service/Section.

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

    a. If the PID is updated, it must be documented in CPRS by a clinical staff member in order to be used for community care wait time eligibility determination. Clinical staff refers to licensed independent providers but this responsibility may be delegated to clinical staff (RN, LISW, Clinical Pharmacists, etc.) on the team based on local policy.

    b. If there is no documented evidence of a new PID by a clinical staff member, the original PID is used when rescheduling.

3. Documentation of Updated PID:

    a. Consults: All Consults impacted by COVID-19 are *strongly* encouraged to have an updated PID in addition to the COVID-19 Consult Tool Box priority group assignment documented by the receiving clinical team member. Each COVID-19 impacted consult request should be reviewed for clinical appropriateness and safety, regardless of the file entry date and original PID. Note: COVID-19 impacted consults refer to all open/active consults at the time the facility moves forward, regardless of whether the initial appointment was cancelled or not.

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

            ▪ Scheduling staff will annotate in the appointment comments, new PID as documented per clinical team member

    ii.   Consults with a PID updated and documented in the consult are scheduled (and linked to the consult) using VistA Scheduling (not VS GUI) in order to capture the most current PID. Note: If VistA is not available, staff will schedule in VS GUI.

b. RTC Orders and follow up appointments: Follow up appointments impacted by COVID-19 (cancelled and not rescheduled or RTC orders not yet scheduled), are strongly encouraged to have an updated PID by entering a new RTC order. See below for guidance.

    i.   The PID of follow up appointments cancelled and not yet rescheduled are updated by the clinician entering a new RTC order following review. The scheduler will disposition the original request as "Removed/Scheduled-Assigned" in VS GUI.

    ii.   For pending RTC orders that require an updated PID, the clinician will review and submit a new RTC order. The scheduler will disposition the "old pending" RTC order as "Removed/Scheduled-Assigned" in VS GUI.

4.   When a Service/Section starts to expand in-person care in addition to care for urgent and emergent care needs, the below wait time community care eligibility criteria apply. Documentation requirements are outlined in #3 above. Additional guidance on the below process can be found in chapter 6, section 6A of the Office of Community Care Field Guidebook.

a. Community Care Wait Time Standards

Wait Time Standards (WTS)

Primary Care/Mental Health/Non-Institutional Extended Care Services	Specialty Care	Criteria
20 days	28 days	The WTS for community care must be considered if the following applies: 1. The PID on the consult is within 20 or 28 days (based on the type of care being requested) from the file entry date. 2. The appointment within the VA cannot be scheduled within the 20/28 days of the file entry date.

b. Consults:

    i.   A Veteran is eligible for community care under the Wait Time Standard (WTS):
- When the original or updated PID is within community care eligibility wait time standards (WTS) and there is no appointment availability.

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

- When the original or updated PID assigned is outside of community care WTS.

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

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

- When the original or updated PID (new RTC order) was within community care eligibility WTS and there is no appointment available within community care WTS.

    ii. A Veteran is not wait time eligible when scheduling/rescheduling the appointment:

- When the original PID or new RTC order is outside community care eligibility WTS.

- When the original PID or new RTC order is within community care WTS and there is VA appointment availability.

d. If at any time a Service/Section must halt non-urgent/emergent in-person care due to an increase in COVID-19 in their community or as otherwise directed by their VAMC and/or VISN leadership, the following applies for community care eligibility:

- Referrals to community care will continue to 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 if the clinician deems it appropriate.
  - 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 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, market availability and safety considerations.

5. Additional Resources

   a. Flow map of consult and RTC/follow up appointment scheduling: https://dvagov.sharepoint.com/:b:/s/ReferralCoordinationInit/Ecklu1B0w-1IqVfm_a6TtYoBJycaREKkoUS-0WS1QlwbzQ?e=M5geEg

   b Office of Community Care Field Guidebook: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

STANDARD MISSION ACT GUIDANCE
PATIENT ELLIGIBILITY AND SCHEDULING REFERENCE SHEET
October 28, 2020

Patient Indicated Date (PID) – Provider-Driven vs Patient-Driven Appointments

The **Patient Indicated Date (PID)** is the appointment date requested by the provider RTC or Consult[1] **or** the date the patient requests an appointment in the absence of a provider request.
- **Provider-driven appointments** must have evidence of the provider's request at the time of scheduling the appointment (e.g., RTC order or Consult).
- **Patient-driven appointments** refers to the patient's requested date (PID) in the absence of a provider's request.
  - Examples: new patient visits to a direct-scheduling clinic, new patients to VA, or established patients requesting an appointment without provider's input/request
- Consults are required for new patients.
- Return to clinic (RTC) orders are required to schedule a follow-up appointment.

Scenario	Details
PID	☐ The PID of the RTC order or Consult must match date entered in the scheduling software

Cancel by Clinic/Patient

Appointment cancellations are categorized based on if the clinic or patient requested the cancellation.
- Cancel by Clinic (Cx by Clinic)
- Cancel by Patient (Cx by Pt)

Scenario	Details
Cancelled by Patient or No-Show:	☐ Appointment must be cancelled by the patient (or no-showed) and rescheduled using new PID (per patient) ☐ Patient was not responsive to scheduling efforts and the appointment request was dispositioned (RTC, PtCSch, Consult). The appointment must be scheduled as a patient generated request and the PID used is the patient requested date. *NOTE: Appointments are scheduled as close to the original PID where possible.*
Cancelled by Clinic:	☐ Appointment is cancelled by the clinic and rescheduled using the PID (per provider) of the original (cancelled) appointment. *NOTE: This applies when a clinic cancels and reschedules to a date earlier or later than the original appointment date.*

Time-Sensitive Appointments

When the provider indicates that an appointment is **time-sensitive**, the appointment must be scheduled no later than (NLT) the PID as indicated in the RTC order or Consult.

Scenario	Details
#NLT#	**#NLT#** must be entered in the comments field of the appointment and the appointment is scheduled on or before the PID (provider-driven)

---

[1] Obtain Veteran's input to determine the date and time of the appointment

STANDARD MISSION ACT GUIDANCE

Community Care (Standard MISSION Act Guidance)

Community Care (CC) wait time eligibility: reviewed for all appointments.

- **Community Care WTS:** The PID is within 20 days (Primary Care, Mental Health, and non-institutional extended care services) or 28 days (Specialty Services) of the appointment request file entry date and there is no appointment availability. (Appointment request refers to a Consult, RTC order, or date the patient requests an appointment).

  NOTE: If eligible, the patient has the option to "opt-in" or "opt-out" of CC

- **For New Patient Appointments:** When the WTS is not met all other CC eligibility[2] must be reviewed

- **For Established Patient Appointments:** Unless the patient requests to review their other eligibility, no additional CC eligibility is required to be reviewed other than wait time. At that time, scheduling staff must honor the patient's request.

  NOTE: Only wait time criteria and documentation established patients are to be reviewed during the scheduling audit process.

Scenario	Details	
New or established patient with wait time CC eligibility	☐ If patient opts out of CC, ***#COO#*** is entered in the appointment comments. This indicates "CC Opt out" based on wait time eligibility. *NOTE: If patient opts out, no further review of CC eligibility is needed.*	
New patient is <u>not</u> wait time eligible for CC	*DST is used:*	*DST is not used:**
	If found **<u>not eligible</u>** for "other CC eligibility" ☐ Save the DST to the Consult ☐ Schedule VA appointment If found <u>eligible</u> for "other CC eligibility" & patient opts out ☐ Select "Opt out" in the DST ☐ Save the DST to the Consult ☐ Schedule VA appointment ***NOTE:*** *DST must be saved to the Consult regardless of other CC eligibility status. If DST is not saved in Consult or "Opt out" is not selected, please refer to instructions for "When DST is not available*"*	If found **<u>not eligible</u>** for "other CC eligibility" ☐ ***DT = XX minutes*** must be entered in appointment comments If found <u>eligible</u> for "other CC eligibility" & patient opts out ☐ ***#COO# DT = XX minutes*** must be entered in appointment comments ***NOTE:*** *DT= XX minutes in the appointment comment shows all Community Care eligibilities were reviewed – it <u>does not</u> mean the patient is drive time eligible for Community Care.*

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[2] Please refer to Appendix A: Types of Community Care Eligibility

STANDARD MISSION ACT GUIDANCE

Appendix A

TYPES OF COMMUNITY CARE ELIGIBILITY

Other Community Care Eligibility	
Type	**Description**
Grandfathered-In	• Patient was eligible under the 40-mile criterion under the Veterans Choice Program on the day before the VA MISSION Act was enacted into law (June 2018), and • Patient continues to reside in a location that would qualify them under that criterion are (North Dakota, South Dakota, Montana, Alaska, and Wyoming) *Per the Veteran Community Care Eligibility Factsheet*
Best Medical Interest (BMI)	• BMI-per episode of care: An episodic hardship that allows the patient to obtain their care in the community for a specific episode of care. • BMI-Hardship: Allows a patient to obtain some or all their care in the community as opposed to Best Medical. **NOTE:** BMI decision is to be made and captured by a physician or non- physician provider (i.e., PA or nurse practitioner).
Veteran Lives in a US State or Territory without a Full-Service VAMC	• Applies to patients' residing in Alaska, Hawaii, New Hampshire, and the U.S territories of Guam, American Samoa, Northern Mariana Islands, and the U.S Virgin Islands. *NOTE: For the states listed above, no CC documentation is required since all patients are CC eligible. If the patient opts in, please follow CC documentation guidelines.*
Service Not Available	• Patient needs a service that is not available at the VA
1703e Eligibility	• Patient needs care from a VA medical service line that does not meet with VA's quality standards. *NOTE: Reminder the decision is made and captured by a physician or non-physician provider (i.e., PA or nurse practitioner)*
Drive Time Eligibility:	• ≥ 30 minutes for Primary Care and Mental Health and non-institutional extended care services. • ≥ 60 minutes for Specialty Care
Wait Time Eligibility:	• PID is within 20 days of the appointment request/file entry date and there is no appointment availability within that timeframe (Primary Care, Mental Health, and non-institutional extended care services) • PID is within 28 days of the appointment request/file entry date and there is no appointment availability within that timeframe (Specialty Care) • *NOTE: File entry date/appointment request date = date consult/RTC was created or patient requested appointment.*

STANDARD MISSION ACT GUIDANCE

Community Care Wait Time Eligibility (Standard MISSION Act Guidance)

Eligible for CC

- The original or New PID is within community care wait time standards (WTS) & the VA appointment cannot be scheduled.

No appointment availability

File entry date — PID — 20/28 days

Not eligible for CC

- The original or new PID is outside community wait time standards

File entry date — 20/28 days — PID

OR

- Original or new PID & appointment availability is within wait time standards

File entry date — PID — 20/28 days
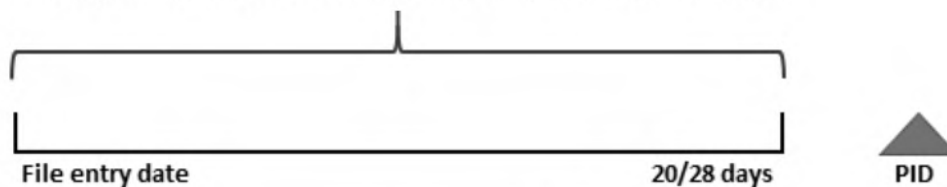
Appointment Availability
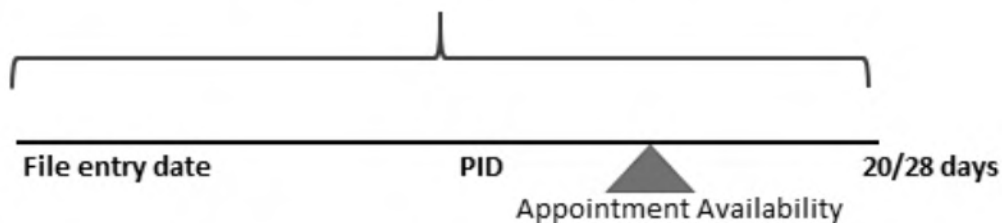
This is only meant to provide a quick, high-level summary. For more detailed information on this topic please refer to: The Office of Community Care Field Guidebook, Chapter 2: Eligibility, Referral, and Scheduling.

TO BE USED WHEN SCHEDULING APPOINTMENTS WITH A PID BETWEEN JAN. 1 – SEPT. 15

COVID-19 COMMUNITY CARE
ELLIGIBILITY AND SCHEDULING REFERENCE SHEET
November 2, 2020

COVID-19 Community Care (CC) Eligibility

COVID-19 Community Care (CC) Wait Time Eligibility:

Unscheduled Consults/Referrals or Return to Clinic (RTC) orders **and** no-showed or cancelled appointments that are not yet rescheduled with a Patient Indicated Date (PID) between **January 1 – September 15, 2020** are considered wait time eligible for Community Care regardless of clinic availability.

- All patients should be notified of Community Care wait time eligibility.
- Applies to appointments cancelled by clinic and cancelled by patient.

NOTE: The patient has the option to "opt-in" or "opt-out" of CC

For any Consult/Referral, RTC order or recall appointment request with a PID/RTC date **prior to January 1, 2020 or after September 15, 2020**, standard MISSION Act guidance applies.

Scenario	Details	
New or established patient is <u>wait time eligible for CC</u> under COVID-19 Standards	*Inside the Window*	
	☐ If PID is **between January 1 and September 15, 2020** and the patient opts out of CC, ***#COO#*** must be entered in the appointment comments. This indicates "CC Opt out" based on wait time eligibility. *NOTE: If patient opts out, no further review of CC eligibility is needed.*	
<u>Not wait time eligible for CC</u> under COVID-19 Standards	*Outside the Window*	
	☐ If PID is **before January 1 and after September 15, 2020** traditional Community Care wait time eligibility standards apply and must follow Standard MISSION Act guidance	
	DST is used:	*DST is not used:**
	If found **not eligible** for "other CC eligibility" ☐ Save the DST to the Consult ☐ Schedule VA appointment	If found **not eligible** for "other CC eligibility" ☐ ***DT = XX minutes*** must be entered in appointment comments
	If found <u>eligible</u> for "other CC eligibility" & patient opts out ☐ Select "Opt out" in the DST ☐ Save the DST to the Consult ☐ Schedule VA appointment	If found <u>eligible</u> for "other CC eligibility" & patient opts out ☐ ***#COO# DT = XX minutes*** must be entered in appointment comments
	NOTE: DST must be saved to the Consult regardless of other CC eligibility status. If DST is not saved in Consult or "Opt out" is not selected, please refer to instructions for "When DST is not available*"	*NOTE: DT= XX minutes in the appointment comment shows all Community Care eligibilities were reviewed – it does not mean the patient is drive time eligible for Community Care.*

COVID-19 Community Care (CC) Wait Time Eligibility

<u>Wait time Eligible</u> for CC based on COVID-19 Standards

Wait Time Eligible for Community Care

PID

January 1, 2020   September 15, 2020
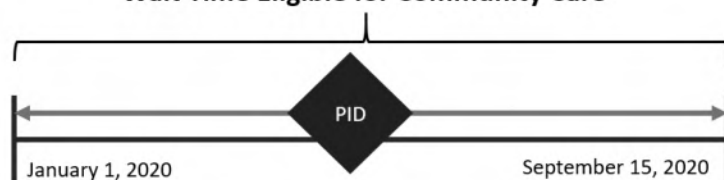
<u>Not Wait time Eligible</u> for CC based on COVID-19 Standards (Eligibility determined by on MISSION Act Standards 20/28 day rule)
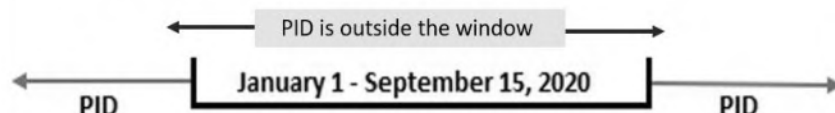
PID is outside the window

January 1 - September 15, 2020

PID   PID

Community Care (CC) Wait Time Eligibility (Standard MISSION Act Guidance)

Eligible for CC under Standard MISSION Act Guidance

The original or New PID is within community care wait time standards (WTS) & the VA appointment cannot be scheduled.

No appointment availability

File entry date   PID   20/28 days

<u>Not eligible</u> for CC under Standard MISSION Act Guidance

The original or new PID is outside community wait time standards

File entry date   20/28 days   PID

<u>OR</u>

Original or new PID & appointment availability is within wait time standards

File entry date   PID   20/28 days
                       Appointment Availability
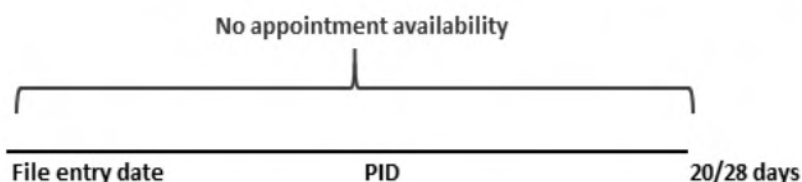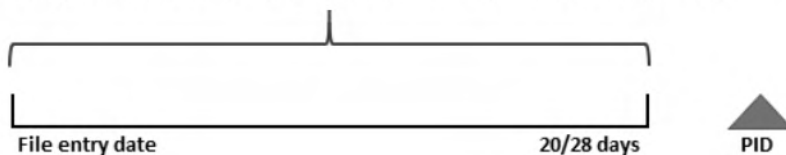
National Standardized Scheduling Audit Program Level 1 Auditor Training

VANTS: 1-800-767-1750 Access Code: 41366

TMS

- Register in TMS
  - TMS ID#
  - National Standardized Scheduling Auditor Training
  - Complete the survey and exam at the end of the training session
- Posting of webinar recording in TMS for auditor staff who are unable the live trainings.
  - View webinar
  - Complete the survey and exam
- TMS Questions/Help
  - (b)(6) Media Education Technician
  - (b)(6) @va.gov

Poll

*What is the purpose of the Level 1 Scheduling Audit?

a. To identify where there may be regional or national gaps in the application of scheduling business rules

b. Based on audit findings; adjust training, communications, or scheduling policy.

c. Standardization of key aspects of the scheduling audit process

d. All of the above

National Standardized Scheduling Audit

- Accuracy in scheduling and meaningful wait time data.

- Standardized measures and process that will identify and remediate scheduling errors and provide constructive feedback to staff.
  - Feedback within 14 days of audit completion
  - Incremental audit feedback over time

- Serves as a feedback mechanism to launch local, regional, and national scheduling improvement programs

Auditor Training

- **Purpose**:   Provide scheduling auditors the necessary information to accurately audit appointments using the national standardized scheduling audit measures and tool

- **Objectives**:

  ➤ Appropriately apply the national scheduling audit measures for a scheduled or completed appointment.

  ➤ Conduct scheduler appointment audit and accurately record results in the national scheduling audit tool.

  ➤ Provide audit results and feedback to the scheduler and/or scheduler supervisor in a timely and effective manner.

  ➤ Utilize key scheduling audit reports in order to complete the required number of audits per scheduler and interpret results of the scheduling audit

Poll

What best describes your auditing experience

a. This will be my first experience as an auditor

b. I have audited in the past but have not attended formal TMS training.

c. I have completed the earlier training and want to learn about the updates in the audit process.

Agenda

- Audit Program
- Details Level One Audit
  - Cycle
  - Frequency of audits
  - Number of audits
- Audit Parameters
- Measures
- Conducting the Audit
- Reports:
  - Facility scheduling audit activity level report
  - National Scheduling Audit Dashboard and facility breakout
- Scheduling Auditor Guide
- Next Steps

Background

- Requirement Government Accounting Organization (GAO/Office of Inspector General (OIG)
  - Variation of auditing practices

- Reliability of VA Outpatient Appointment Wait Times

- Measures

- Audit Infrastructure
  - VISN POC
  - Medical Center POC
    - Scheduling Auditors (Level 1)
    - Audit of the Auditors (Level 2)
    - Compliance & Business Integrity – local reporting

Audit Pool

- Exemptions
  - *Staff 100% accurate at the end of the audit cycle may be exempt the next audit cycle

  - Staff who schedule EXCLUSIVELY in programs that are exempted from the scheduling directive

- Appointments not included in the audit pool:
  - Unscheduled

  - Noncount clinics

  - Cancelled/no-show and NOT rescheduled

  - Specified stop codes (see Guidebook)

Audit Details

- Audit Cycle

Scheduling Audit Cycle		
Start	Start	End
Cycle 1	October 1st	March 31st
Cycle 2	April 1st	September 30th

- Minimum of 10 Audits/scheduler each cycle

- Audit Frequency: Throughout the cycle

Scheduling Audit Completion		
Audits Conducted	# Appointments	Month Audited
October	2	**October**
November	2	**October/November**
December	1	**November/December**
January	1	**January**
February	2	**January/February**
March	2	**February/March**

Highlighted: Recommended month

*Audit Sample is taken **after** feedback/remediation of the previous audit*

Audit Frequency

Start Date

End Date

- Audit sampling date range
  - Taken after the last audit sample
  - Start date after feedback/remediation provided to the staff member

Scheduling Audit Completion		
Audits Conducted	# Appointments	Month Audited
October	2	**October**
November	2	**October/November**
December	1	**November/December**
January	1	**January**
February	2	**January/February**
March	2	**February/March**

Highlighted: Recommended month

Audit Sample is taken **after** feedback/remediation of the previous audit

Audit Parameters

- **Start/End date:**
  - Factor in time for feedback.
- **Max Sample Time:**
  - The audit sample will never return more than X results.
  - Based on scheduler(s) selected
- **Max Sample per L1 Auditor:**
  - How many L1 auditor audits I want to review right now.
- **Max Completed Audits per L1 Auditor:**
  - This setting is increased (cumulative) each month to bring in the additional audits per step in the cycle.

Audit Sample Example

Start Date

End Date

Example: 10 schedulers grouped to audit

Month	Recommened audit sample	Date Range	Max Sample Size	Max Sample PerScheduler	Max Completed Per Scheduler
October	2	October	10 schedulers x 2 audits = **20**	2	2
November	2	November	10 schedulers x 2 audits = **20**	2	4
December	1	December	10 schedulers x1 audits = **10**	1	5
January	1	January	10 schedulers x1 audits = **10**	1	6
February	2	February	10 schedulers x 2 audits = **20**	2	8
March	2	March	10 schedulers x 2 audits = **20**	2	10
	Recommended Audit sample per scheduler	Factor in time for feedback. Do not sample until feedback from the previous audit has been completed	# of schedulers X sample audits. Provides # of audits the Auditor should complete in the month designated. (total =100, the number of audits to be conducted per Auditor at the end of the cycle)	Recommended Audit Sample per scheduler	Cumulative number of audits to have been completed at the end of the month. (= Past month + current month)

Auditing per scheduler: As above except NOW the max sample size is adjusted to the number of audits planned to sample for the individual scheduler.

National Audit Measures

- <u>Patient Indicated Date (PID)</u>:
  - The appointment date the Veteran and provider agree upon or in the absence of a provider, the date the Veteran requests.
    - Presence of RTC/Consult when applicable
- <u>Community Care</u>:
  - Veterans are to be provided the opportunity to "opt in or out" of the Community Care if the wait time criteria is met. The PID must be within 20 (primary care and mental health) /28 (specialty care) days of the create date of the appointment request and there is no appointment availability.
    - Note: No availability between appointment request date and PID.
    - Note: Appointment request date=date consult/RTC was created or patient requested appointment.
- <u>Time Sensitive Appt</u>:
  - This is an appointment that must be completed by the date specified on the return to clinic (RTC) order or consult.

National Scheduling Audit

Mandatory Audit Finding will be updated April 1 with a section for Community Care. The two findings in that section will be Comments missing #COO# WT "Vet Opts Out" and #COO# WT Not Supported.

Audit Details

Audit Type: Appointment Audit

Audit Result:
- ○ Audit Cancelled - Not counted as correct or incorrect.
- ○ Correct - No problems found.
- ◉ Findings - Audit resulted in findings.

Audit Findings:

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Optional

None
- ☐ Insufficient Comments

Audits Remaining: 1

Submit Audit

Level 1 Measures & Findings

PID

☐ PID Not Used or Incorrect
☐ No Consult
☐ No RTC

- The **Patient Indicated Date (PID)** is entered into the VistA CID/Pt Preferred Date field. The date entered is based on one of two scenarios.

- What are the two scenarios? – Enter into the CHAT

16

Poll

Examples of appointments scheduled using the patient's requested appointment date include:

- There is more than one answer

Patient Indicated Date (PID)

- Provider generated: The date agreed upon by the patient and provider, entered in the RTC or consult

- The date the patient requests in the absence of provider input such as:
  - New Patient to the VA
  - Direct scheduling clinic ("self-referral")
  - Unanticipated appointment need outside of the already scheduled return appointment
  - Rescheduled appointment where the patient cancelled or "no-show"
  - When the patient was not responsive to scheduling efforts and the appt request was dispositioned (RTC, PtCSch, Consults)

18

Measure – Patient Indicated Date

- The patient indicated date is entered into the VistA CID/Pt Preferred Date field. The date entered is based on one of two scenarios.

- Audit Findings: Correct

- When to use:
  - The date agreed upon by the patient and provider such as the RTC or Consult date.
  - The date the patient requests in the absence of provider input such as a New Patient to the VA or an unanticipated appointment need outside of the already scheduled return appointment (others as listed on the preceding slide).
  - RTC or Consult is present when required.

- Audit Action Required – None

Level 1 Measures & Findings

```
PID
  ☑ PID Not Used or Incorrect
  ☐ No Consult
  ☐ No RTC
```

- PID Not Used or Incorrect
  - Date other than the agreed upon date set by the provider and patient.
    - The date entered into VistA/VS GUI CID/Pt Preferred Date field is not what was entered in the RTC order
  - Cancel by Patient:
    - Patient initiated the appointment cancellation. The appointment was rescheduled incorrectly, using the PID (provider input) of the cancelled appointment.
  - Cancel by Clinic:
    - Clinic initiated the appointment cancellation. The appointment is rescheduled incorrectly using the PID (per patient) or another PID other than of the original cancelled appointment.

Impact: Inaccurate appointment wait time

Note: This finding is not used in scenarios where there is no RTC or Consult and there should be.

Chat function

- Based on the appointment details below, was this appointment scheduled correctly?
- Appointment Details:
  - The PID in the RTC order is 11/6/2019.
  - The patient requested an appointment date of 11/19/2019
  - The appointment was scheduled in VistA for 11/19/2019.
  - The scheduler entered an appointment PID of 11/19/2019.

a. Yes

b. No

c. Not enough information

Test your Knowledge

- Dr. Jones calls in sick and Mr. Anderson's appointment scheduled for 2/7/2019 was cancelled and rescheduled.
  - PID of the original appointment is   2/1/2019
  - Appointment is rescheduled to   2/21/2019

What is the PID of the rescheduled appointment?

a. 2/7/2019
b. 2/1/2019
c. 2/21/2019

PID
☐ PID Not Used or Incorrect
☑ No Consult
☑ No RTC

Level 1 Measures & Findings

- ## No Consult or No RTC
  - Consult or RTC Order was not present at the time the appointment was scheduled.

- ## All provider generated appointment requests require a RTC or Consult
- ## Reminder: RTC/Consult is NOT required:

The date the patient requests in the absence of provider input such as:

➢ New Patient to the VA

➢ Direct scheduling clinic ("self-referral")

➢ Unanticipated appointment need outside of the already scheduled return appointment

➢ Rescheduled appointment where the patient cancelled or "no-show"

➢ When the patient was not responsive to scheduling efforts and the appt request was dispositioned (RTC, PtCSch, Consults)

Impact: Wait time reliability

23

Poll Time Sensitive

- Which time sensitive appointment statements are true:
  a. #NLT# is entered in the appt comments
  b. Patient must be seen no later than the PID indicated by the patient
  c. Patient must be seen no later than the PID indicated by the provider
  d. Documentation of time sensitive needs is required in the RTC/Consult and the appt comments
  e. Documentation of time sensitive is required only in the appt comments
  f. Correct when the appointment is scheduled on or before the PID and #NLT# is entered in the appt. comments
  g. Correct when the appointment is scheduled after the PID and #NLT# is entered in the appt. comments

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Level 1 Measures & Findings – Time Sensitive

- Time Sensitive: Appointment must take place no later than the PID (provider input).

- Correct use:
  - The provider indicates in the RTC order if the appointment is time sensitive.
    - Scheduler enters #NLT# in the comments field of the appointment scheduled
    - Appointment is scheduled before or one the PID (provider input)

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Level 1 Measures & Findings

Time Sensitive
- ☑ #NLT# Entered But Not Used. Appt Sched After PID.
- ☑ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

- **Incorrect findings:**
  - **#NLT# Entered but not used. Appt Sched After PID**
    - #NLT# entered in the comments field but the appointment is entered after the PID
    Impact: May have adverse impact on Veteran's health if not seen timely. Reduced ability to track time sensitive appointments

  - **NLT not supported:**
    - Scheduler entered #NLT# in the comments field of the appointment but there is no documentation in the RTC order.
    Impact: Reduced ability to track time sensitive appointments

  - **PID Entered Correctly but #NLT# Not Entered**
    - Scheduler entered the correct PID but did not enter #NLT# in the comments field of the appointment
    Impact: Reduced ability to track time sensitive appointments

Audit Measure – Community Care

- All staff who schedule appointments are to determine if the Veteran is wait time eligible for community care.
  - If the patient is wait time eligible, the Veteran is offered a choice to schedule an appointment in VA or in the community.
  - If the patient opts out of community care and prefers VA care, the scheduler will enter #COO# WT in the appointment comments.
    - ✓ This indicates community care opt out based on time eligibility.
    - ✓ Wait time eligibility to be verified as part of the scheduling audit.
- Staff are not required to review community care eligibility other than wait time (except for PC NEAR which will also check drive time if wait time eligible in order to select the appropriate SEOC).
  - Scheduling staff, upon the Veteran's request, will check other community care eligibilities.
  - If the Veteran is found eligible for community care, he/she will be provided an option to schedule in VA or in the community.
  - If the patient opts out of community care and prefers VA care, the scheduler will enter and the community care eligibility.
    - ✓ Example: #COO# DT; #COO# GF
    - ✓ DT and GF eligibility not verified as part of the scheduling audit.

Measure – Community Care Wait Time, No findings

- Veterans are to be provided the opportunity to "opt in or out" of the Community Care if the wait time criteria is met. The PID must be within 20 (primary care and mental health) /28 (specialty care) days of the create date of the appointment request and there is no appointment availability.
  - Note: No availability between appointment request date and PID.
  - Note: Appointment request date=date consult/RTC was created or patient requested appointment. Audit Findings: Correct
- When to Use:
  - If the patient opts out of community care based on the wait time eligibility standard of 20/28 days and prefers VA care, the scheduler will enter #COO# WT in the appointment comments.
    - This indicates community care opt out based on wait time eligibility.
  - #COO# WT clearly annotated in the pending or completed appointment (Community Care Opt out)
    - Audit Action Required: None

Measure – Community Care Wait Time, Findings

- Audit Findings - Incorrect
- Audit Issue: #COO# WT
  - Veteran scheduled a VA appointment
  - #COO# WT is not annotated in the VA appointment comment field (wait time criteria)
- Audit Action Required: Scheduler Education Required

Impact: If #COO# WT is not clearly annotated in the appointment comments, (ex: #COO WT) there is no mechanism to track which Veterans were eligible but declined care in the community.

Measure – Community Care Wait Time, Findings

- Audit Findings - Incorrect

- Audit Issue: #COO# WT Not Supported

- When to use:
  - The appointment is scheduled within 20/28 day wait time standard but the scheduler enters #COO# WT into the appointment comments.

- Audit Action Required: Scheduler Education Required

- Impact: Inappropriately utilizes #COO# WT and may alter supporting wait time measures.

Test Your Knowledge

#COO# WT is found in the appointment comments field indicates – select all that apply:

1. The create date of the consult/RTC/appointment request and the PID are within the community care wait time standards
2. There is no appointment availability within 30 days of the PID
3. There is no appointment availability within 20/28 days of the appointment create date
4. The patient requests Care in the Community
5. The patient requests VA Care

Level 1 Measures & Findings

Optional

None

☑ Insufficient Comments

- Optional audit findings that ARE NOT required nationally and will not be included in national scheduling accuracy reports.

- Insufficient Comments:
    - Comments do not match documentation or does not identify how wait time was determined
    - As determined by SET standard at the medical center or VISN. This must have been communicated to the scheduler and in a SOP/Policy document

Level 1 Audit Examples

COMPLETING AN AUDIT

Level 1 Audit Parameters

L1 Audit Parameters

Where?

StaPc

589A4 ⌄

Service Group

CO-SAT-SURGERY ⌄

Supervisor Group

SURGERY (b)(6) ⌄

Scheduler

All Schedulers ⌄

Non-Count Clinic Flags

No ⌄

When?

Date Column

Appointment Made Date ⌄

Date column used to filter appointments.

Start Date

2018-10-01

End Date

2018-10-31

Days In Range

30

Days in date range (1 - 184)

Additional Filters

Max Sample Size

2

Limit Total Results (1 - 300)

Max Sample Per Scheduler

2

Limit Results Per Scheduler (1 - 75)

Max Completed L1 Audits Per Scheduler

4

Limit Results For Schedulers With Completed Audits (1 - 75)

Appt Wait Time Range

Any Value (Random) ⌄

PID Different From Actual

-99999   99999

Start and Stop of Range

Scheduling Audit Completion		
Audits Conducted	# Appointments	Month Audited
October	2	**October**
November	2	**October/November**
December	1	**November/December**
January	1	**January**
February	2	**January/February**
March	2	**February/March**

Highlighted: Recommended month
*Audit Sample is taken **after** feedback/remediation of the previous audit*

Start and end date for when appointments were made.

The total number of appointments you will be auditing.

Sites you have access to perform L1 audits for.

L1 Audit Parameters

Where?

StaPc

589A4

Service Group

CO-SAT-SURGERY

Supervisor Group

SURGERY (b)(6)

Scheduler

All Schedulers

Non-Count Clinic Flags

No

When?

Date Column

Appointment Made Date

Date column used to filter appointments.

Start Date

2018-10-01

End Date

2018-10-31

Days In Range

30

Days in date range (1 - 184)

This field auto populates based on the start and end date you select.

Additional Filters

Max Sample Size

2

Limit Total Results (1 - 300)

Max Sample Per Scheduler

2

Limit Results Per Scheduler (1 - 75)

Max Completed L1 Audits Per Scheduler

4

Limit Results For Schedulers With Completed Audits (1 - 75)

Appt Wait Time Range

Any Value (Random)

PID Different From Actual

-99999   99999

Start and Stop of Range

The number of appointment per scheduler.

This allows you to limit the number of results for L1 audits completed. This means you will not be given appointments to review for a scheduler who has met the target for L1 audits.

Example 1: Correct

Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-DENTAL DR (b)(6)
Scheduler:	
Comment:	PRE OP SEEING (b)(6) AT 1, NEEDS ALL 3 LABS, RESCHEDULED FROM 1/30/20 DUE TO ANESTHESIA STAFFING SHORTAGE
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	ESTABLISHED
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

Appointment Date Info

Appt Made Date:	01-29-2020
Appt Date:	02-13-2020 14:00:00
PID:	02-13-2020
(Patient Indicated Date)	
PID Difference:	0
(Days between Appointment Date and PID)	
Made Date and Date Difference	15
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

PID: 2/13/2020

- Hover to see the Patients name/SSN.
- New "Copy" feature allows for easy Patient look up in VISTA/CPRS.

Order Details - 139967006;2

Return to CO-DENTAL DR (b)(6) on or around (Feb 13, 2020)
for a total of 1 appointment(s)
Prerequisites: Imaging,
Labs (Non-Fasting),
No Overbook,
PreOp,
Appointment Duration 60 Minutes
PRE OP SEEING (b)(6) AT 1

Activity:
01/29/2020 08:48 New Order entered by (b)(6) (DENTAL ASSISTAN)
          Order Text: Return to CO-DENTAL DR (b)(6) on or around (Feb 13, 2020)
                           for a total of 1 appointment(s)
                           Prerequisites: Imaging,
                           Labs (Non-Fasting),
                           No Overbook,
                           PreOp,
                           Appointment Duration 60 Minutes
                           PRE OP SEEING (b)(6) AT 1
          Nature of Order: WRITTEN
          Ordered by: (b)(6) (ORAL SURGEON-CO)
          Released by: (b)(6) (DENTAL ASSISTANT) on 01/29/2020 08:49
          Signature: ON CHART WITH WRITTEN ORDERS
01/29/2020 08:50 Change entered by (b)(6) (DENTAL ASSISTAN)
          Changed to: Return to CO-DENTAL DR (b)(6) on or around (Feb 13, 2020)
                           for a total of 1 appointment(s)
                           Prerequisites: Imaging,
                           Labs (Non-Fasting),
                           No Overbook,
                           PreOp,
                           Appointment Duration 60 Minutes
                           PRE OP SEEING (b)(6) AT 1
          Nature of Order: POLICY
          Signature: NOT REQUIRED
          Disposition by: (b)(6) (DENTAL ASSISTAN) on 01/29/2020 08:50

Current Data:
Treating Specialty:
Ordering Location: CO-DENTAL DR (b)(6)
Start Date/Time: 01/29/2020
Stop Date/Time: 01/29/2020 08:50
Current Status: COMPLETE
  Orders that require no further action by the ancillary service.
  E.g., Lab orders are completed when results are available,
  Radiology orders are complete when results are available.
Order #139967006

Order:
Clinic Location: CO-DENTAL DR (b)(6)
Time sensitive: NO
Return to clinic date: Feb 13, 2020
Number of Appointments: 1
Prerequisites: Imaging
                            Labs (Non-Fasting)
                            No Overbook
                            PreOp

View Orders

All Orders - CLINIC S

Write Delayed Orde

Write Orders

Activity/GetWell ^
****
ADD NEW ORD
****
Allergy/Adverse
****
Consults
Dietetic Orders

All Orders - CLINIC SCHEDULING

Service	Order	Start / Stop
Clinic Sche	*Return to CO-DENTAL DR (b)(6) on or around (Feb 13, 2020) for a total of 1 appointment(s) Prerequisites: Imaging, Labs (Non-Fasting), No Overbook, PreOp, Appointment Duration 60 Minutes PRE OP SEEING (b)(6) AT 1	Start: 01/29/20 Stop: 01/29/20 08:50
	*Return to CO-DENTAL DR (b)(6) on or around (Feb 13, 2020) for a total of 1 appointment(s) Prerequisites: Imaging, Labs (Non-Fasting), No Overbook, PreOp, Appointment Duration 60 Minutes PRE OP SEEING (b)(6) AT 1	Start: 01/29/20 Stop: 01/29/20 08:50

Find the RTC order in CPRS.

This is not a "Time Sensitive" Appointment

The PID matches what the scheduler entered into the scheduling package

Poll Question:

Was this appointment scheduled correctly?

A. True

B. False

- The PID was Correct
- This was not a Consult appointment
- There was a RTC order entered
- This was not a "Time Sensitive Appointment"
- This appointment is not Community Care eligible

This audit is CORRECT

Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-DENTAL DR (b)(6)
Scheduler:	
Comment:	PRE OP SEEING (b)(6) AT 1, NEEDS ALL 3 LABS, RESCHEDULED FROM 1/30/20 DUE TO ANESTHESIA STAFFING SHORTAGE
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	ESTABLISHED
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

Appointment Date Info

Appt Made Date:	01-29-2020
Appt Date:	02-13-2020 14:00:00
PID:	02-13-2020
	(Patient Indicated Date)
PID Difference:	0
	(Days between Appointment Date and PID)
Made Date and Date Difference	15
	(Days between Appointment Date and the date the appointment was made)
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

Audit Details

Audit Type:	Appointment Audit
Audit Result:	○ Audit Cancelled - Not counted as correct or incorrect. ● Correct - No problems found. ○ Findings - Audit resulted in findings.
Audit Findings:	None (Correct) – No Findings. Appointment was scheduled correctly.

Example 2: Correct

Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-BH PRRC COMMUNITY CARR
Scheduler:	
Comment:	PER RTC 2/3
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	ESTABLISHED
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

Note appointment comment

Appointment Date Info

Appt Made Date:	02-04-2020
Appt Date:	03-23-2020 12:30:00
PID:	03-23-2020
(Patient Indicated Date)	
PID Difference:	0
(Days between Appointment Date and PID)	
Made Date and Date Difference	48
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

PID: 3/23/2020

Audit Details

Audit Type:	Appointment Audit
Audit Result:	○ Audit Cancelled - Not counted as correct or incorrect. ○ Correct - No problems found. ○ Findings - Audit resulted in findings.
Audit Findings:	
Audits Remaining:	1

View Orders

All Orders - CLINIC S

Write Delayed Orde

Write Orders

Activity/ GetWell ∧
****
ADD NEW ORD
****
Allergy/ Adverse
****
Consults
Dietetic Orders
Discharge Order

All Orders - CLINIC SCHEDULING

Service	Order	Start / Stop
	Return to CO-BH PRRC BEAT DEPRESSION on or around (Feb 10, 2020) for a total of 1 appointment(s) Prerequisites: Overbook OK apt at 11am	Start: 02/ 03/ 20 Stop: 02/ 04/ 20 08:57
	*Return to CO-BH PRRC COMMUNITY CARR on or around (Feb 24, 2020) for a total of 6 appointment(s) with a frequency of every 7 day(s) *UNSIGNED*	Start: 02/ 03/ 20 Stop: 02/ 04/ 20 10:02
	*Return to CO-PODIATRY 1 on or around (Apr 05, 2020) for a total of 1 appointment(s)	Start: 01/ 30/ 20 Stop: 01/ 30/ 20 14:23
	*Return to CO-PODIATRY 1 on or around (Apr 05, 2020) for a total of 1 appointment(s)	Start: 01/ 30/ 20 Stop: 01/ 30/ 20 14:23
	Return to CO-OPTOMETRY4 on or around (Jul 27, 2020) for a total of 1 appointment(s)	Start: 01/ 29/ 20 Stop: 02/ 04/ 20 14:06

- Not a Time Sensitive Order
- PID on RTC Order is 2/24/2020
- Multibook appointment-6 appointments each appointment 7 days apart.

Previous Appointment was not Cancelled by the Patient, No Showed, or Cancelled by clinic.

Reflection Workspace - [VISTA Heartland West (KAN)]

File   Edit   Connection   Setup   Macro   Productivity   Help   Search...

Print   Copy   Paste   More VistA   80   132   250   FTP Client   Page Setup   Capture Setup   Start Capture   Stop Capture

```
PC Prov:        (b)(6)                                          Team:
Total Appointment Profile          * - New GAF Required        01/
+     Clinic                       Appt Date/Time              Status
*29   Co-bh Prrc Community Carr   03/02/2020@12:30            Future
*30   Co-bh Prrc Cope Mindful     03/05/2020@13:00            Future
*31   Co-bh Prrc Community Carr   03/09/2020@12:30            Future
*32   Co-bh Prrc Cope Mindful     03/12/2020@13:00            Future
*33   Co-bh Prrc Community Carr   03/16/2020@12:30            Future
*34   Co-bh Prrc Cope Mindful     03/19/2020@13:00            Future
*35   Co-bh Prrc Community Carr   03/23/2020@12:30            Future
+            Enter ?? for more actions
CI   Check In              EP   Expand Entry          DE   Dele
UN   Unscheduled Visit     AE   Add/Edit              WD   Wait
MA   Make Appointment      RT   Record Tracking       CP   Proce
CA   Cancel Appointment    PD   Patient Demographics  DA   Apt
NS   No Show               CO   Check Out             PC   PCMM
DC   Discharge Clinic      EC   Edit Classification   PX   PCE
AL   Appointment Lists     PR   Provider Update       TI   Disp
PT   Change Patient        WE   Wait List Entry       RCI  Reca
CL   Change Clinic         DX   Diagnosis Update      RR   Reca
CD   Change Date Range     DL   Wait List Display          RECAL
Select Action: Next Screen//
```

Poll Question:

- What should the PID be for this appointment?

A. 2/24/2020

B. 3/23/2020

C. 2/3/2020

Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-BH PRRC COMMUNITY CARR
Scheduler:	(
Comment:	PER RTC 2/3
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	ESTABLISHED
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

Appointment Date Info

Appt Made Date:	02-04-2020
Appt Date:	03-23-2020 12:30:00
PID:	03-23-2020
(Patient Indicated Date)	
PID Difference:	0
(Days between Appointment Date and PID)	
Made Date and Date Difference	48
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

- The PID was Correct-multibook appointment noted in RTC
- This was not a Consult appointment
- There was a RTC order entered
- This was not a "Time Sensitive Appointment"
- This appointment is not Community Care eligible

This audit is CORRECT

GOOD JOB!

Audit Details

Audit Type:	Appointment Audit
Audit Result:	○ Audit Cancelled - Not counted as correct or incorrect.
	● Correct - No problems found.
	○ Findings - Audit resulted in findings.
Audit Findings:	None (Correct) - No Findings. Appointment was scheduled correctly.
Audits Remaining:	1

Submit Audit

Example 3: Community Care Wait Time

Find the RTC order in CPRS.

This is not a "Time Sensitive" Appointment

The PID matches what the scheduler entered into the scheduling package

Order Details - 100197016;2

Return to JC-GI (b)(6) on or around (Dec 24, 2018)
for a total of 1 appointment(s)

Activity:
10/29/2018 14:26   New Order entered by (b)(6) (PHYSICIAN (STAF)
         Order Text: Return to JC-GI (b)(6) on or around (Dec 24, 2018)
                           for a total of 1 appointment(s)
         Nature of Order: ELECTRONICALLY ENTERED
         Elec Signature: (b)(6) (PHYSICIAN (STAF) on 10/29/2018 14:26
10/29/2018 14:46   Change entered by (b)(6) (ADVANCED MEDICA)
         Changed to: Return to JC-GI (b)(6) on or around (Dec 24, 2018)
                           for a total of 1 appointment(s)
         Nature of Order: POLICY
         Signature: NOT REQUIRED
         Disposition by: (b)(6) (ADVANCED MEDICA) on 10/29/2018 14:46

Current Data:
Treating Specialty:
Ordering Location: JC-GI (b)(6)
Start Date/Time: 10/29/2018
Stop Date/Time: 10/29/2018 14:46
Current Status: COMPLETE
  Orders that require no further action by the ancillary service.
  g., Lab orders are completed when results are available,
  Radiology orders are complete when results are available.
Order #100197016

Order:
Clinic Location: JC-GI (b)(6)
Time sensitive: NO
Return to clinic date: Dec 24, 2018
Number of Appointments: 1

Print   Close

Poll Question:

- Based on the what you know, was this appointment scheduled correctly?

A. Yes

B. No

- The PID was Correct
- This was not a Consult appointment
- There was a RTC order entered
- This was not a "Time Sensitive Appointment"
- **This appointment is not Community Care eligible. Veteran "opted out" of community care and the PID is not within 28 (specialty care) of the create date of the appointment request.**

This audit is INCORRECT

Mandatory Audit Finding will be updated April 1 with a section for Community Care. The two findings in that section will be Comments missing #COO# WT "Vet Opts Out" and #COO# WT Not Supported.

Audit Details

Audit Type:	Appointment Audit

Audit Result:
- ○ Audit Cancelled - Not counted as correct or incorrect.
- ○ Correct - No problems found.
- ⦿ Findings - Audit resulted in findings.

Audit Findings:

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Optional

None
- ☐ Insufficient Comments

Audits Remaining: 5

[Submit Audit]

Example 4: Incorrect

Appointment Info		Appointment Date Info	
SID:	(b)(6)	Appt Made Date:	11-06-2018
IEN:	(b)(6)	Appt Date:	04-29-2019 08:30:00
Location:	JC-RENAL (b)(6)	PID:	04-29-2019
			(Patient Indicated Date)
Scheduler:			
Comment:		PID Difference:	0
			(Days between Appointment Date and PID)
Non-Count Clinic:	N		
Type:	SERVICE CONNECTED	Made Date and Date Difference	174
		(Days between Appointment Date and the date the appointment was made)	
Purpose Of Visit:	SCHEDULED VISIT		
Patient Status:	ESTABLISHED	Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.
Patient (hover to see):			
LAST,FIRST1234 (hover to see):			
Patient SSN (hover to see):			

There is no RTC Present for appointment.

Appointment was completed on appt made date

Poll Question:

What will the audit finding be for this appointment?

A. PID not used or incorrect

B. NO RTC

C. Appointment was scheduled correctly-no finding

Audit Details

Audit Type:	Appointment Audit

Audit Result:
- ○ Audit Cancelled - Not counted as correct or incorrect.
- ○ Correct - No problems found.
- ◉ Findings - Audit resulted in findings.

Audit Findings:

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☑ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Optional

None
- ☐ Insufficient Comments

Audits Remaining:	1

Submit Audit

- PID Not Used or Incorrect is not applicable
- This was not a Consult appointment
- There was **NOT** a RTC order entered when it should have been
- This was not a "Time Sensitive Appointment"
- This appointment is not Choice eligible.
- This is not a New Patient waiting greater than 90 days

This audit is INCORRECT

Mandatory Audit Finding will be updated April 1 with a section for Community Care. The two findings in that section will be Comments missing #COO# WT "Vet Opts Out" and #COO# WT Not Supported.

Scheduling Audit Reports

Reports Updated nightly, unless otherwise specified

Scheduling Audit Dashboards

- SAT – National Audit Scheduling Accuracy Dashboard

Scheduling Audit L1 (Findings)

- SAT – Cumulative National Findings Monthly Trending
- SAT – Facility Scheduling Audit Findings
  - Data Definitions
- SAT – National L1 Audit Removal Tracking
- SAT – National Scheduling Audit Findings
- SAT – Scheduling Audit Finding Details
- SAT – VISN L1 Audit Detail Removal Tracking

Supplemental Report Maintenance

- Facility – SAT Tool Access Permissions Detail User Report
- National – SAT Tool Access Permissions
- SAT Site Setup Structure

Scheduling Audit L1 (Activity)

- SAT – Audit Activity Monthly Report
- SAT – Facility Audit Activity Report
- SAT – National Audit Activity Report

Scheduling Audit L2 (Activity)

- SAT – Audit L2 Activity Monthly Report
- SAT – Audit L2 Auditors Monthly Activity Report
- SAT – Facility L2 Audit Activity Report
- SAT – National L2 Audit Activity Report

Scheduling Audit L2 (Findings)

- SAT – Facility Scheduling L2 Audit Findings
- SAT – National L2 Audit Removal Tracking
- SAT – National Scheduling L2 Audit Findings
- SAT – Scheduling L2 Audit Finding Details
- SAT – VISN L2 Audit Detail Removal Tracking

Supplemental Scheduling Reports

- Appointment List
- Clinic Setup Location With Associated Providers

National Scheduling Activity

Key:

	>=30% - Audits Complete
	20% -29% - Audits Complete
	< 8% - Audits Complete

Total Audits Completed / # Staff x *10

* # of audits required per scheduler

* Max 10 audits counted per scheduler

VISN / Facility	Appointments Made	Total Level 1 Audits	# Schedulers	Level 1 Audits Remaining (% Completion)
⊞ 1	310,398	3,219	1,731	12527 (20.21%)
⊞ 2	406,724	2,125	1,594	12652 (14.05%)
⊞ 4	320,484	4,283	1,286	9198 (21.41%)
⊞ 5	214,878	1,229	890	7130 (13.27%)
⊞	466,785	3,823	1,516	10485 (25.34%)
⊞	488,633	5,063	1,622	11027 (27.56%)
⊞	720,634	8,909	2,245	12385 (40.48%)
⊞	313,974	3,955	1,531	9920 (27.64%)
⊞ 10	608,512	3,209	2,318	18357 (14.22%)
⊞ 12	347,526	3,304	1,442	10665 (20.03%)
⊞ 15	205,844	3,374	857	4725 (40.71%)
⊞ 16	468,786	10,234	1,856	8145 (52.32%)
⊞ 17	431,907	4,975	1,661	10699 (29.50%)
⊞ 19	310,859	18,776	1,334	1872 (85.02%)
⊞ 20	272,909	1,288	1,209	10301 (8.48%)
⊞ 21	372,008	6,013	1,744	10609 (33.53%)
⊞ 22	555,756	12,138	2,505	14698 (35.28%)
⊞ 23	317,870	1,496	1,471	12129 (10.97%)
National Total	**7,134,487**	**97,413**	**28,755**	**187524 (29.27%)**

Drill down to the Medical Centers

Hyperlink to the facility details

	(589) KANSAS CITY VAMC	44,936	1,146	193	649 (62.42%)
	(589A4) COLUMBIA, MO VAMC	19,502	401	86	398 (50.19%)
	(589A5) EKHCS TOPEKA VAMC	11,317	161	58	346 (31.76%)
⊟ 15	(589A6) EKHCS LEAVENWORTH VAMC	10,146	122	42	271 (31.04%)
	(589A7) ROBERT J. DOLE VAMC	16,929	222	70	448 (33.13%)
	(657) ST. LOUIS VAMC	46,617	581	230	1542 (27.37%)
	(657A4) POPLAR BLUFF MO VAMC	18,186	182	50	380 (24.00%)
	(657A5) MARION IL VAMC	38,211	559	129	691 (44.72%)

Facility Audit Activity Report

Breaks down audits completed and appointments made per month. Locate appointments for low volume schedulers

Drill down to the service, supervisor, and/or individual schedulers

Service Group	Supervisor Group	Staff Name	Audits / Appointments October	Audits / Appointments November	Total Appointments	Total Audits	# Schedulers
⊞DAYTONA - HAS	Total	Total	171 / 11544	0 / 5030	16,574	171	32
⊞HEALTH ADMINISTRATION SERVICE	Total	Total	1087 / 59585	13 / 23905	83,490	1,100	195
⊞INTEGRATED HEALTH SERVICE	Total	Total	0 / 1	0 / 0	1	0	1
⊞MENTAL HEALTH	Total	Total	14 / 114	0 / 40	154	14	3
⊞NURSING - TELEHEALTH	Total	Total	55 / 271	0 / 123	394	55	11
⊞NUTRITION	Total	Total	37 / 466	0 / 88	554	37	7
⊞NUTRITION & FOOD SERVICE	Total	Total	0 / 0	0 / 2	2	0	1
⊟OEF/OIF	⊟OEF/OIF		5 / 101	0 / 44	145	5	
		MED SUPPORT ASST					
		Total	5 / 101	0 / 44	145	5	1
	Total	Total	5 / 101	0 / 44	145	5	1
⊞PHARMACY	Total	Total	10 / 141	0 / 113	254	10	2
⊞PROSTHETICS	Total	Total	10 / 18	0 / 7	25	10	1
⊞RADIATION ONCOLOGY	Total	Total	13 / 733	0 / 255	988	13	2
⊞TELECARE	Total	Total	104 / 4645	0 / 2029	6,674	104	22
⊞VIERA - HAS PRIMARY CARE	Total	Total	140 / 6588	0 / 2590	9,178	140	23
⊞VIERA - HAS SPECIALTY	Total	Total	132 / 5262	0 / 2003	7,265	132	15
⊞VIERA HAS SUPERVISORS	Total	Total	19 / 97	0 / 30	127	19	4
⊞VIERA-HAS BUSINESS	Total	Total	16 / 213	0 / 63	276	16	4
⊞VIERA-HAS MENTAL HEALTH	Total	Total	61 / 4672	0 / 1973	6,645	61	13

National Scheduling Audit Findings Report

Date Range: 10/1/2018 - 3/31/2019   Data Current Through: 11/14/2018

Click here for national findings breakout report.

	VISN / Facility	Appointments Made	Total Audits	Total Findings	% Correct	% Correct (Exclude Clinician)	% Audit Finding
⊞	1	345,136	3,499	391	3153 (90.11%)	3249 (92.86%)	346 (9.89%)
⊞	2	443,484	2,337	412	1948 (83.35%)	2111 (90.33%)	389 (16.65%)
⊞	4	348,684	4,770	416	4383 (91.89%)	4483 (93.98%)	387 (8.11%)
⊞	5	253,512	1,999	221	1809 (90.50%)	1870 (93.55%)	190 (9.50%)
⊞	6	525,662	4,091	537	3605 (88.12%)	3736 (91.32%)	486 (11.88%)
⊞	7	535,997	5,396	444	4978 (92.25%)	5041 (93.42%)	418 (7.75%)
⊞	8	767,207	9,205	1,035	8261 (89.74%)	8589 (93.31%)	944 (10.26%)
⊞	9	336,681	4,064	707	3443 (84.72%)	3517 (86.54%)	621 (15.28%)
⊞	10	649,611	3,408	432	3000 (88.03%)	3058 (89.73%)	408 (11.97%)
⊞	12	371,541	3,763	855	2932 (77.92%)	3315 (88.09%)	831 (22.08%)
⊞	15	295,379	3,617	982	2731 (75.50%)	3110 (85.98%)	886 (24.50%)
⊞	16	501,681	11,365	1,063	10349 (91.06%)	10514 (92.51%)	1016 (8.94%)
⊞	17	469,457	5,235	707	4584 (87.56%)	4709 (89.95%)	651 (12.44%)
⊞	19	331,042	20,010	2,535	17581 (87.86%)	18185 (90.88%)	2429 (12.14%)
⊞	20	306,729	1,482	184	1312 (88.53%)	1316 (88.80%)	170 (11.47%)
⊞	21	397,625	6,267	1,738	4582 (73.11%)	4840 (77.23%)	1685 (26.89%)
⊟ 22	(501) NEW MEXICO HCS	60,543	529	8	522 (98.68%)	522 (98.68%)	7 (1.32%)
	(600) LONG BEACH VAMC	76,369	494	159	343 (69.43%)	480 (97.17%)	151 (30.57%)
	(605) LOMA LINDA HCS	90,738	5,398	444	4959 (91.87%)	4973 (92.13%)	439 (8.13%)
	(644) PHOENIX VAMC	97,585	1,314	140	1186 (90.26%)	1206 (91.78%)	128 (9.74%)
	(649) NORTHERN ARIZONA HCS	19,426	285	95	190 (66.67%)	190 (66.67%)	95 (33.33%)
	(664) SAN DIEGO HCS	85,930	2,955	127	2845 (96.28%)	2863 (96.89%)	110 (3.72%)
	(678) SOUTHERN ARIZONA VA HCS	62,329	59	2	57 (96.61%)	57 (96.61%)	2 (3.39%)
	(691) WEST LA VAMC	94,540	1,793	143	1653 (92.19%)	1653 (92.19%)	140 (7.81%)
⊞	23	345,878	1,533	196	1348 (87.93%)	1408 (91.85%)	185 (12.07%)
	National Total	**7,812,766**	**104,868**	**13,973**	**91754 (87.49%)**	**94995 (90.59%)**	**13114 (12.51%)**

National Findings – Breakout Report

Date Range: 10/1/2018 - 3/31/2019   Data Current Through: 11/14/2018

May have more than one finding per appointment.

Hyperlink to drill down to the facility

VISN / Facility	Appointments Made	Total Audits	Total Findings	% Correct	% Correct (Exclude Clinician)	% Findings	National Measure Findings Totals				
							Time Sensitive	Choice	EWL	PID	
										PID Error	No Consult No RTC
1	345,136	3,500	394	3153 (90.09%)	3249 (92.83%)	347 (9.91%)	3	86	1	183	121
2	2,337	412	1948 (83.35%)	2111 (90.33%)		389 (16.65%)	6	28	0	196	182
4	4,770	416	4383 (91.89%)	4483 (93.98%)		387 (8.11%)	4	46	1	254	111
5	2,000	222	1809 (90.45%)	1871 (93.55%)		191 (9.55%)	10	17	1	103	91
6	4,092	537	3606 (88.12%)	3737 (91.32%)		486 (11.88%)	8	101	9	262	157
7	535,997	5,396	444	4978 (92.25%)	5041 (93.42%)	418 (7.75%)	7	70	12	275	80
(516) C.W. BILL YOUNG DEPT OF VAMC	116,376	1,001	73	929 (92.81%)	946 (94.51%)	72 (7.19%)	0	4	0	52	17
(546) MIAMI VAMC	71,719	1,038	62	1001 (96.44%)	1007 (97.01%)	37 (3.56%)	4	15	1	23	19
(548) WEST PALM BEACH VAMC	81,997	2,060	156	1914 (92.91%)	1928 (93.59%)	146 (7.09%)	1	26	0	107	22
8 (573) N. FLORIDA/S. GEORGIA HCS	144,412	1,727	269	1473 (85.29%)	1612 (93.34%)	254 (14.71%)	0	33	1	84	151
(672) SAN JUAN VA MEDICAL CENTER	95,946	473	78	406 (85.84%)	415 (87.74%)	67 (14.16%)	3	3	0	52	20
(673) TAMPA FL VAMC	116,817	944	245	709 (75.11%)	831 (88.03%)	235 (24.89%)	0	4	1	109	131
(675) ORLANDO VAMC	139,940	1,969	155	1835 (93.19%)	1856 (94.26%)	134 (6.81%)	3	54	0	65	33
9	336,681	4,064	707	3443 (84.72%)	3517 (86.54%)	621 (15.28%)	11	42	2	513	139
10	649,611	3,412	432	3004 (88.04%)	3062 (89.74%)	408 (11.96%)	5	32	0	318	77
12	371,541	3,763	855	2932 (77.92%)	3315 (88.09%)	831 (22.08%)	2	30	0	423	400
15	295,379	3,620	985	2732 (75.47%)	3112 (85.97%)	888 (24.53%)	20	111	4	414	436
16	501,681	11,365	1,063	10349 (91.06%)	10514 (92.51%)	1016 (8.94%)					
17	469,457	5,235	707	4584 (87.56%)	4709 (89.95%)	651 (12.44%)					
19	331,042	20,010	2,535	17581 (87.86%)	18185 (90.88%)	2429 (12.14%)					
20	306,729	1,482	184	1312 (88.53%)	1316 (88.80%)	170 (11.47%)					
21	397,625	6,268	1,740	4582 (73.10%)	4840 (77.22%)	1686 (26.90%)	48		2	1,307	294
22	587,460	12,827	1,118	11755 (91.64%)	11944 (93.12%)	1072 (8.36%)		146	6	674	210
23	345,878	1,533	196	1348 (87.93%)	1408 (91.85%)	185 (12.07%)	1	22	0	107	66
National Total	**7,812,766**	**104,886**	**13,985**	**91766 (87.49%)**	**95009 (90.58%)**	**13120 (12.51%)**	**287**	**1,522**	**44**	**8,352**	**3,780**

Only one finding per appointment is counted in the appointment error total

Facility Scheduling Audit Findings

Service Group	Appointments Made	% Appt Findings	% Correct	% Correct (Exclude Clinician)	Local Findings	National Findings	Audits Performed	Audits Cancelled
⊞MEDICAL SERVICE	2,512	0	0	0	0	0	0	0
⊞MENTAL HEALTH	16,322	8 (3.77%)	204 (96.23%)	208 (98.11%)	6	9	212	1
⊞NEUROLOGY	907	6 (26.09%)	17 (73.91%)	22 (95.65%)	0	7	23	0
⊞NURSING AND PATIENT CARE SVC?		1 (1.52%)	65 (98.48%)	66 (100.00%)	0	1	66	1
⊞NUTRITION & FOOD SERVICES		0	6 (100.00%)	6 (100.00%)	0	0	6	0
⊞PHARMACY SERVICE		0	0	0	0	0	0	0
⊞PHYSICAL AND REHAB MEDICINE		0	5 (100.00%)	5 (100.00%)	0	0	5	0
⊟PRIMARY CARE SERVICE	1,877	2 (7.69%)	24 (92.31%)	24 (92.31%)	2	2	26	0
EL CENTRO PRIMARY CARE	642	2 (7.69%)	24 (92.31%)	24 (92.31%)	2	2	26	0
LVN	225	0	6 (100.00%)	6 (100.00%)	0	0	6	0
HEALTH TECHNICIAN	198	0	6 (100.00%)	6 (100.00%)	1	0	6	0
MEDICAL SUPPORT ASSISTANT			6 (100.00%)	6 (100.00%)	0	0	6	0
MEDICAL SUPPORT ASSISTANT			0	0	0	0	0	0
LVN			0	0	1	2	2	0
HEALTH AIDE	55	0	6 (100.00%)	6 (100.00%)	0	0	6	0
NOT DEFINED	64	0	0	0	0	0	0	0
MEDICAL SUPPORT ASSISTANT	64	0	0	0	0	0	0	0
⊞RESEARCH SERVICE	93	0	0	0	0	0	0	0
⊞SCI	829	0	0	0	0	0	0	0
⊞SOCIAL WORK	261	0	0	0	0	0	0	0
⊞SURGERY	73	0	0	0	0	0	0	0
Total	84,958	110 (3.72%)	2845 (96.28%)	2863 (96.89%)	74	127	2,955	47

Drill down to the service and individual scheduler

Appointments scheduled but the scheduler is unassigned

Individual Appointment Audit Details

Service Group	Appointments Made	% Appt Findings	% Correct	% Correct (Exclude Clinician)	Local Findings	National Findings	Audits Performed	Audits Cancelled
Scheduler Name ADVANCED MED SUPPORT ASSISTANT	1,020	3 (11.54%)	23 (88.46%)	24 (92.31%)	1	3	26	0

Local Findings Details

Reporting Measure	Responsible Group	Audit Result	Findings Type	Audit Finding	Description
None	Scheduler	Correct	Local	Insufficient Comments	Scheduler comments do not match documention or do not identify how they decided entered wait time (PID).

National Findings Details

Reporting Measure	Responsible Group	Audit Result	Findings Type	Audit Finding	Description
PID	Clinician	Findings	National	No RTC	No RTC Present
PID	Scheduler	Findings	National	PID Not Used or Incorrect	PID not used by scheduler, incorrect PID used.
Choice	Scheduler	Findings	National	Comments missing #COO#. Vet "Opts Out"	#COO# is not entered in the comments field of VA appointment when the Veteran "Opts Out" of Choice.

Audit Activity Report Summary

Service Group	Supervisor Group	Staff Name	Appointments Made	Total Audits	# Schedulers	Audits Remaining (% Completion)
⊟ SOCIAL WORK	⊟ NOT DEFINED NOT DEFINED	Patsy Cline SENIOR SOCIAL WORKER	3	0		3 (0.00%)
		Total	3	0	1	3 (0.00%)
	Total	Total	3	0	1	3 (0.00%)

Important steps to utilizing the Audit Activity Report Correctly

1. Look for schedulers in "NOT DEFINED" Supervisor group. These staff need to be added to the Grouping Tool.
2. Low volume schedulers who schedule less than mandated audits need only complete the total audits to attain 100% completion. Be mindful that even if they are 100% this can change if they schedule up to two weeks prior to closing of the audit cycle.
3. There's a hyperlink on the appointments made column which will guide you to exactly the period of time to conduct audits. Below is an example of the Appointments Made Detail Report.

Service Group	Supervisor Group	Staff Name	Audits / Appointments January	Total Appointments	Total Audits	# Schedulers
⊟ SOCIAL WORK	⊟ NOT DEFINED NOT DEFINED	Patsy Cline SENIOR SOCIAL WORKER	0 / 3	3	0	
		Total	0 / 3	3	0	1
	Total	Total	0 / 3	3	0	1
Total	Total	Total	0 / 3	3	0	1

Next Steps

- Complete quiz in TMS

- Attend monthly auditor check-in calls offered the 1st Monday of the month at 2pm ET

- Provide feedback to the schedulers within 14 days!

- Facility Audit Goal: 93% (stretch goal of 94%)

- Standardize your VISN Audit process.

Cerner Implementation & Scheduling Audits

- Current scheduling audits will continue using the BISL tool

- Sites that are implementing Cerner Scheduling will pause on L1 scheduling audits the month prior to implementation and must be at 100% of the expected completion rate for the month at the audit is paused.
  - Example – Cerner go live date is March 2020
    - ✓ L1 scheduling audit activity will end January 31, 2020
    - ✓ L1 facility audit completion rate should be at $\geq$ 50%. Note all staff who schedule should have 5 of the 10 required appointment audited
    - ✓ L2 facility audits will end February 28, 2020 with the expected completion rate as listed above.

- Post Cerner implementation:
  - Assess the risks for scheduling accuracy based on new software functionality and scheduling process
  - Design new audit program based on identified areas that may negatively impact scheduling accuracy

Cycle 1 - Scheduling Audit Progress Indicators	
October	
November	30%
December	40%
January	50%
February	70%
March weeks 1 &2	85%
March week 3	90%
March week 4	100%

Cycle 2 - Scheduling Audit Progress Indicators	
April	
May	30%
June	40%
July	50%
August	70%
September weeks 1 &2	85%
September week 3	90%
September week 4	100%

Q&A

National Scheduling Audit

Level 2 Scheduling Auditor Training

"Audit the Auditor"

Access Office
6/4/2021

VA | **U.S. Department of Veterans Affairs**

Agenda

- **Background**
  - **Change Management**
  - **Training Objectives**
- **L2 Audit Details**
  - Cycle
  - Frequency of audits
  - Number of audits
- **L2 Audit Parameters**
- **L2 Audit Measures**
- **Practical Application**
- **Reports**
- **Next Steps**
- **Q&A**

Change Management

Why the Change?

- Level 2 (L2) Audits are no longer "double-blind"

- Discontinuation of the Electronic Wait List (EWL)

Why Now?

- To ensure the National Standardized Scheduling Audit Program requirements appropriately reflect recent changes to scheduling policies and processes

What is not Changing?

- Facilities are still required to conduct L2 Scheduling Audits

Choose VA

VA | U.S. Department of Veterans Affairs

Training Objectives

As a result of this training, L2 Scheduling Auditors will understand how to:

✓ **Apply audit standards when reviewing and evaluating the accuracy of L1 scheduling audits**

- Understand audit measures

- Correctly review appointment documentation

- Accurately complete the L2 Audit in the BISL tool

✓ **Appropriately adjust the number of audits evaluated based per audit cycle**

L2 Audit Definitions

Terms and Definitions

- **Audit Finding**: The outcome of the audit process (e.g., whether an audit measure is correct or incorrect).

- **L1 Audit**: A review of a scheduler's appointments to evaluate scheduling accuracy.

- **L2 Audit**: A review of a scheduling auditor's findings to assess auditor accuracy to ensure the reliability of the audit results and that appropriate scheduler audit performance feedback is provided.
    - *E.g., Are the findings of the L1 Auditor accurate?*

L2 Auditor
"Audit the Auditor"

⬇

L1 Auditor
"Audit the Scheduler"

⬇

Scheduler

L2 Audit Framework and Requirements

L2 Audit Framework

The **VISN Scheduling Audit Lead** is responsible for determining the audit model and facilitating access to the facility scheduling system, CPRS, and the BISL Tool.

- **VISN Model:** A designated VISN staff member conducts the L2 Audits.

- **Interfacility Model:** One medical center conducts L2 Audits of another facility within the VISN.

  - *NOTE: L2 Auditors are not to conduct scheduling audit reviews of staff at their facility.*

VISN Oversight
✓ No more than 5 L2 Auditors per facility/VISN
✓ A minimum of 10 L2 Audits completed for each L1 Auditor per cycle
✓ L2 reviews are to be completed during the same L1 cycle (concurrent)
✓ L1 Audit accuracy goal is 96% or better

Choose VA

VA | **U.S. Department of Veterans Affairs**

Requirements and Responsibilities

L2 Auditor Requirements:

✓ Must have expert knowledge of scheduling practice and have completed scheduler training, L1 and L2 Auditor training.

✓ Must be a VISN staff level designee or medical center designee who will review another facility.

✓ Should not review L1 Auditors at their facility, except for facility Compliance staff who have completed the necessary training.

✓ Should communicate audit results timely to the VISN Audit POC to ensure timely feedback to the L1 Auditors.

L2 Auditor Responsibilities:

✓ Provide feedback on audit results to the auditor within **14 calendar days** of the audit sample

✓ Provide audit results directly to the supervisor

– *NOTE: The supervisor will communicate the audit findings directly to the scheduler*

L2 Audit Cycle

	Cycle 1	Cycle 2
L1 Audit	October 1st - March 31st	April 1st - September 30th
L2 Audit	November 1st – April 30th	May 1st – October 31st

Month	L2 Audit Monthly Progress Indicators for Cycle 1		
	On Track → Behind		
November	---	---	---
December	30%	20 - 29%	< 20%
January	40%	30 - 39%	< 30%
February	50%	40 - 49%	< 40%
March	70%	55 - 69%	< 55%
April (week 1 & 2)	85%	75 - 84%	< 75%
April (week 3)	90%	85 - 89%	< 85%
April (week 4)	100%	---	< 100%

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L2 Audit Cycle

- L2 Auditors **must** conduct a small sample of audits each month throughout the audit cycle to allow time for improvement

- Audit feedback **must** be communicated verbally (or in writing at a minimum), within **14 calendar days** of the completed audit.

    - Best practice is "just in time feedback" immediately after the audit is completed

    NOTE: *L2 Audit sample should be taken after feedback/remediation*

	Cycle 1	Cycle 2
L1 Audit	October 1st - March 31st	April 1st - September 30th
L2 Audit	November 1st – April 30th	May 1st – October 31st

Example: L2 Audit Sampling for Cycle 2

Month when L1 Audit was Completed	No. of Appts	Month to Conduct the L2 Audit
May	2	April
June	2	April / May
July	1	May / June
August	1	June / July
September	2	July / August
October	2	August / September

10

L2 Audit Parameters

Parameter	Details
When	The Date Column Start, and End Date reflect the monthly sampling period.
Where	Details who is being audited; select L1 Auditors whose audits will be reviewed.
Additional Filters	Used to target the exact samples needed to meet auditing requirements.
Max Sample Size	Limits the total results for the audit sample.
Max Sample per Auditor	Limits the total number of audit samplers per L1 Auditor
Max Completed L2 Audits per Auditor	Total number of L1 auditors with a completed L2 audit. – This setting is increased cumulatively to account for the additional audits performed each month. – The final month of the audit period should reflect the total number of required audits for the cycle.

L2 Audit Parameters

When?

Start Date

2021-04-01

End Date (Inclusive)

2021-04-30

Days In Range

30

Days in date range (1 - 184)

Where?

StaPc

508

L1 Auditor

Any

Additional Filters

Max Sample Size

10

Limit Total Results (1 - 300)

Max Sample Per L1 Auditor

2

Limit Results Per L1 Auditor (1 - 75)

Max Completed Audits Per L1 Auditor

2

Limit Results For L1 Auditors With Completed L2 Audits (1 - 75)

L2 Audit Activity - Example #1

Scenario Example	Value
Number of L1 Auditors	39
Required Number of L2 Audits per Cycle **NOTE:** *At least 10 L2 Audits must be completed <u>for each</u> L1 Auditor by the end of the cycle*	39 x 10 = 390
Number of L2 Auditors	5
Required Number of Audits per L2 Auditor	390 ÷ 5 = 78

Month	L1 Audits	Date Range	Max Sample Size per L2 Auditor	Max Sample Per L1 Auditor	Max Completed Per L1 Auditor
May	2	4/1-4/30/2021	39 x 2 / 5 = **15.6**	2	2
June	2	5/1-5/31/2021	39 x 2 / 5 = **15.6**	2	4
July	1	6/1-6/30/2021	39 x 1 / 5 = **7.8**	1	5
August	1	7/1-7/31/2021	39 x 1 / 5 = **7.8**	1	6
September	2	8/1-8/31/2021	39 x 2 / 5 = **15.6**	2	8
October	2	9/1-9/30/2021	39 x 2 / 5 = **15.6**	2	10
	Recommended Audit sample per L1 Auditor	Factor in time for feedback. Do not sample until feedack from the previous audit has been completed	# of L1 auditors X sample audits / # of L2 Auditors. Provides approximate # of audits the L2 Auditor should complete in the month. (total = the number of audits to be conducted per L2 Auditor or d)	Recommended Audit Sample per L1 Auditor	Cumulative number of audits to have been completed at the end of the month. (= Past month + current month)

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L2 Audit Activity - Example #2 (Question)

Question: What would be the parameters for *Max. Completed Audits per L1 Auditor* in May?

Scenario:

- # of L1 Auditors = 10
- # of L2 Auditors = 5
- # of Completed L2 Audits in April = 2
- # of Completed L2 Audits May = 2

Reminder: *At least 10 L2 Audits must be completed <u>for each</u> L1 Auditor by the end of the audit cycle.*

Month	# of L1 Audits	Date Range	Max. Sample Size	Max. Sample Size per L1 Auditor	Max. Completed Complete per L1 Auditor
April	2	4/1 - 4/15	(10 * 2) ÷ 5 = 4	2	2
May	2	5/1 - 5/15	(10 * 2) ÷5 = 4	2	?

NOTE: *Max Sample Size Calculation* = *(10 * # of L1 Audits) ÷ # of L2 Auditors*

L2 Audit Activity - Example #2 (Answer)

Question: What is the max completed per L1 Auditor parameter setting when conducting an L2 Audit in May?

Answer:

Month	# of L1 Audits	Date Range	Max. Sample Size	Max. Sample Size per L1 Auditor	Max. Completed Complete per L1 Auditor
April	2	4/1 - 4/15	4	2	2
May	2	5/1 - 5/15	4	2	**4**

NOTE: **Max Sample Size Calculation** = (10 * # of L1 Audits) ÷ # of L2 Auditors

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L2 Audit Template

- L2 Auditor is to perform self-review of the L1 Audit appointment and compare results to L1 Audit findings

    - **Same results** = Correct L1 Audit

    - **Different results** = Incorrect L1 Audit

Mandatory

PID

☐ PID Not Used or Incorrect

☐ No Consult

☐ No RTC

Time Sensitive

☐ #NLT# Entered But Not Used. Appt Sched After PID.

☐ "#NLT# not supported" Incorrect.

☐ PID Entered Correctly But #NLT# Not Entered

Community Care

☐ Comments missing #COO# Vet "Opts Out"

☐ #COO# Not Supported

☐ #COO# Not Selected in DST

☐ No Evidence other CC Eligibilities

Optional

None

☐ Insufficient Comments

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National Audit Measures

Patient Indicated Date (PID)

- The appointment date the Veteran and provider agree upon **or** the date the Veteran requests in the absence of a provider.
- Presence of RTC/Consult when applicable

Time Sensitive Appointment

- This is an appointment that must be completed by the date specified on the return to clinic (RTC) order or Consult.

Community Care

- Veterans are to be provided the opportunity to "opt-in or opt-out" of the Community Care if the wait time criteria is met. The PID must be within 20 (Primary Care and Mental Health) /28 (Specialty Care) days of the create date of the appointment request and there is no appointment availability.
  - *NOTE: No availability between appointment request date and PID.*
  - *NOTE: Appointment request date=date Consult/RTC was created or patient requested appointment.*

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Patient Indicated Date (PID)

The **Patient Indicated Date (PID)** is entered into the VistA CID/Pt Preferred Date field. The date entered is based on one of two scenarios.

```
PID

    ☐ PID Not Used or Incorrect
    ☐ No Consult
    ☐ No RTC
```

1. **Provider-driven:** The date agreed upon by the patient and provider, entered in the RTC or Consult

2. **Patient-driven:** The date the patient requests in the absence of provider input such as:

   – New Patient to the VA

   – Direct-scheduling clinic ("Self-Referral")

   – Unanticipated appointment need outside of the already scheduled return appointment

   – Rescheduled appointment where the patient cancelled or "no-show"

   – When the patient was not responsive to scheduling efforts and the appt request was dispositioned (RTC, PtCSch, Consults)

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L1 Measures & Findings: Appropriate Use of PID

Patient Indicated Date (PID)

- **Audit Findings:** Correct, No Action Required
  - The date agreed upon by the patient and provider such as the RTC or Consult date (provider-driven).
  - The date the patient requests in the absence of provider input (patient-driven).
  - RTC or Consult is present when required.

L1 Measures & Findings: Appropriate Use of PID

Audit Findings: Incorrect, Scheduler Education Required

PID
☑ PID Not Used or Incorrect
☐ No Consult
☐ No RTC

- **Audit Issue: PID Not Used or Incorrect**
  The date entered into VistA/VS GUI CID/Pt Preferred Date field is not what was entered in the RTC Order

  - **Cancel by Patient:** Patient initiated the appointment cancellation. The appointment was rescheduled incorrectly, using the PID (provider input) of the cancelled appointment.

  - **Cancel by Clinic:** Clinic initiated the appointment cancellation. The appointment is rescheduled incorrectly using the PID (per patient) or another PID other than of the original cancelled appointment.

  Impact: Inaccurate appointment wait time

  *Note: This finding is **not used** in scenarios where there is no RTC or Consult and there should be.*

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L1 Measures & Findings: Appropriate Use of Consult /RTC Orders

PID: Return to Clinic (RTC) Order and Consults

Audit Findings: Correct, No Action Required

- Provider-driven appointment requests require a RTC Order or Consult

- Patient-driven appointment requests (w/o provider input) do not require an RTC Order or Consult (See slide 15 for examples)

Audit Findings: Incorrect, Scheduler Education Required

- **Audit Issue:** No Consult or No RTC
  Consult or RTC Order was not present at the time the appointment was scheduled.

Impact: Wait time reliability

PID
- ☐ PID Not Used or Incorrect
- ☑ No Consult
- ☑ No RTC

L1 Measures & Findings: Time Sensitive Appointments (#NLT#)

Time Sensitive Appointments:

Appointment must take place no later than the PID (provider-driven)

Audit Findings: Correct, No Action Required

- The provider indicates in the RTC order if the appointment is time sensitive.

  - Scheduler enters **#NLT#** in the comments field of the appointment scheduled

  - Appointment is scheduled before or one the PID (provider input)

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L1 Measures & Findings: Time Sensitive Appointments(#NLT#)

Audit Findings: Incorrect, Scheduler Education Required

Time Sensitive
- ✓ #NLT# Entered But Not Used. Appt Sched After PID.
- ✓ "#NLT# not supported" Incorrect.
- ✓ PID Entered Correctly But #NLT# Not Entered

1. **Audit Issue: #NLT# Entered but not used. Appt Sched After PID**
   #NLT# entered in the comments field but the appointment is entered after the PID

   Impact: May have adverse impact on Veteran's health if not seen timely. Reduced ability to track time sensitive appointments

2. **Audit Issue: NLT not supported**
   Scheduler entered **#NLT#** in the comments field of the appointment but there is no documentation in the RTC Order.

   Impact: Reduced ability to track time sensitive appointments

3. **Audit Issue: PID Entered Correctly but #NLT# Not Entered**
   Scheduler entered the correct PID but did not enter **#NLT#** in the comments field of the appointment

   Impact: Reduced ability to track time sensitive appointment

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Community Care (CC) Wait Time Standards

File entry date starts the timeline

No appointment availability

June 1st | June 15th | 20/28 days
File entry date | PID |

Wait Time Standards (WTS)

Primary Care/Mental Health/Non-Institutional Extended Care Services	Specialty Care	Criteria
20 Days	28 Days	The WTS for community care must be considered if the following applies: 1. The PID on the consult, RTC, or patient generated request is within 20 or 28 days (based on the type of care being requested) from the file entry date. If the request is patient generated, the date the patient initiated the request for care. 2. The appointment wihtin the VA cannot be scheduled within 20/28 days of the file entry date

Community Care (CC) Wait Time Eligibility

Consults, RTC Orders, and Patient-driven Requests

– <u>**Eligible**</u> **for Community Care when scheduling:**

The PID is within Community Care wait time standards (WTS) <u>**AND**</u> the VA appointment cannot be scheduled.

No appointment availability

File entry date   PID   20/28 days
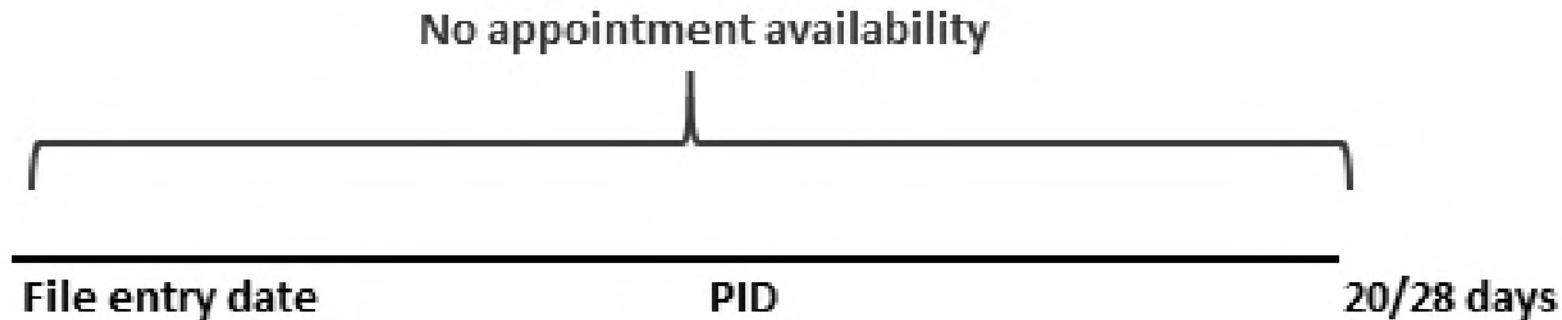
Community Care (CC) Wait Time Eligibility

Consults, RTC Orders and Patient-driven Requests

- ## Not eligible for Community Care when scheduling:
  - The PID is outside Community Care wait time standards

File entry date   20/28 days   PID

OR

  - PID **AND** appointment availability is within wait time standards

File entry date   PID   20/28 days

Appointment Availability
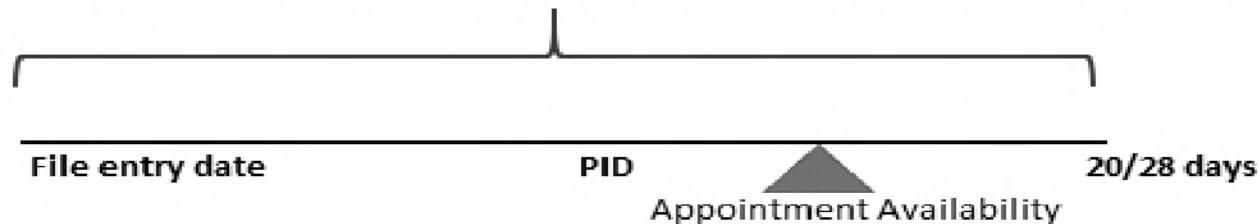
Community Care (CC) Eligibly Standards

- ## Wait time Standards (WTS):
  - The PID must be within 20 (Primary Care and Mental Health)/28 (Specialty Care) days of the create date of the appointment request and there is no appointment availability.
  - **NOTE:**
    - No availability between appointment request date and PID.
    - Appointment request date=date Consult/RTC was created or patient requested appointment.

- ## Drive time Standards:
  - > 30 minutes for Primary Care and Mental Health
  - >60 minutes for Specialty Care

- ## Other Criteria:
  - Service not available
  - Veteran Lives in a US State or Territory without a Full-Service VAMC
  - Grandfathered In
  - Best Medical Interest
  - VAMC Service line does not meet Quality Standards

Community Care Field Guidebook: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx

Community Care (CC) Eligibility Documentation Key Points

- **Wait time eligibility is checked for all appointments, both new and established**
  - Check wait time by referencing the exact clinic where the Veteran is to be scheduled
  - If eligible for CC and Veteran opts out →enter **#COO#** in the appointment comments
  - No further review of "other CC eligibility" is needed

- **New Patients:**
  - When not wait time eligible, scheduler must review for "other CC eligibilities"
  - Documentation of review is required

    Exception: Veterans who live in a US State or Territory without a Full-Service VAMC: Alaska, Hawaii, New Hampshire, & US Territories of GUAM, American Samoa, Northern Mariana Islands, and the US Virgin Islands. No documentation of "other" Community Care is required

- **Established Patients:**
  - If not wait time eligible, check "other" eligibilities upon the patient's request. No further documentation is required.

New Patients –"Other" Eligibilities Documentation

The **new patient** is not CC wait time eligible AND is eligible under the "other CC eligibilities"

1. **If using DST:**

   Check if eligible based on "other CC eligibility"

   a. **If "other CC eligible"**
   - Select "Opts out" in the DST
   - Save the DST to the Consult
   - Schedule VA appointment

     Note: If not "other CC eligible" save DST to consult

   Veteran Community Care Option

   (required)

   - ◯ TBD/Deferred
   - ◯ Opt-in for CC   ✓ Opt-out of CC

2. **If not using DST:**

   Use CPRS to check Community Care eligibility based on other Community Care eligibility criteria and BING Maps to review Drive Time Eligibility.

   a. **If "other CC eligible"** and opts out → enter **#COO# DT=minutes** in the appointment comments
      Note: If not "other CC eligible" enter DT = XX minutes in the appointment comments

NOTE: DT=minutes does not mean the Veteran is drive time eligible for Community Care. Annotation DT=minutes in the appointment comment shows all Community Care eligibilities were reviewed.

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Community Care (CC) Audit Measure – Established Patients

- **Wait Time, Auditor will look for the below and appropriate evidence**:
  - **#COO#** is in the appointment comments
    - Patient is wait time eligible for Community Care and Opts. Out and is scheduled for an appointment in VA
  - Nothing is entered in the appointment comments
    - Patient is not eligible for Community Care based on the Community Care wait time standard

- **The auditor will only review wait time eligibility for established patients.**
  - Although the scheduler will check other eligibilities when requested by the patient, the auditor will not specifically audit and review documentation for this.

*Reminder: For **established patients only**, the scheduler is not required to check other Community Care eligibilities unless the patient specifically requests this. The scheduler is to honor the request at that time.*

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Community Care (CC) Audit Measures & Findings

Audit Findings: Correct, No Action Required

New patients:

- Meets WTS and prefers care in VA. Scheduler enters **#COO#** in the appointment comments **OR**
- Evidence of DST being run
  - Meets Other eligibility standards and selects **#COO#** in the DST (Consult)
  - When not meeting other eligibility standards, evidence of DST in the Consult
- DST not Available
  - Meets Other eligibility standards and enters **#COO# , DT = XX minutes** in the appointment comments
  - When not meeting other eligibility standards, enters **DT = XX minutes** in the appointment comments

Established Patients

- Meets WTS and prefers care in VA. Scheduler enters #COO# in the appointment comments
- If does not meet WTS, nothing is required in the appointment comments

Community Care (CC) Audit Measures & Findings

Audit Findings: Incorrect, Scheduler Education Required

1. **Audit Issue: Comment Missing #COO# Vet Opts Out**

   - **New patients:** Meets WTS and prefers care in VA. Scheduler **does not** enter **#COO#** in the appointment comments

   - **Established patients:** Meets WTS and prefers care in VA. Scheduler **does not** enters **#COO#** in the appointment comments

   Impact: If new patient or established is wait time eligible and #COO# is not clearly annotated in the appointment comments, (ex: #COO) there is no mechanism to track which Veterans were eligible but declined care in the community.

2. **Audit Issue: #COO# Not Supported**

   The appointment is scheduled within 20/28 day wait time standard, but the scheduler enters **#COO#** into the appointment comments.

   Impact: Inappropriately utilizes #COO# and may alter supporting wait time measures.

Community Care (CC) Audit Measures & Findings

Audit Findings: Incorrect, Scheduler Education Required

3. <u>Audit Issue</u>: #COO# not selected in DST

   - **When the new patient is not wait time eligible:**
     a) The DST is run to check for other Community Care eligibility:
        - **#COO#** is not selected by the scheduler in the DST when found to be "other" Community Care eligible and the patient opts-out of Community Care
     b) The DST is not available, and the scheduler manually checks other Community Care eligibilities:
        - **#COO# DT = XX Minutes** is not in the appointment comments when the patient is found to be "other" Community Care eligible and opts-out of Community Care

4. <u>Audit Issue</u>: No Evidence Other CC eligibilities
   DST was not saved **OR** no evidence of **DT=XX minutes** in cases where DST is not available (not run)

   - **New Patients:** When a new patient is not wait time eligible and the DST was not run and saved to indicate the scheduler checked the patient's other Community Care eligibility

   - When a new patient is not wait time eligible and the DST is not used at your facility and there is no evidence of checking CPRS for Community Care. The scheduler did not enter **DT = XX minutes** in the appointment comments to indicate other eligibilities were checked.

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Optional Audit Findings

- Optional audit findings **<u>are not required</u>** nationally and will not be included in national scheduling accuracy reports.

- **Insufficient Comments:**

  – Comments do not match documentation or does not identify how wait time was determined

  – As determined by standards set by the medical center or VISN. This must have been communicated to the scheduler and in a SOP/Policy document

Optional
None
☑ Insufficient Comments

Practical Application:
L2 Audit Examples

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L2 Audit Parameters

Start and End Date: Represents when the L1 Audits were performed.

StaPC: drop down list of facilities accessible to L2 Auditor.

...arameters

When?

Start Date

2021-04-01 📅

End Date (Inclusive)

2021-04-30 📅

Days In Range

30

Days in date range (1 - 184)

Where?

StaPc

589A4 ⌄

L1 Auditor

Any ⌄

Additional Filters

Max Sample Size

1

Limit Total Results (1 - 300)

Max Sample Per L1 Auditor

1

Limit Results Per L1 Auditor (1 - 75)

Max Completed Audits Per L1 Auditor

75

Limit Results For L1 Auditors With Completed L2 Audits (1 - 75)

Max Sample Size = total number of L1 Audits to be reviewed by L2 Auditor.

Max Sample Per L1 Auditor: The number of L1 audits per auditor.

Days in Range: auto-populates based on the Start Data and End Date selected.

Max Completed Audits Per L1 Auditor: limits the number of results for L1 Auditors with completed L2 Audits. (e.g., you will not be given an L1 Audit for an auditor who has met the target for L2 Audits).

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Example #1 – Incorrect L2 Audit

Example #1 – Find the Patient/Appointment in VISTA

Example #1 – Find the Patient's Order/Consult in CPRS

Example #1 - L2 Audit Finding of Incorrect

**L1 Auditor's Finding =** Incorrect, PID Not Used or Incorrect"

L2 Review marks the L1 finding as incorrect. There are no additional findings to add.

L2 Auditor's Finding:
1. PID entered by the scheduler and the PID on the RTC Order match
2. L1 Auditor's finding was **incorrect**
3. All national scheduling requirements were met -- should have been marked as 'Correct'

Example #2 - Incorrect L2 Audit

Example #2 - Find the Patient/Appointment in VISTA


```
Appt Mgt Module              Oct 03, 2018@14:02:59      Page:   1 of    1
Patient:                                   MT: COPAY EX          Outpatient
PC Prov: (b)(6)                            Team: JC-WSH PACT B3 PCP *WH*
Total Appointment Profile        * - New GAF Required    10/30/18 thru 05/31/19
     Clinic                       Appt Date/Time        Status
   1   Jc-ophth Eye (b)(6)        10/30/2018@13:00      Cancelled By Clinic
   2   Jc-ophth Eye              12/11/2018@15:30      Future
   3   Jc-wsh Pact B3 Pcp        12/17/2018@15:30      Future



          Enter ?? for more actions
CI   Check In              CD   Change Date Range      DX   Diagnosis Update
UN   Unscheduled Visit     EP   Expand Entry           DL   Wait List Display
MA   Make Appointment      AE   Add/Edit               DE   Delete Check Out
CA   Cancel Appointment    RT   Record Tracking        WD   Wait List Disposition
NS   No Show               PD   Patient Demographics   CP   Procedure Update
DC   Discharge Clinic      CO   Check Out              CM   C&P E/E
AL   Appointment Lists     EC   Edit Classification    PC   PCMM Assign or Unassign
PT   Change Patient        PR   Provider Update        RR   Recall Reminder Action
CL   Change Clinic         WE   Wait List Entry        TI   Display Team Informatio
Select Action: Quit//
```

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Example #2 - Find the Patient's Order/ Consult in CPRS

Example #2 - L2 Audit Finding of Incorrect

L1 Auditor's Finding = marked as "Correct"

L2 Auditor's Finding =

1. PID entered by the scheduler and the PID on the RTC Order do not match.

2. L1 Auditor's finding was **incorrect**

3. L1 Audit should have been marked:

   - 'PID not used or incorrect'

   - #COO# not Supported

NOTE: All other requirements were satisfied:

✓ #COO# was present but patient was not wait time eligible
✓ This was not a time sensitive appointment
✓ RTC order was used.

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Example #3 - L2 Audit Incorrect

Example #3 - Find the Patient/Appointment in VISTA or VS GUI

Example #3 - Find the Patient's Order/ Consult in CPRS

Example #3 - L2 Audit Finding of Incorrect

L1 Auditor's Finding = Incorrect, No Evidence of Other Eligibility

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure	Responsible Group
No Evidence other CC Eligibilities	Incorrect ⌄	Community Care	Scheduler

Missing L1 Findings

Mandatory

    PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

    Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

    Community Care
- ☐ Comments missing #COO# Vet "Opts Out"
- ☐ #COO# Not Supported
- ☐ #COO# Not Selected in DST
- ☐ No Evidence other CC Eligibilities

Optional

    None
- ☐ Insufficient Comments

The L2 Auditor's Finding =
1. Appointment was requested by the patient
2. Veteran is an established patient
   - Patient received care by the service in October 2019.
   - Other Community Care Eligibilities do not need to be reviewed for established patients unless the patient is not wait time eligible and requests them reviewed
3. Patient was scheduled within the Community Care Wait Time Standard.
4. L1 Auditor's finding was **incorrect**
5. L1 Audit should have been marked as '**Correct**'.

Example #4 - L2 Audit Correct

L1 AuditID 5538081

L1 Audit Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-BH MHC IND NEUDECKER NEURO
Scheduler:	(b)(6)
Comment:	SPOKE WITH PT TO SCHEDULE #COO#
Non-Count Clinic:	N
Type:	REGULAR
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	NEW
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

L1 Audit Appointment Date Info

Appt Made Date:	04-01-2021
Appt Date:	05-12-2021 11:00:00
PID:	03-30-2021
(Patient Indicated Date)	
PID Difference:	43
(Days between Appointment Date and PID)	
Made Date and Date Difference	41
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

L1 Audit Findings

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Example #4 - Find the Patient's Order/ Consult in CPRS

Example #4 - Find the Patient/Appointment in VISTA or VS GUI

Example #4 - L2 Audit Finding of Correct

L1 Auditor's Finding = Correct

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure	Responsible Group
None (Correct)	Correct ▾	None	N/A

Missing L1 Findings

Mandatory

  PID

    ☐ PID Not Used or Incorrect
    ☐ No Consult
    ☐ No RTC

  Time Sensitive

    ☐ #NLT# Entered But Not Used. Appt Sched After PID.
    ☐ "#NLT# not supported" Incorrect.
    ☐ PID Entered Correctly But #NLT# Not Entered

  Community Care

    ☐ Comments missing #COO# Vet "Opts Out"
    ☐ #COO# Not Supported
    ☐ #COO# Not Selected in DST
    ☐ No Evidence other CC Eligibilities

Optional

  None

    ☐ Insufficient Comments

L2 Auditor's Finding:

1. This appointment was made correctly.
   - The patient was wait time eligible and "Opted Out" of Community Care.
   - The scheduler entered #COO# in the appointment comments correctly.
2. L1 Auditor's finding was **correct**.
3. L2 Audit is Correct.

L2 Scheduling Audit Reports

Scheduling Audit Reports

Reports Updated nightly, unless otherwise specified

Contingency Plan (Activity)

- SAT Contingency Plan (Activity) - FY20 Cycle One - L1 Facility Audit
- SAT Contingency Plan (Activity) - FY20 Cycle One - L1 National Audit
- SAT Contingency Plan (Activity) - FY20 Cycle One - L2 Facility Audit
- SAT Contingency Plan (Activity) - FY20 Cycle One - L2 National Audit
- SAT Scheduling Practice Audits (Activity) - FY21 Cycle One - L1 Facility Audit
- SAT Scheduling Practice Audits (Activity) - FY21 Cycle One - L1 National Audit

Scheduling Audit L1 (Findings)

- SAT - Cumulative National Findings Monthly Trending
- SAT - Facility Scheduling Audit Findings
  - Data Definitions
- SAT - National Findings Measure Dashboard
- SAT - National L1 Audit Removal Tracking
- SAT - National Scheduling Audit Findings
- SAT - Scheduling Audit Finding Details
- SAT - VISN L1 Audit Detail Removal Tracking

Scheduling TMS Audit

- SAT – Scheduling TMS Training Completion
- SAT – Scheduling TMS Training Completion Detail

Supplemental Scheduling Reports

- Appointment List
- Clinic Setup Location With Associated Providers

Scheduling Audit Dashboards

- SAT - National Audit Scheduling Accuracy Dashboard

Scheduling Audit L1 (Activity)

- SAT – Audit Activity Monthly Report
- SAT – Facility Audit Activity Report
- SAT – National Audit Activity Report

Scheduling Audit L2 (Activity)

- SAT – Audit L2 Activity Monthly Report
- SAT – Audit L2 Auditors Monthly Activity Report
- SAT – Facility L2 Audit Activity Report
- SAT – National L2 Audit Activity Report

Scheduling Audit L2 (Findings)

- SAT – Facility Scheduling L2 Audit Findings
- SAT – National L2 Audit Removal Tracking
- SAT – National Scheduling L2 Audit Findings
- SAT – Scheduling L2 Audit Finding Details
- SAT – VISN L2 Audit Detail Removal Tracking

Supplemental Report Maintenance

- Facility - SAT Tool Access Permissions Detail User Report
- National - SAT Tool Access Permissions
- SAT Site Setup Structure

BISL Tool Link:

https://app.cdw.va.gov/BISL_SCHEDAUD/App/#/home

National Level 2 Audit Dashboard - Accuracy

VISN / Facility	L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Correct	% L2 Audits Incorrect
1	273	0	0	0	0
2	6	0	0	0	0
4	399	2	1	1 (50.00%)	1 (50.00%)
5	41	0	0	0	0
6	636	0	0	0	0
7	398	0	0	0	0
8	886	0	0	0	0
9	703	0	0	0	0
10	152	0	0	0	0
12	181	0	0	0	0
15	711	3	2	1 (33.33%)	2 (66.67%)
16	1,354	0	0	0	0
17	505	0	0	0	0
19	3,286	15	9	6 (40.00%)	9 (60.00%)
20	105	0	0	0	0
21	865	0	0	0	0
22	1,036	1	1	0	1 (100.00%)
23	30	7	3	4 (57.14%)	3 (42.86%)
National Total	**11,567**	**28**	**16**	**12 (42.86%)**	**16 (57.14%)**

Expanded Medical Center View

	VISN / Facility	L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Correct	% L2 Audits Incorrect
	(508) ATLANTA VAMC	339	0	0	0	0
	(509) AUGUSTA VAMC	0	0	0	0	0
	(521) BIRMINGHAM VAMC	26	0	0	0	0
	(534) CHARLESTON VAMC	26	0	0	0	0
7	(544) COLUMBIA, SC VAMC	4	0	0	0	0
	(557) DUBLIN VAMC	3	0	0	0	0
	(619) CENTRAL ALABAMA HCS	0	0	0	0	0
	(679) TUSCALOOSA	0	0	0	0	0
		398	0	0	0	0

Parameters

Fiscal Year
2019

Audit Cycle
Cycle One

Use: National and VISN L1 Audit Accuracy

L2 Audit - Medical Center Dashboard

Parameters

VISN

Facility

Appt. Made Start Date

Appt. Made End Date

EvaulationCode

Correct, Incorrect, Missing Findi

Level 1 Auditor Name	L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Incorrect	% L2 Audits Correct	Local Finding Incorrect
	53	1	0	0	1 (100.00%)	0
	13	0	0	0	0	0
	259	1	1	1 (100.00%)	0	0
Total	**325**	**2**	**1**	**1 (50.00%)**	**1 (50.00%)**	**0**

U.S. Department of Veterans Affairs

Drill Down Details − L1 Audit Correct

L2 Audit ID	Sta Pc	L2 Evaluation Code	Reporting Measure	Responsible Group	L1 Audit Finding	L1 National Error	L1 Finding Description	Service Group
1182	542	Correct	None	N/A	None (Correct)	No	No Findings. Appointment was scheduled correctly.	Mental Health Services

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure	Responsible Group
None (Correct)	Correct ⌄	None	N/A

Details – Incorrect L1 Audit

L2 Audit ID	Sta Pc	L2 Evaluation Code	Reporting Measure	Responsible Group	L1 Audit Finding	L1 National Error	L1 Finding Description	Service Group
1183	542	Incorrect	None	N/A	None (Correct)	No	No Findings. Appointment was scheduled correctly.	PRIMARY CARE SERVICES
	542	Missing Finding	Choice	Scheduler	Comments missing #COO#. Vet "Opts Out"	Yes	#COO# is not entered in the comments field of VA appointment when the Veteran "Opts Out" of Choice.	PRIMARY CARE SERVICES
	542	Missing Finding	None	Scheduler	Insufficient Comments	No	Scheduler comments do not match documentation or do not identify how they decided entered wait time (PID).	PRIMARY CARE SERVICES

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure
None (Correct)	Incorrect ▾	None

Missing L1 Findings

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Community Care
- ☑ Comments missing #COO# Vet "Opts Out"
- ☐ #COO# Not Supported
- ☐ #COO# Not Selected in DST
- ☐ No Evidence other CC Eligibilities

Optional

None
- ☑ Insufficient Comments

National L2 Activity Level

	VISN / Facility	Level 1 Audits	Level 2 Audits	# Level 1 Auditors	L2 Audits Remaining (% Completion)
1		273	0	12	74 (0.00%)
2		6	0	4	6 (0.00%)
4		399	2	12	71 (2.74%)
5		41	0	2	11 (0.00%)
6		636	0	8	62 (0.00%)
7		398	0	20	144 (0.00%)
8		886	0	34	199 (0.00%)
9		703	0	18	148 (0.00%)
10		152	0	12	87 (0.00%)
12		181	0	7	44 (0.00%)
15		711	3	5	24 (11.11%)
16		1,354	0	30	190 (0.00%)
17		505	0	24	179 (0.00%)
19		3,286	15	68	579 (2.53%)
20		105	0	7	51 (0.00%)
21		865	0	15	121 (0.00%)
22		1,036	1	43	317 (0.31%)
23		30	9	3	10 (47.37%)
National Total		**11,567**	**30**	**324**	**2317 (1.28%)**

Scheduling Audit Level 2 - Progress Indicators

November	no color		
December	30%	20 - 29%	< 20%
January	40%	30 - 39%	< 30%
February	50%	40 - 49%	< 40%
March	70%	55 - 69%	< 55
April 1 & 2	85%	75 - 84%	< 75%
April week 3	90%	85% - 89%	< 85%
April week 4	100%	No yellow	<100%

Expanded Medical Center View

		636	0	8	62 (0.00%)
7	(508) ATLANTA VAMC	339	0	12	98 (0.00%)
	(521) BIRMINGHAM VAMC	26	0	3	19 (0.00%)
	(534) CHARLESTON VAMC	26	0	2	20 (0.00%)
	(544) COLUMBIA, SC VAMC	4	0	2	4 (0.00%)
	(557) DUBLIN VAMC	3	0	1	3 (0.00%)
		398	0	20	144 (0.00%)

Facility Level

Level 1 Auditor Name	Level 1 Audits	Level 2 Audits	L2 Audits Remaining (% Completion)
Last name, first name	4	0	4 (0.00%)
	2	0	2 (0.00%)
	4	0	4 (0.00%)
	12	0	10 (0.00%)
	2	0	2 (0.00%)
	4	0	4 (0.00%)
	2	0	2 (0.00%)
	1	0	1 (0.00%)
	2	0	2 (0.00%)
	2	0	2 (0.00%)
	2	0	2 (0.00%)
Facility Auditors Totals	38	0	36 (0.00%)

Parameters

VISN

Sta Pc

Fiscal Year
2019

Audit Cycle
Cycle One

Use: Audit 2 Completions per L1 Auditor

BISL Tool - L2 Auditor Access Requirements

For each facility being audited, the L2 Auditor must:

✓ Have PHI/PII Access

✓ Obtain access to the BISL Tool according to role
  - Access Manager/Medical center access *(Recommended Level)*

✓ Email the access manager at their station <u>User Access Permissions Dashboard</u>

BISL Tool Link: https://app.cdw.va.gov/BISL_SCHEDAUD/App/#/home

BISL Tool Levels of Access and Roles	
Access Manager	Has the highest level of access and assigns roles/permissions to other users
Grouping Manager	Has access to develop or modify a service group, supervisor group, or scheduler.
Appointment Auditor	Has access to group schedulers and conducts the scheduling audit.
L1 Auditor Remover	Able to remove a Level audit. Access to this function is limited and is recommended to be the Facility Scheduling Audit Lead or a designee
L2 Auditor	Has access to conduct an audit of the L1 Auditor.

Next Steps

1. Complete quiz in TMS

2. Review the New Scheduling Audit Guidebook

3. Standardize your VISN Audit process

4. Provide feedback to the schedulers **within 14 calendar days**

5. L2 Audit Accuracy Goal: 96%

6. Attend monthly auditor check-in calls
    - **When:** 1st Monday of the month at 2:00pm EST

Choose VA

VA | U.S. Department of Veterans Affairs

Resources and Helpful Bookmarks

- **BISL Tool:** https://app.cdw.va.gov/BISL_SCHEDAUD/App/#!/home

- **BISL Tool Training Materials:**
  https://spsites.cdw.va.gov/sites/BISL_SCHEDAUD/Public%20Documents/Forms/AllItems.aspx?RootFolder=%2fsites%2fBISL%5fSCHEDAUD%2fPublic%20Documents%2fTraining%20Materials&FolderCTID=0x012000CFCFD528A6A75649AFCD8CAA607B0144

- **Scheduling Audit SharePoint**: https://dvagov.sharepoint.com/sites/VHASchedulingAudits

- **Scheduling Community of Practice (CoP):** https://dvagov.sharepoint.com/sites/VHASchedulingCoP

- **OVAC SharePoint Main Page**: https://dvagov.sharepoint.com/sites/vhaovac

Choose VA

VA | U.S. Department of Veterans Affairs

**Department Of
Veterans Affairs**

Memorandum

Date: MAY 3 0 2019

From: Executive in Charge (10)

Subj: Guidance on Discussions of Veteran Eligibility for Community Care

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

1. Employees of the Veterans Health Administration (VHA) are devoted to providing excellent health care and service to Veterans. Veteran experience is at the core of VHA's approach to implementing the Department of Veterans Affairs (VA) MISSION Act of 2018 (MISSION Act), and this law strengthens our ability to deliver timely, high-quality care through our direct services and through VA's network of community providers. In concert with the VHA Modernization Plan, the MISSION Act represents an unprecedented opportunity for VHA to lead U.S. health care on behalf of America's Veterans.

2. As leaders and employees at all levels of the organization strive to deliver VHA's hallmark excellence during this time of change, clarity of roles and responsibilities is essential. I am providing guidance that will govern discussions of Veteran eligibility for community care and use of the associated Decision Support Tool (DST).

3. First and foremost, all VHA employees are empowered, at all times and as explicitly stated in the MISSION Act, to act in the best medical interest of Veterans. As VHA grows both its direct and community care delivery systems into a unified, integrated network, VA will be able to provide Veterans with a broader range of excellent choices that meet their individual needs. I fully appreciate that VHA's direct care system is often the best and safest care option for Veterans, and employees are endorsed to invite Veterans to choose VA. The additional choices Veterans will have under the MISSION Act include enhanced telehealth programming, better ability to hire and retain key clinicians and staff in areas where this has historically been a challenge, and a streamlined community care experience. As we assist Veterans in navigating the new options offered under the MISSION Act, Veterans' well-being is our unwavering compass. This will always be our first consideration, and care teams should make available to Veterans the range of direct and community care options VA offers. Acting in the best medical interest of Veterans is the responsibility of the provider and care team in every encounter.

Page 2. Guidance on Discussions of Veteran Eligibility for Community Care

4. Employees are required to determine Veteran eligibility for community care and must proactively communicate the result to the Veteran:

   a. When a Veteran requests a determination of community care eligibility, whether by phone, electronically, or in person, and inclusive of both new and established patients;
   b. When a newly enrolled Veteran requests a first appointment;
   c. With each new outpatient clinical consult;
   d. With procedures and radiology orders that require scheduling;
   e. When a provider or care team believes the use of community care to be in the best medical interest of the Veteran.

   Additionally, when VHA is not able to offer a return appointment within the wait times standards it has established, eligibility must be determined and communicated to the Veteran at the point of scheduling.

   Use of the Decision Support Tool is expected in the scenarios above, in combination with an official determination of wait time and drive time eligibility at the time of scheduling.

5. When a Veteran requests a determination of community care eligibility, whether by phone electronically, or in person, the employee or team receiving this request must make every effort to immediately answer the Veteran's question.

6. In the case of a new Veteran requesting a first appointment, employees shall determine the ability of VA's direct care system to meet the Veteran's needs and determine the Veteran's eligibility for community care; employees shall communicate these findings to the Veteran. While a Veteran who is eligible for community care can always choose whether to receive community care, employees are encouraged to invite Veterans to receive their care through VA's direct system and highlight the benefits of VA care.

7. When a new outpatient consult is placed, providers and care teams are expected to complete the Decision Support Tool and should have a conversation about eligibility with the Veteran if that discussion is clinically relevant. If an eligibility discussion is not clinically relevant, the provider and care team should still complete the Decision Support Tool but may defer an eligibility conversation to the time of scheduling. At the time of scheduling the new consult, schedulers are required to reference Decision Support Tool information in the consult and communicate eligibility, including wait time and drive time eligibility, to the Veteran.

8. When orders are placed for radiology or procedures that require scheduling, scheduling teams are expected to determine and communicate eligibility to the Veteran at the point of scheduling.

9. Providers and care teams are expected to complete the Decision Support Tool and communicate eligibility to the Veteran any time the provider or care team believes community care to be in the best medical interest of the Veteran.

10. I recognize that staffing and personnel assignments differ across care teams and that processes may need to be adapted for operational necessity. However, the expectation remains that eligibility be determined and documented in the above scenarios.

Thank you for your devotion to excellence as we work to implement the MISSION Act. We will succeed on this journey together and continue to evolve our ability to deliver state of the art health care to those we serve.

Richard A. Stone, MD.

NATIONAL AUDIT FINDINGS REFERENCE SHEET
November 02, 2020

Patient Indicated Date (PID) – Provider-Driven vs Patient-Driven Appointments

The **Patient Indicated Date (PID)** is the appointment date requested by the provider RTC or Consult[1] **or** the date the patient requests an appointment in the absence of a provider request.

- **Provider-driven appointments** must have evidence of the provider's request at the time of scheduling the appointment (e.g., RTC order or Consult).

- **Patient-driven appointments** refers to the patient's requested date (PID) in the absence of a provider's request.
  - Examples: new patient visits to a direct-scheduling clinic, new patients to VA, or established patients requesting an appointment without provider input/request.
- Consults are required for new patients scheduling in a non-direct-scheduling clinic.

- Return to clinic (RTC) orders are required to schedule a follow-up appointment for established patients.

Auditor Findings	Correct	Incorrect	
	None	**PID not used or Incorrect**	**No RTC, No Consult**
Details	☐ The date entered in the scheduling software matches PID of the RTC order or Consult. ***NOTE***: *Auditor assumes the PID is that of the patient in cases of patient-driven appointment requests.*	☐ The date entered in scheduling software <u>does not</u> match RTC order or Consult.	☐ The RTC or Consult was not present at the time appointment was scheduled. ***NOTE***: *Consults and RTCs are required for provider-driven appointments but are not required for patient-driven appointments.*

Time-Sensitive Appointments

When the provider indicates that an appointment is **time-sensitive**, the appointment must be scheduled no later (NLT) than the PID as indicated in the RTC order or Consult. (**NOTE:** PID is provider-driven).

Auditor Findings	Correct	Incorrect	
	None	**#NLT# (not used)**	**#NLT# (not supported)**
Details	☐ **#NLT#** is entered in the appointment comments and the appointment is scheduled <u>on or before the PID</u>.	☐ **#NLT#** is found in the appointment comments but the appointment was scheduled <u>after the PID.</u> ☐ Scheduler entered the correct PID but did not enter **#NLT#** in the appointment comments.	☐ **#NLT#** is entered in the appointment comments but there is <u>no documentation</u> in the RTC order or Consult.

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[1] Obtain Veteran's input to determine the date and time of the appointment

AUDITOR REFERENCE SHEET

Cancel by Clinic/Patient		
Appointment cancellations are categorized based on if the clinic or patient requested the cancellation. • Cancel by Clinic (Cx by Clinic) **OR** Cancel by Patient (Cx by Pt) • Apply rules for Cancel by Patient when rescheduling No Shows		
Auditor Finding	**Correct**	**Incorrect**
	None	**PID not used or Incorrect**
Details	**Cancelled by Patient or No-Show** ☐ If appointment is rescheduled using new PID (per patient) when cancelled by the patient or patient was a no-show. ☐ If appointment is scheduled as a patient generated request and the PID used is the patient requested date. **NOTE:** *Appointments are scheduled as close to the original PID where possible.* **Cancelled by Clinic** ☐ If appointment is rescheduled using the PID (per provider) of the original (cancelled) appointment when cancelled by the clinic.	**Cancelled by Patient or No-Show** ☐ If appointment is rescheduled using the PID of the original appointment request (RTC, PtCSch, Consult). **Cancelled by Clinic** ☐ If appointment is cancelled by the clinic and rescheduled using a new PID (per patient). **NOTE:** *It is incorrect to change the PID when rescheduling an appointment that was cancelled by clinic.*

AUDITOR REFERENCE SHEET

COMMUNITY CARE (STANDARD MISSION ACT)

Community Care (CC) wait time eligibility should be reviewed for all appointments[2]

- **Community Care wait time standard (WTS):** PID is within 20 days (Primary Care and Mental Health) or 28 days (Specialty and Surgery Services) of the appointment request[3] file entry date and there is no appointment availability

  NOTE: If eligible, the patient has the option to "opt-in" or "opt-out" of CC

- **For New Patient Appointments:** when WTS is not met all "*other CC eligibility*"[4] must be reviewed

- **For Established Patient Appointments:** when WTS is not met, no additional CC eligibility is required to be reviewed unless the patient requests to review their other eligibility. Scheduling staff must honor the Veteran's request at the time of scheduling

  NOTE: Only wait time criteria and documentation established patients are to be reviewed during the scheduling audit process.

Correct		
Audit Scenario	**Details**	
New OR established patient is wait time eligible for CC and opts out of CC	☐ *#COO#* is entered in the appointment comments. *NOTE: This indicates "CC opt out" based on wait time eligibility. If Veteran opts out, no further review of "other CC eligibility" is needed.*	
New patient is not wait time eligible for CC and determined to be not eligible for other CC eligibility	**DST is used** ☐ DST saved to the Consult. *NOTE: DST must be saved to the Consult regardless of other CC eligibility status. In cases where DST not saved in Consult, please refer to instructions for "when DST is not available*"*	**DST is not used *** ☐ *DT = XX minutes* is entered in appointment comments. *NOTE: This indicates that all other CC eligibility has been reviewed and the patient is not eligible for CC.*
New patient is not wait time eligible for CC and determined to be eligible for other CC eligibility	**DST is used** ☐ DST saved to the Consult and "**Opt out**" is selected in the DST *NOTE: DST must be saved to the Consult regardless of other CC eligibility status. In cases where DST not saved in Consult, "**Opt out**" is not selected, please refer to instructions for "when DST is not available*"*	**DST is not used *** ☐ *#COO# DT = XX minutes* is entered in comments *NOTE: This indicates that all other CC eligibility has been reviewed and the patient is eligible but opts out of CC.*

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[2] Refer to Appendix B: Community Care Wait Time Eligibility
[3] Appointment request refers to a Consult, RTC order, or date the patient requests an appointment
[4] Refer to Appendix A: Other Community Care Eligibility Types

AUDITOR REFERENCE SHEET

COMMUNITY CARE (STANDARD MISSION ACT)			
Incorrect			
Audit Scenario	**Auditor Finding**	**Details**	
New OR established patient is wait time eligible for CC and patient opts out of CC.	*Comments Missing #COO# Vet Opt Out*	☐ **#COO#** is **not** entered in the comments. ☐ If "**#COO**" **OR** "**COO**" is entered in the appointment comments	
New OR established patient is not wait time eligible for CC and patient is not eligible through other CC eligibility	*#COO# not supported*	☐ If **#COO#** is entered in the appointment comments.	
New patient is not wait time eligible and patient is not eligible through other CC eligibilities.	**No evidence other CC eligibilities**	**DST used:** ☐ If DST is not saved to Consult. ***NOTE:*** *DST must be saved to the Consult regardless of other CC eligibility status. In cases where DST is not saved to the Consult the scheduler should enter* ***DT = XX minutes*** *in the appointment comments*	**DST not used:** ☐ If ***DT=XX minutes*** is not entered in the appointment comments ***NOTE:*** *This is incorrect because there is no evidence of reviewing for other CC eligibility*

New patient is not wait time CC eligible but is eligible through other CC eligibilities AND opts out.	**#COO# not selected in DST**	**DST used:**
		
		☐ DST is not saved to the Consult.
		
		    NOTE: *This is incorrect because there is no evidence that other CC eligibilities was reviewed.*
		
		☐ If DST is saved to Consult and "**Opt out**" is <u>not selected.</u>
		
		    NOTE: *the scheduler should enter* ***#COO# DT=XX minutes*** *in comments*
			DST not used:
			
			☐ **#COO# DT = XX minutes** is not indicated in the appointment comments

AUDITOR REFERENCE SHEET

Patient Type	Wait time eligible for CC	Other CC eligibility	Opt out of CC	DST Used or Saved	Appointment Comments/Details		Finding	Notes
					Correct	**Incorrect**		
COMMUNITY CARE								
New & Established Patient	Y	*N/A*	Y	*N/A*	**#COO#** entered	**#COO#** not entered **OR** **#COO** or **COO** entered	**#COO#**	#COO# indicates "CC opt out" based on wait time eligibility. If Veteran opts out, no further review of "other CC eligibility" needed.
New & Established Patient	N	N	*N/A*	*N/A*	None	**#COO#** entered	**#COO# not supported**	#COO# must be used appropriately.
New Patient	N	N	*N/A*	Y	DST saved to Consult	DST not saved to Consult	**No evidence other CC eligibilities**	DST must be saved to Consult regardless of other CC eligibility status. If DST not saved to Consult DT = XX minutes must be in appointment comments.
New Patient	N	N	*N/A*	N	**DT = XX minutes** entered	**DT=XX minutes** not entered	**No evidence other CC eligibilities**	Need evidence of reviewing for other CC eligibility. DT=XX minutes indicates that all other CC eligibility has been reviewed and patient is eligible, but opts out of CC.
New Patient	N	Y	Y	Y	DST saved to Consult **AND** "Opt out" selected in DST	DST saved to Consult **AND** "Opt out" not selected in DST	**#COO# not selected in DST**	DST must be saved to Consult regardless of other CC eligibility status to indicate other CC eligibilities was reviewed. If DST not saved in Consult or "Opt out" not selected, refer to instructions for when DST not used.
New Patient	N	Y	Y	N	**#COO# DT = XX minutes** entered	**#COO# DT = XX minutes** not entered	**#COO# not selected in DST**	#COO# DT=XX minutes must be in appointment comments if DST saved to Consult and "Opt out" not selected to indicate all other CC eligibility has been reviewed and patient is eligible but opts out of CC.

AUDITOR REFERENCE SHEET

OTHER COMMUNITY CARE ELIGIBILITIES	
Type	**Description**
Grandfathered-In	• Veteran was eligible under the 40-mile criterion under the Veterans Choice Program on the day before the VA MISSION Act was enacted into law (June 2018), and • Veteran continues to reside in a location that would qualify them under that criterion are (North Dakota, South Dakota, Montana, Alaska, and Wyoming) *Per the Veteran Community Care Eligibility Factsheet*
Best Medical Interest (BMI)	• 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. • BMI-Hardship: Allows a Veteran to obtain some or all of their care in the community as opposed to Best Medical. **NOTE:** BMI decision is to be made and captured by a physician or non- physician provider (i.e., PA or nurse practitioner).
Veteran Lives in a US State or Territory without a Full-Service VAMC	• Applies to Veterans residing in Alaska, Hawaii, New Hampshire, and the U.S territories of Guam, American Samoa, Northern Mariana Islands, and the U.S Virgin Islands. **NOTE:** *For the states listed above, no CC documentation is required since all Veterans are CC eligible. If the Veteran opts in, please follow CC documentation guidelines.*
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 does not meet with VA's quality standards. **NOTE:** *Reminder the decision is made and captured by a physician or non-physician provider (i.e., PA or nurse practitioner)*
Drive Time Eligibility:	• ≥ 30 minutes for Primary Care and Mental Health and non-institutional extended care services. • ≥ 60 minutes for Specialty Care
Wait Time Eligibility:	• PID is within 20 days of the appointment request/file entry date and there is no appointment availability within that timeframe (Primary Care, Mental Health, and non-institutional extended care services) • PID is within 28 days of the appointment request/file entry date and there is no appointment availability within that timeframe (Specialty Care) • **NOTE**: *File entry date/appointment request date = date consult/RTC was created or patient requested appointment.*

AUDITOR REFERENCE SHEET

COMMUNITY CARE WAIT TIME ELIGIBILITY (STANDARD MISSION ACT)

Eligible for CC

The original or New PID is within community care wait time standards (WTS) AND the VA appointment cannot be scheduled.

No appointment availability

File entry date   PID   20/28 days

Not eligible for CC

The original or new PID is outside community wait time standards

File entry date   20/28 days   PID

OR
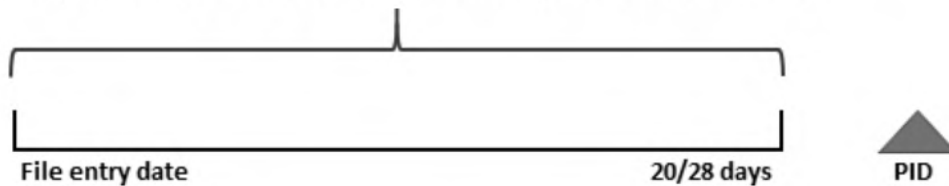
Original or new PID AND appointment availability is within wait time standards
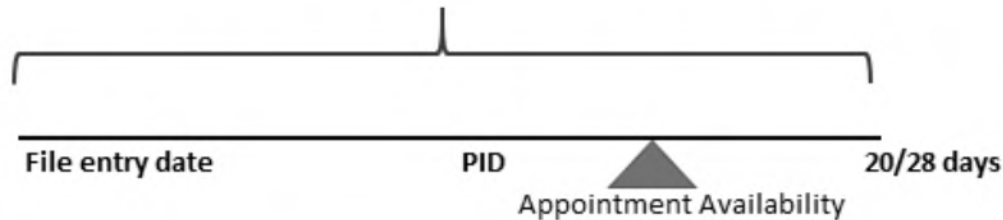
File entry date   PID   20/28 days

Appointment Availability

This is only meant to provide a quick, high-level summary. For more detailed information on this topic please refer to: The Office of Community Care Field Guidebook, Chapter 2: Eligibility, Referral, and Scheduling.

National Standardized Scheduling Audit Guidebook

JUNE 2021

Access Office (15ACC)

Table of Contents

Last Updated: May 10, 2021

Last Updated: May 10, 2021

Chapter 1   National Standardized Scheduling Audit Program

1.1   Purpose and Authority

The National Standardized Scheduling Audit Guidebook sets forth mandatory procedures and processes to ensure compliance with VHA Directive 1230, Outpatient Scheduling Processes and Procedures dated July 15, 2016. This guidebook serves as a Standard Operation Procedure (SOP) for the National Standardized Scheduling Audit Program. The purpose of this guidebook is to establish procedures for conducting Level 1 (L1) and Level 2 (L2) Scheduling Audits to ensure the reliability of outpatient appointment wait times. The processes outlined must be followed by staff who oversee and conduct L1 and L2 Audits of outpatient appointments.

1.2   Responsible Parties & Requirements

The processes and procedures outlined in this guidebook apply to the following roles and positions:

1. VISN Scheduling Business/Audit Lead
2. VA Medical Facility Scheduling Audit Lead
3. L1 Scheduling Auditor(s)
4. L2 Scheduling Auditor(s)

1.3   Auditor Requirements:

The auditor role must be fulfilled by a person who meets the following conditions:

1. Advanced Medical Support Assistant (AMSA), Scheduling Lead or higher
2. Strong interpersonal skills and the ability to provide constructive feedback
3. Working knowledge of VHA Directive 1230 – Outpatient Scheduling Process and Procedures
4. Understanding of local and regional scheduling policy
5. Must have access to scheduling software and Computerized Patient Record System (CPRS)
6. Must have access to the Business Intelligence Service Line (BISL) Audit Tool
7. Successful completion of the National Scheduling Auditor Training
    - **NOTE:** L1 Auditors are required to take the L1 Auditor training. L2 Auditors are required to take both the L1 and L2 Auditor Training
8. Successful completion of National Scheduler Onboarding or National Scheduler Refresher Training
    - **NOTE:** VISN Scheduling Audit Leads are not required but are strongly encouraged to take this training.

1.4   Responsibilities

VISN Scheduling Business/Audit Lead

The VISN Scheduling Business/Audit Lead is responsible for:

1. Collaborating with VA Medical Facility Scheduling Audit Leads to implement changes in national scheduling audit requirements and scheduling process improvements.
2. Serving as primary liaison between the Access Office and the VA Medical Facility Scheduling Audit Leads.
3. Ensuring that facilities are compliant with National Standardized Scheduling Audit requirements.
4. Overseeing medical center scheduling accuracy score trends and their actions to remediate at L1 level and direct responsibility for L2 accuracy.

1.4.1 VA Medical Facility Scheduling Audit Lead

The VA Medical Facility Scheduling Audit Lead is responsible for:

1. Reporting scheduling accuracy audit results and scheduling process improvement plans to Compliance Officers/Compliance Committee and VISN Scheduling Audit Lead on a monthly basis.
2. Ensuring that all scheduled appointments that are otherwise not exempt are subject to audit. This includes MSA and non-MSA scheduled appointments in all clinics. Refer to Exemption List
3. Ensuring that auditors review and update audit groupings following each audit cycle and are audited per assigned groupings.
4. Ensuring auditors have the appropriate level of access to the National Standardized Scheduling Audit Tool.
5. Ensuring that auditors sample the required number of appointments each month and provide feedback to schedulers and supervisors within specified parameters.
6. Ensuring that auditors complete the National Scheduling Auditor Training and required refresher trainings.
7. Identifying scheduling accuracy trends and develop action plans for improvement.
8. Collaborating with the VISN Scheduling Audit Lead to implement changes in National Scheduling Audit Requirements and scheduling process improvements.
9. Collaborating with the scheduling business owner and scheduling trainer to identify annual scheduler refresher training requirements based on facility scheduling needs and scheduling audit results and trends.

1.4.2 L1 and L2 Scheduling Auditors

L1 and L2 Auditors are responsible for:

1. Providing feedback on audit results to the scheduler or L1 auditor within 14 calendar days of the audit sample.
2. Providing audit results directly to the supervisor.
   – **NOTE:** The supervisor will communicate the audit findings directly to the scheduler.

1.5 Definitions

Term	Definition
Audit Finding	The outcome of the audit process (e.g., whether an audit measure is correct or incorrect).
L1 Audit	A review of a scheduler's appointments to evaluate scheduling accuracy.
L2 Audit	A review of a scheduling auditor's findings to assess auditor accuracy to ensure the reliability of the audit results and that appropriate scheduler audit performance feedback is provided.

Chapter 2   Processes and Procedures

2.1 Overview

Scheduling audits are to be conducted in two cycles, with L2 Audits beginning 1-month after the L1 Audits.

	Cycle 1	Cycle 2
L1 Audit	October 1st - March 31st	April 1st - September 30th
L2 Audit	November 1st – April 30th	May 1st – October 31st

1. A minimum of 10 appointments per person (scheduler or L1 Auditor) should be audited each audit cycle.
   - **NOTE:** If a staff member schedules less than 10 appointments then all appointments must be reviewed.
2. Schedulers who obtain 100% accuracy after a full L1 Audit cycle may be exempt from the next immediate audit cycle.
3. A minimum of 1 audit per person (scheduler or L1 Auditor) are to be audited each month and feedback should be provided within 14 days of the audit sample.
4. Each successive audit sample is to begin only after feedback from the previous audit is provided to the scheduler or L1 Auditor.

2.2 Scheduling Audit Exemptions:

Appointments scheduled from programs that are exempt from VHA Directive 1230 are not subject to the audit requirement. Consults entered for Telehealth Store & Forward stop code 694 and Diabetic Eye Screening stop code 718 are exempt from the community care scheduling audit measures. Store & Forward and Diabetic Eye Screening Consults are audited for Patient Indicated Date (PID) and time sensitive scheduling audit measures. See Appendix A for list of exemptions.

2.3   Audit Model

L1 Audit Framework	L2 Audit Framework

• The **Facility Scheduling Audit Lead** provides oversight of the L1 Audits.
• The number of L1 Auditors may range from 1 – 10, depending on the size of the facility.
• Facilities **must not exceed 10 auditors** to ensure consistency and accuracy of each audit.
 	
– **NOTE:** Sites with extenuating circumstances may request approval from the VISN Scheduling Business/Audit Lead to have an auditor size greater than 10.
	• The **VISN Scheduling Audit Lead** is responsible for determining the L2 Audit model; and facilitating access to the facility scheduling system, CPRS, and the BISL Tool.
	  ○ **VISN Model:** A designated VISN staff member conducts the L2 Audits.
	  ○ **Interfacility Model**: One medical center conducts L2 Audits of another facility within the VISN.
	• The number of L2 Auditors may range between 1 – 5, depending on the size of the organization.
	  ○ VISN/Facilities **must not exceed 5 L2 auditors** to ensure consistency and accuracy of each audit.
	• L2 Auditors are **not** to conduct scheduling audit reviews of staff at their facility.

2.4   Audit Accuracy

2.4.1 Level 1 (L1) Audit Accuracy:

1. The facility scheduling accuracy goal is 93%
2.   A scheduler's individual scheduling accuracy is goal 90%.
3. The scheduler supervisor/designee (e.g., Program Analyst and Program Specialist), is to review the audit results and provide remediation or training based on findings.
4. Staff who schedule appointments as part of their primary duties are to include scheduling accuracy and audit performance as a critical element standard in their performance plan. Fully successful schedulers should be rated at the passing audit score or higher based on facility needs.
5. If the L1 Auditor has made an error, the appointment audit should be removed.
    a. In situations where a scheduler disputes the L1 Audit finding, the Facility Scheduling Audit Lead is responsible for making a final determination. If the Facility Scheduling Audit Lead is also the L1 Auditor, the decision is then left to the VISN Scheduling Business/Audit Lead.

2.4.2 Level 2 (L2) Audit Accuracy

1. The L2 Auditor accuracy is ≥ 96%.
2. If an L2 Auditor identifies an L1 Audit error, the L1 Audit is removed. The L2 Audit finding will remain, and the L1 Auditor must conduct another appointment audit within the same time period.
    a. In situations where an L1 Auditor disputes the L2 Audit finding, the VISN Scheduling Business/Audit Lead is responsible for making the final determination.

2.5 Audit Frequency

Appointment audits should be performed throughout the entire audit cycle with scheduling auditors sampling one or more audits each month. Feedback must be provided within 14 calendar days of the audit sample. This allows for the scheduler to receive timely feedback and an opportunity for improvement. The next monthly audit sample should begin after the feedback the has been provided. The overall effectiveness of feedback efforts is better represented when the time between the when the "feedback was provided" and the "date of the next audit sample" is shorter.

2.5.1 Audit Sample Example:

- **Initial Audit Sample Date Range**: October 1 - October 14
- **Audit Completion Date**: October 15
- **Audit Feedback Due Date**: October 29
- **Next Audit Sample Date Range**: After October 29

2.5.2 Audit Frequency Examples

Below is an example outlining the number of audits to complete each month and the recommended month of the audit sampled. The number of audits each month may vary by facility as long as at least one audit per month per scheduler is conducted each month.

2.5.3 L1 Audit Frequency

Month L1 Audit is Conducted	No. of Appts	Month of Audit Sample
October	2	October
November	2	October / November
December	1	November / December
January	1	January
February	2	January / February
March	2	February / March

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2.5.4 L2 Audit Frequency

Month L2 Audit is Conducted	No. of Appts	Month of Audit Sample
November	2	October
December	2	November
January	1	December
February	1	January
March	2	February
April	2	March
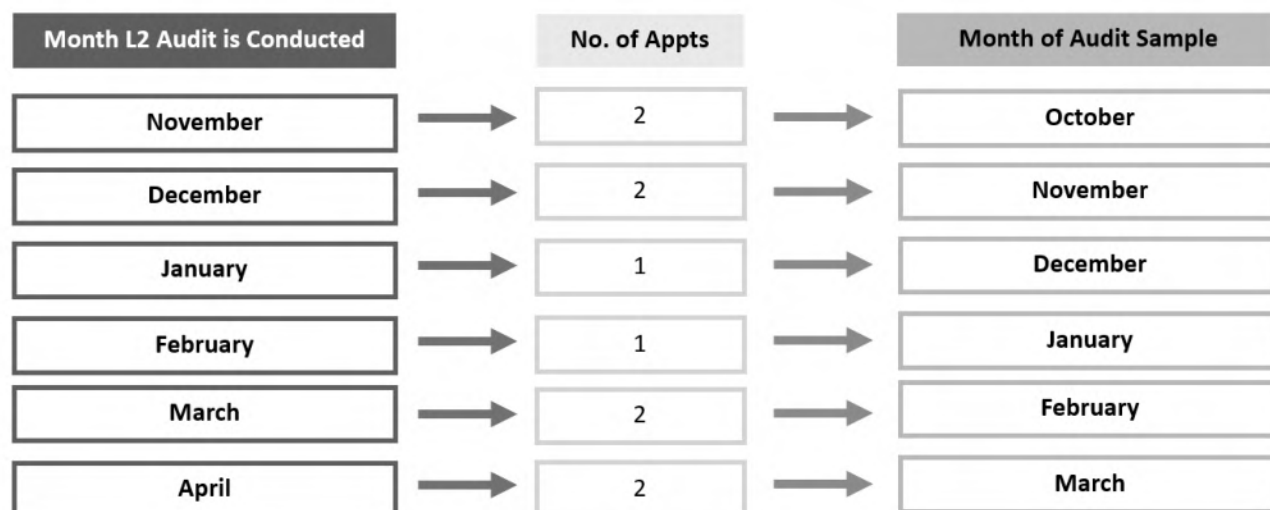
Chapter 3   National Audit Measures

3.1   Level 1 (L1) Audit Measures

L1 Audit Measure	Notes
Patient Indicated Date (PID)	• Correct PID used when scheduling or rescheduling an appointment • A Consult or Return to Clinic (RTC) order present when scheduling provider-driven appointments
Time-sensitive Appointments	• Appointments identified as "time-sensitive" scheduled on or before the PID • Correct documentation present
Community Care Eligibility	• All outpatients reviewed for wait time eligibility prior to scheduling an appointment • All new patients scheduled in VA have documented review of other Community Care (CC) eligibilities (drive time, grandfathered in, etc.) when not wait time eligible • Correct documentation present

3.2   Level 2 (L2) Audit Measures

L2 Audit Measure	Notes
L1 Audit Accuracy	• Validate audit accuracy by assessing whether the L1 Audit finding is correct or incorrect • Identification of any missing L1 Audit findings

3.3   Local Audit Measures (Optional)

VISNs and VA Medical Facilities have the ability to enter additional audit findings as part of their local education and improvement efforts. These additional findings are considered "optional" and are not required or included in National Scheduling Audit Accuracy reporting.

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Chapter 4 National Audit Findings

The National Audit Measures listed below must be reviewed for all appointments and their respective findings can be found in the National Audit Findings section of the Audit Tool.

National Audit Findings	
Patient Indicated Date (PID) – Return to Clinic/Consult	
The PID is entered in the Clinically Indicated Date (CID)/Patient Preferred Date field. In the cases where an RTC Order is written, the date is automatically entered. It is referenced when measuring wait times for all appointments for new VHA patients and Consults. It is also referenced when measuring wait times where appointments have been cancelled and rescheduled.	
Correct Findings	✓ The PID of the RTC Order or the CID/EAD of the Consult is the same date entered in the CID/Patient Preferred Date field. Appointments scheduled without provider input (new to VA, patient self-directed scheduling…) do not require a Consult or RTC Order.
Incorrect Findings	**PID not used or Incorrect** ✗ Date other than the agreed upon date set by the provider and patient. (PID - provider input). ✗ The date entered in the CID/Patient Preferred Date field is not what was entered in the RTC Order or Consult. ***Impact:*** Inaccurate appointment wait time.
	No RTC, No Consult ✗ The RTC or Consult was not present at the time the original appointment was scheduled where required. **NOTE**: Consults are not required in clinics that have patient direct scheduling. ***Impact:*** Not following scheduling policy and potential for inaccurate wait time.
Patient Indicated Date (PID) - Cancel by Clinic/Patient	
Appointment cancellations are categorized based on who requested the cancellation (e.g., patient or clinic).	
Correct Findings	✓ Appointment is cancelled by the patient and rescheduled using new PID (per patient).
	✓ Appointment is cancelled by the clinic and rescheduled using the PID (provider input) of the original appointment cancelled.
	✓ Patient was not responsive to scheduling efforts and the appointment request was dispositioned (RTC, PtCSch, Consult). The appointment scheduled is treated as a patient generated request and the PID used is the patient requested date. **NOTE:** Appointments are scheduled as close to the original PID where possible.
Incorrect Findings	**Cancelled by Patient or No-Show:** ✗ Patient initiated the appointment cancellation. The appointment is rescheduled incorrectly, using the PID of the original (cancelled) appointment. ✗ RTC/Consult dispositioned due to failed scheduling attempts: The appointment is scheduled incorrectly, using the PID of the original (dispositioned) appointment request (RTC, PtCSch, Consult). ✗ Clinic initiated the appointment cancellation. The appointment is rescheduled incorrectly using the PID (per patient). ***Impact:*** Incorrect cancellation and rescheduling of the appointment will impact wait time reliability

Time-Sensitive Appointment	
An appointment that must be scheduled no later (NLT) than the PID as indicated in the RTC Order or Consult.	
Correct Findings	✓ Scheduler enters **#NLT#** in the comments field of the appointment and the appointment is scheduled on or before the PID (provider input).
Incorrect Findings	**#NLT# Entered but Not Used. Appt Sched After PID** ✗ Scheduler entered **#NLT#** in the comments field of the appointment but the appointment was scheduled after the PID (provider input). *Impact:* May have adverse impact on Veteran's health if not seen timely. Reduced ability to track Time-Sensitive Appointments and results in unreliable data.
	#NLT# not Supported ✗ Scheduler entered **#NLT#** in the comments field of the appointment but there is no documentation in the RTC Order. *Impact:* Reduced ability to track Time-Sensitive Appointments and results in unreliable data.
	PID Entered Correctly But #NLT# Not Entered ✗ Scheduler entered the correct PID but did not enter **#NLT#** in the comments field of the appointment. *Impact:* Reduced ability to track Time-Sensitive Appointments and results in unreliable data.

Community Care

Veterans who meet the wait time eligibility standard for Community Care are to be provided the opportunity to "opt in or out" under the following conditions:
• **The PID is within 20 days (Primary Care and Mental Health) and 28 days (Specialty Care) of the appointment request date and there is no appointment availability.**
• For all **new patients**, all Community Care eligibility options will be reviewed and discussed with the Veteran prior to scheduling the appointment.
    o RCT members may review this with the Veteran. Appropriate Community Care eligibility documentation is required when the appointment is scheduled within VA.
• For all **established patients**, Community Care wait time eligibility will be reviewed prior to scheduling the appointment.
    o When established patients request to have their other CC eligibilities reviewed, the scheduler must honor this request.
    o If other CC eligibilities were reviewed, further documentation is not required.
NOTE: Store & Forward and Diabetic Eye Screenings exempt from this audit requirement

Correct Findings

✓ If the new or established patient opts out of Community Care based on the wait time eligibility standard of 20/28 days and prefers VA care, the scheduler will enter **#COO#** in the appointment comments.
This indicates Community Care opt out based on wait time eligibility.
    – **NOTE:** No availability between appointment request date and PID.
    – **NOTE:** Appointment request date=date Consult/RTC was created, or patient requested appointment.
✓ **#COO#** clearly annotated in the pending or completed appointment (Community Care Opt out).

Community Care
Incorrect Findings

Comment Missing #COO# Vet Opts Out

✗ **#COO#** is not entered in the comments field of VHA appointment when the new or established patient "opts out" of Community Care and the PID is within 20/28 days of the Community Care wait time standards. The patient was eligible for Community Care.

*Impact: If **#COO#** is not clearly annotated in the appointment comments, (ex: #COO) there is no mechanism to track which Veterans were eligible but declined care in the community.*

#COO# Not Supported

✗ **#COO#** is entered when the PID is within the Community Care wait time standards (over 20/28 days). The patient was not wait-time eligible for Community Care.

*Impact: Inappropriately utilizes **#COO#** WT and may alter supporting wait time measures.*

No Evidence Other CC Eligibilities

✗ If the new patient is not Community Care wait time eligible and there is no evidence the Veterans other CC eligibility was reviewed.

➡ **DST[1] used**: A new patient is not wait time eligible and there is no evidence the DST was run to check other CC eligibility because the DST was not saved in the Consult.

➡ **DST was not used**: If DST is not used at your facility and there is no evidence of reviewing CPRS Coversheet Other for Community Care eligibility because DT=XX minutes is not entered in the appointment comment.

NOTE: For this measure to be correct, there must be evidence of DST being run OR DT = XX minutes in the appointment comments.

#COO# not selected in DST

✗ When a new patient is not wait time eligible, the scheduler runs the DST to check other CC eligibility and when the DST is not available, reviews CPRS Coversheet for other CC eligibility and the patient prefers care in the VA. The schedulers must mark **#COO#** in the DST or when the DST is not available enter **#COO#** DT=XX minutes in the appointment comment.

➡ **DST was used**: **#COO#** not selected in the DST when found to be "other" Community Care eligible and the patient opts out of Community Care

➡ **DST was not used**: Does not indicate **#COO#** DT = XX Minutes, in the appointment comments

NOTE: For this measure to be correct, there must be evidence of DST being run and "Opt-Out" selected OR **#COO#** DT = XX minutes in the appointment comments.

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[1] Decision Support Tool (DST)

Chapter 5   Scheduling Audit Performance Actions

The purpose of auditing is to identify and determine the reasons behind scheduling errors. It is important to provide timely feedback to eliminate future mistakes. Feedback should be provided no later than 14 calendar days after an audit is completed. It is best practice to deliver immediate or "just-in time" feedback after the audit.

5.1   Scheduler Feedback and Remediation Training – L1 Audits

A passing "score" for one audit cycle is 90% correct or better. The schedulers supervisor/designee will review the audit results and provide remediation/training based on findings. Refer to next page for an example remediation template.

1. Follow up appointments scheduled in the absence of an RTC Order or Consult should be counted as a national error.

    a. If RTC orders are repeatedly absent, it is important that the clinic team communicate with the provider(s).

    b. RTC Orders for follow up visits are to be entered into CPRS at the end of the clinic visit and prior to patient checkout.

2. Scheduling Supervisor/designee and auditors who review the appointments have a responsibility to collaborate and provide timely feedback to the scheduler.

    a. Afterwards, it is the supervisor's responsibility to ensure steps are taken for remediation and performance management.

    b. It is important for supervisors to include scheduling accuracy and audit performance as an element in scheduling staff performance plans. Below is an example of a performance standard:

Patient Administrative Processing (Critical Element):
Schedules all appointments accurately using appropriate PID, ensuring all patient data input is accurate, maintains patient appointments using Appointment Management /VistA Scheduling Graphical User Interface (VS GUI) software as per all current scheduling policies and procedures. Fully successful XX%, Exceptional XX% based on findings of required scheduling audits.

Table of Scheduling Matrix FY20-Best Practice (Recommended)	
Completion of 1st Audit Cycle	
100%	No review required for the second 6 month cycle
≥90 - <100%	No additional feedback required other than initial feedback at the time of the audit sampling.
< 90%	Prior to audit for next cycle, supervisor or designee conducts 5 audits with scheduler side-by side (outside of BISL). Shares feedback and walks through the scheduling process for each appointment audited.
Completion 2nd Audit Cycle	
100%	No review required for the second 6 month cycle
≥90 - <100%	No additional feedback required other than initial feedback at the time of the audit sampling.
< 90% ≥80% (2nd consecutive audit in the cycle)	Prior to conducting audit for next cycle the supervisor or designee conducts 5 audits with scheduler side-by side (outside of BISL). Shares feedback and discusses scheduling process for each appointment audited.
<80% (2nd consecutive audit in the cycle)	Attend scheduling practice scenarios (VS GUI). Supervisor or designee conducts 10 audits with scheduler side-by side (outside of BISL). Shares feedback and discusses scheduling process for each appointment audited.
Completion 3rd Audit Cycle	
100%	No review requesired for the second 6 month cycle
≥90 - <100%	No additional feedback required
< 90% ≥80% (3rd consecutive audit in the cycle)	Prior to audit for next cycle, supervisor or designee conducts 10 audits with scheduler side-by side (outside of BISL). Shares feedback and discusses scheduling process for each appointment audited.
<80% (3rd consecutive audit in the cycle)	Removal of scheduling keys. Attend scheduling practice scenarios (VS GUI). Completes scheduling training scenarios check list with passing score. If fails, additional training based on trainers assessment. Keys restored at time of a passing score.

NOTE: There are two accuracy scores – a National Scheduling Accuracy score that includes all national findings and a second score that excludes the RTC Order and Consult findings from the national total. It is up to the facility to determine which accuracy score reflects scheduler performance.

5.2 Auditor Feedback and Remediation Training – L2 Audits

A "passing score" for one audit cycle is ≥ 96% correct. The schedulers VISN/Facility Audit Lead will review the audit results and provide remediation/training based on findings. Refer to table below for an example of a remediation template.

1. The VISN/Medical center Scheduling Audit Lead are best suited to provide the auditor's feedback.

2. It is the VISN's responsibility to ensure L2 Auditors are assigned and that there is collaboration and timely feedback between the L1 and L2 Auditors.

3. The L1 Auditor's supervisor should be kept informed of staff audit performance and should take action to ensure steps for remediation are completed, as necessary. Below is an example best practice to use for L1 Auditor remediation.

Table of L1 Auditor Matrix FY21-Best Practice (Recommended)	
Completion of 1st Audit Cycle	
100%	No review required for the second 6 month cycle
96% - <100%	No additional feedback required other than initial feedback at the time of the audit sampling.
< 96%	Prior to audit for next cycle, Medical Center Audit Lead/POC or VISN Audit Lead/POC shares feedback and walks through the audit process for each appointment audited incorrectly.
Completion 2nd Audit Cycle	
100%	No review required for the second 6 month cycle
96% - <100%	No additional feedback required other than initial feedback at the time of the audit sampling.
< 96% ≥80% (2nd consecutive audit in the cycle)	Prior to audit for next cycle, Medical Center Audit Lead/POC or VISN Audit Lead/POC shares feedback and walks through the audit process for each appointment audited incorrectly.
<80% (2nd consecutive audit in the cycle)	Retakes the National Standardized Scheduling Auditor L1 and training in TMS. First 5 L1 audits completed after retraining and will be conducted side-by-side with the Medical Center or VISN Audit Lead/POC.
Completion 3rd Audit Cycle	
100%	No review required for the second 6 month cycle
96% - <100%	No additional feedback required
< 96% ≥80% (3rd consecutive audit in the cycle)	Prior to audit for next cycle, Medical Center Audit Lead/POC or VISN Audit Lead/POC shares feedback and walks through the audit process for each appointment audited incorrectly.
<80% (3rd consecutive audit in the cycle)	Removal of L1 auditor access. Medical Center Audit Lead/POC or VISN Audit Lead/POC will conduct a face-to-face training and conduct 10 L1 audits side-by-side with the VISN Audit Lead/POC. L1 audit access restored at time of a passing score.

Chapter 6   Scheduling Audit Tools

The Business Intelligence Service Line (BISL) National Scheduling Audit Tool is used to randomly identify scheduled and completed appointments for auditing and is used as a repository to capture audit data for both L1 and L2 Scheduling Audits.

The BISL Scheduling Audit Reports are to be reviewed, at a minimum, on a monthly basis by auditors, scheduling supervisors, Facility and VISN Scheduling Audit Leads to assess scheduling accuracy and compliance with audit completion targets.

6.1   Auditor Training Materials

Auditors can locate all audit training material and reference sheets within the "Training Materials" tab on the BISL Audit Tool.

SAT v0.3.15	🏠	🎓 Training Materials	🔊 Auditing ⌄	👥 Grouping	👤 VHA15\VHACMOARCHAT	🔑 ✉ ?

NOTICE 11-18-2020 (11:00AM CENTRAL): The Community Care Audit Measures will not be counted in the scheduler accuracy scores from November 1, 2020-March 31, 2021 and are pulled out separately in the Scheduling Audit Findings reports. Please review community care measure accuracy progress and share with scheduling staff and trainers to ensure preparedness for FY 21 audit cycle. Thanks, SAT Team.

Chapter 7   Setting Up the National Standardized Scheduling Audit Tool

7.1   Levels of Access

The BISL Audit Tool requires special access and preparation.

BISL Tool Levels of Access and Roles	
Access Manager	Has the highest level of access and assigns roles/permissions to other users
Grouping Manager	Has access to develop or modify a service group, supervisor group, or scheduler.
Appointment Auditor	Has access to group schedulers and conducts the scheduling audit.
L1 Auditor Remover	Able to remove a Level audit. Access to this function is limited and is recommended to be the Facility Scheduling Audit Lead or a designee
L2 Auditor	Has access to conduct an audit of the L1 Auditor.

7.2   Requesting Access

To use the tool, users must first have CDW Local Data Access (LSV) for each site audited. This requires protected health information/personally identifiable information (PHI/PII) access. To request this basic level of required access, click on the Request Reporting Access (LSV) on the front page of the Supervisory Appointment Tools (SAT) page under Systems Access. The approval process can take a few weeks.

Once PHI/PII access is obtain, the next step is to obtain access to the BISL Tool according to role (as outlined in table above). To request access users are to email the access manager at their station who can be located on the User Access Permissions Dashboard.

7.3 Assigning Permissions

1. Go to the homepage of the BISL Audit Tool. On the right upper corner of the webpage, find the key icon and click drop-down arrow.

2. Click on the name, in this case, "Scooby Doo."

3. Click "Add" and select the role desired, and then save.

4. If "Scooby" already had a role assigned, the screen will indicate the role. Click "Edit" if you wish to modify the role and then save.

7.4   Grouping

Grouping enables a facility to define its organizational structure for schedulers, supervisors of those schedulers, and the services those employees work for. Through this structure a site can analyze key scheduling performance metrics, identify individual and common problems, and work towards a solution.

There are three levels of groupings that are customizable for your facility – Service Groups, Supervisor Groups, and Schedulers. Each service has one or more supervisors that have schedulers assigned. See below for an example.

- ServiceGroup1
  - SupervisorGroup1 (Supervisor 1 Name)
    - Scheduler1
    - Scheduler2
    - Scheduler3
  - SupervisorGroup2 (Supervisor 2 Name)
    - Scheduler4
    - Scheduler5
    - Scheduler6
- ServiceGroup2
  - SupervisorGroup3 (Supervisor 3 Name)
    - Scheduler7
    - Scheduler8
    - Scheduler9
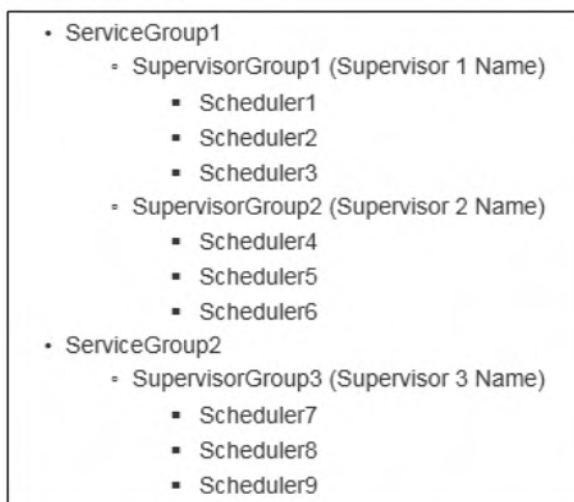
7.4.1 How to Manage a Group

1. Click on the "Grouping" tab on the top of the BISL Audit Tool. Then select your station number.

2. Next, select your service group and expand using the Supervisor Groups down arrows.

7.4.2 Edit the Grouping
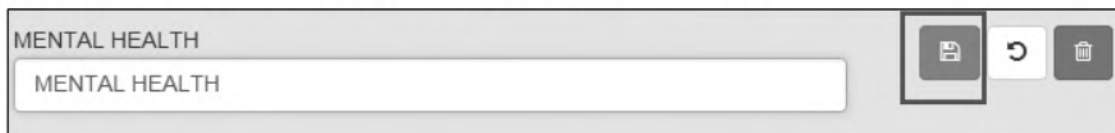
A. *Change the Name of the Group.*

1. To change the name of the service group, simply click on the blue edit icon to the right of the service to open the information field.

2. Enter the updated group name and click on the blue save button.

B. *Change the Group Owner*
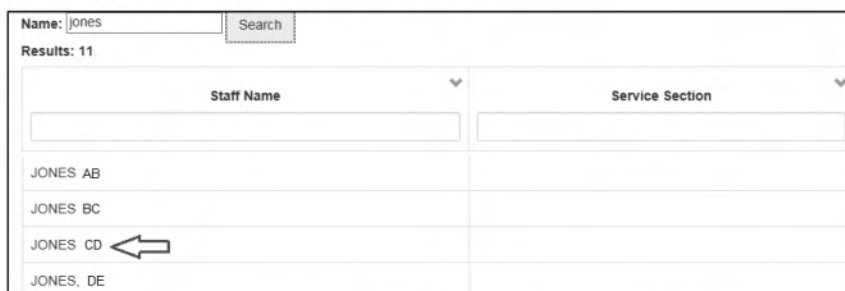
1. Edit the Group Owner by clicking on the blue edit icon to the right of the owner's name.

2. Click on the name of the desired name.

3. Then click on the save button to save the new group owner's name.

C. *Add a Scheduler to a Group*

   1. After clicking on the down arrow, as illustrated above (Section 7.4.1, Step #2), you will see the name of the supervisor group, the Group Owner/Supervisor and all schedulers assigned to the Group Owner/Supervisor.

   2. Click on the "+" button to add a scheduler, and the below information field will be displayed. Enter the last name of the staff member and select the individual desired. In this example, we are looking for Sam Smith.

   3. Once selected, the name will appear below the last scheduler listed. Click on the blue button to save, the circular arrow to cancel. Then, click "Save."

7.5   Audit Exemption Groupings

Appointments for staff listed in an exempt audit grouping are removed from the required audit count and will not appear in the BISL Audit Tool. This feature is offered to ensure accurate reflection of audit activity at the medical center. Members of an exempted group must either:

   1. Schedule exclusively in one or more exempted programs outlined in Appendix A.

   2. Meet the criteria for a staff exemption as outlined below

7.5.1 Set up of an Exempt Group

To set up exempt audit grouping(s) and who/what programs are exempt you must:

1. Develop a supervisory group name that includes the word "Exempt."
2. All appointments scheduled by members in this group will be excluded from the counts in the national compliance reports.
3. You may have multiple supervisory exempt groups based on the service.
4. You must ensure the term "Exempt" is in the name of the supervisory group.
5. Staff who schedule in both exempt and non-exempt programs **should not** be placed in an exempt group.

Staff Exemption Groups	
Staff who schedule at multiple facilities	• Add the scheduler to the exempted supervisory group at all facilities but one • Ensure that the scheduler and the appointments made are counted at one facility. This will alleviate the need to audit the appointments scheduled at the other facilities by the same scheduler.
Staff who schedule in an integrated VistA System	To ensure correct assignments per medical center, follow the steps 1- 5 outlined above (Section 7.5.1).
Staff who no longer possess the scheduling option or key	To ensure correct assignments per medical center, follow the steps 1- 5 outlined above (Section 7.5.1).
Staff who are exempt from the scheduling audit for one cycle	Staff who demonstrated 100% accuracy in the past audit cycle may be exempt from the scheduling audit in the next immediate scheduling cycle. At the end of the next cycle, exempted staff in this group rejoin the audit "pool" and are removed from the exempt group. It is recommended that staff exempted because of exemplary scheduling performance remain in one exempt group clearly marked "Exempt, Scheduling Accuracy." Follow the steps outlined for development of Exempt Groups.

7.6   Audit Tool Technical Assistance

First line support for technical questions related to access and set up of the BISL Audit Tool is at the VISN/medical center level. Each VISN and their medical centers are to develop a sustainable support network and ensure access and grouping managers are assigned and knowledgeable. Day-to-day questions of set up, managing the audit, and obtaining access to the tool is to be managed locally. As changes are made in the BISL Audit Tool, the Access Office (15ACC) will provide the required training and education.

Second-level support is available through the BISL Supervisory Appointment Tools mail group: BISLSupervisoryAppointmentTools@va.gov. It is important to email the group rather than one individual to ensure timely communications.

Chapter 8   Level 1 (L1) Audits

8.1   How to Conduct Level 1 (L1) Audit

The BISL Audit Tool is found here.
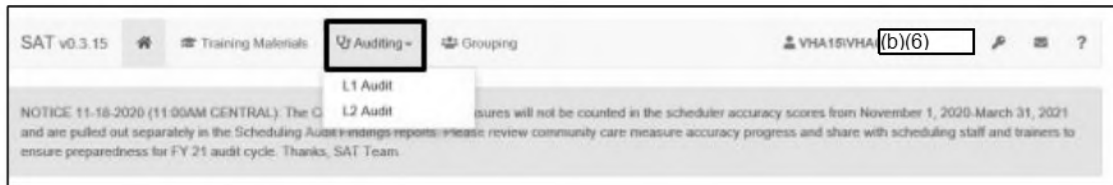
8.2   Setting up the Level 1 (L1) Audit Parameters

Setting the audit date range and additional filters correctly to ensure appointment audit sampling throughout the audit cycle is critical.

Where	Details who is being audited
When	The Date Column, Start Date, and End Date reflect the monthly sampling period.
Additional Filters	Used to target the exact samples needed to meet auditing requirements.
Maximum Sample Size	Limits the total results for the audit sample. – *Practical Application*: If you do not want to start more than 10 audits, set "Max Sample Size" to 10.
Maximum Sample per Scheduler	Limits the total appointment samples per scheduler. – *Practical Application*: If only performing two audits per scheduler for the month, set "Max Sample Per Scheduler" to two.
Maximum Completed L1 Audits per Scheduler	Limits results for schedulers with completed audits – This setting is increased cumulatively to account for the additional audits performed each month. – The final month of the audit period should reflect the total number of required audits for the cycle. – *Practical Application*: If only performing two audits per scheduler each month, set "Max Completed Audits Per Scheduler" to two in the first month. Set to four the following month to account for the two additional audits per scheduler.

8.2.1 L1 Audit Parameter Example

Below is an illustration on how to set the date range and additional filters to capture and complete the required number of audits each month. In this example, the auditor has 10 schedulers to audit.

  − **NOTE:** The required number of audits per scheduler is 10.

Month	Recommened audit sample	Date Range	Max Sample Size	Max Sample PerScheduler	Max Completed Per Scheduler
October	2	October	10 schedulers x 2 audits = 20	2	2
November	2	November	10 schedulers x 2 audits = 20	2	4
December	1	December	10 schedulers x1 audits = 10	1	5
January	1	January	10 schedulers x1 audits = 10	1	6
February	2	February	10 schedulers x 2 audits = 20	2	8
March	2	March	10 schedulers x 2 audits = 20	2	10
	Recommended Audit sample per scheduler	Factor in time for feedback. Do not sample until feedback from the previous audit has been completed	# of schedulers X sample audits. Provides # of audits the Auditor should complete in the month designated. (total =100, the number of audits to be conducted per Auditor at the end of the cycle)	Recommended Audit Sample per scheduler	Cumulative number of audits to have been completed at the end of the month. (= Past month + current month)

8.3 Veterans' Health Information System Technology Architecture (VistA)

1. Find the corresponding appointment in VistA on every sample.

2. Notice this appointment has previously been cancelled by the clinic. Often when a PID is incorrect it is due to the patient previously cancelling or no-showing. The default date range in VistA Appointment Management is T-1 to approximately 30 months in the future (depending on the number of appointments the patient has scheduled).

3. Using the "EP" or Expand Entry function; you can view the details of the appointment.

4. The information found should match that is in the sample. If it does not, it means an appointment has been scheduled on top of the one being audited—creating what is sometimes called a "phantom appointment." If you notice these details such as (A) Other Information, (B) Create Date/ User Name, (C) Request Type, or (D) Desired Date do not match, stop the audit process and mark as "Audit Incomplete" for a replacement sample. Please note that scheduling an appointment over another is not permitted. In instances where this is found, the scheduler is to receive feedback to this effect.

*Pages 4 and 5 of the EP function, display Patient Demographic Information.

8.4 VistA Scheduling Enhancements (VSE) Scheduling Software

1. Find the corresponding appointment in VSE on every sample.

2. Notice this appointment has previously been no showed by patient. Often when a PID is incorrect it is due to the patient previously cancelling or no-showing.

3. By right clicking on the appoint you can Expand the Entry for the appointment which allows you to view the details for that appointment.

Appointment Event Log

EVENT	DATE	USER
Appt Made:	AUG 07, 2017@08:39:43	(b)(6)
Check In:		
Check Out:		
Check Out Entered:		
No-Show/Cancel:		

Checked Out:
Cancel Reason:
Cancel Remark:
Rebook Date:

Appointment Wait Time Information

Request Type:	'NEXT AVAILABLE' APPT.
Next Available Type:	'NEXT AVA.' APPT. INDICATED BY USER
CID Preferred Date:	AUG 07, 2017
Follow-Up Visit:	No
Clinic Wait Time 1:	1
Clinic Wait Time 2:	1

NOTES:
-Clinic Wait Time 1 represents the difference between the date the appointment was entered and the date it was performed.
-Clinic Wait Time 2 represents the difference between the 'CID/Preferred date' and the date the appointment was performed.

4. The information found should match that is in the sample. If it does not, it means an appointment has been scheduled on top of the one being audited—creating what is sometimes called a "phantom appointment." If you notice these details such as Other, Appointment made Date/Time, Request Type, or CID Preferred Date do not match, stop the audit process and mark as "Audit Incomplete" for a replacement sample. Please note that scheduling an appointment over another is not permitted. In instances where this is found, the scheduler is to receive feedback to this effect.

5. Patient Demographic Information is also found under the expanded entry function of VSE.

8.5   Computerized Patient Record System (CPRS)

To ensure the CID/PID is used, refer to the CPRS Orders tab. You may have to change the view to see any orders that have been completed. To do this, from the CPRS Orders tab, select "View" at the top of the screen. To see the desired date field of a cancelled appointment, use the "Appointment List" report in the GPM/SAT Suite.

Looking at the Calendar- you will see that the CID is January 10, 2017.

December 2016

Date of last apt and RTC entered for 6 weeks.

January 2017

This is the CID for the new appointment.

Ensure this date matches the CID that was entered in the Desired Date Field in VISTA which also is present on the SAT sample.

8.6   Auditor Errors

If an L1 auditor is aware an L1 audit error which has been submitted and wishes to correct this, they are to contact the designated staff member at the medical center or VISN who has access to remove L1 Audits. The name of this individual can be found in the User Access Permissions Dashboard, listed as a L1 Audit Remover.

1.   The Audit ID number must be included in your message/request.

2.   To obtain the Audit ID number the auditor will need to pull the BISL Scheduling Audit Finding Details Report.

3.   The auditor must find the erroneous audited appointment from the list.

4.   The Audit ID number is located as the last column of the report.

5.   Once confirmation of the action has been taken, the auditor can go back to the audit and make the correction.

Appointment SID	Audit ID
(b)(6)	1152852

8.7   L1 Audit Examples

8.7.1 Consult Appointment (Correct Finding)

1. Find the corresponding appointment in VistA.

2. The appointment comment indicates that this is a Consult (facility is optional).

3. Identify the PID/CID in CPRS; this date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts.

(b)(6)

(b)(6)

(b)(6)

(b)(6)

4. **The appointment audit would be marked as "Correct" because:**

✓ the PID was transcribed correctly

✓ this was not a Community Care eligible appointment

✓ this was not a Time-Sensitive Appointment

8.7.2 Established Patient/RTC Order (Correct Finding)

1. Find the corresponding appointment in VistA

2. Since this is an established patient, identify the PID/CID in the RTC Order in CPRS. This date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts. The order was placed on January 3, 2018, with a PID of 7+ days so the PID is January 10, 2018.

3. **The appointment audit would be marked as "Correct" because:**

   ✓ the PID was transcribed correctly
   ✓ this was not a Community Care eligible appointment
   ✓ this was not a Time-Sensitive Appointment

8.7.3 Established Patient – Incorrect PID (Incorrect Finding)

1. This is an established patient, identify the PID/CID in the RTC Order in CPRS. This date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts. The PID is January 9, 2018.

2. **The appointment audit would be marked as "Findings" because**
   ✓ the PID was transcribed incorrectly

3. **Other required elements were correct:**
   ✗ this was not a Community Care eligible appointment
   ✗ this since was not a Time-Sensitive Appointment

BID:	(b)(6)		Appt Made Date:	01-03-2018
IEN:	(b)(6)		Appt Date:	01-09-2018 12:00:00
Location:	JC/ENT HEAD AND NECK EST		PID:	01-09-2018
Scheduler:	▮▮▮▮▮		*(Patient Indicated Date)*	
Comment:			PID Difference:	0
Non-Count Clinic:	N		*(Days between Appointment Date and PID)*	
Type:	REGULAR		Made Date and Date Difference	6
Purpose Of Visit:	SCHEDULED VISIT		*(Days between Appointment Date and the date the appointment was made)*	
Patient:	▮▮▮▮▮		Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.
Patient Last 4:	▮▮▮▮			
Patient Status:	ESTABLISHED			

Audit Type: Appointment Audit

Audit Result:
- ○ Audit Cancelled - Not counted as correct or incorrect.
- ○ Correct - No problems found.
- ◉ Findings - Audit resulted in findings.

Audit Findings:

Mandatory

PID
- ☑ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Community Care
- ☐ Comments missing #COO# Vet "Opts Out"
- ☐ #COO# Not Supported
- ☐ #COO# Not Selected in DST
- ☐ No Evidence other CC Eligibilities

Optional

None
- ☐ Insufficient Comments

Audits Remaining: 1

[Submit Audit]

8.7.4 NLT Error (Incorrect Finding)

1. Since this is an established patient, identify the PID/CID in the RTC Order in CPRS. This date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts. The PID is December 7, 2017. This is also an NLT Time-Sensitive Appointment, so the **#NLT#** comment will be required in the appointment comment.

2. **The appointment audit would be marked as "Findings" because:**
   ✖ the appointment comment did not include **#NLT#**

3. **Other required elements were correct:**
   ✓ the PID was transcribed correctly
   ✓ this was not a Community Care eligible appointment

Audit Appointment Audit

Appointment Info

BID:	(b)(6)
IEN:	(b)(6)
Location:	JC-PACT 06 PCP
Scheduler:	▇▇▇▇▇▇
Comment:	
Non-Count Clinic:	N
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient:	▇▇▇▇▇▇
Patient Last 4:	▇▇▇
Patient Status:	ESTABLISHED

Appointment Date Info

Appt Made Date:	12-05-2017
Appt Date:	12-08-2017 13:00:00
PID:	12-07-2017
(Patient Indicated Date)	
PID Difference:	1
(Days between Appointment Date and PID)	
Made Date and Date Difference	3
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

Audit Type: Appointment Audit

Audit Result:
- ○ Audit Cancelled – Not counted as correct or incorrect.
- ○ Correct – No problems found.
- ● Findings – Audit resulted in findings.

Audit Findings:

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☑ PID Entered Correctly But #NLT# Not Entered

Community Care
- ☐ Comments missing #COO# Vet "Opts Out"
- ☐ #COO# Not Supported
- ☐ #COO# Not Selected in DST
- ☐ No Evidence other CC Eligibilities

Optional

None
- ☐ Insufficient Comments

Audits Remaining: 1

Submit Audit

Last Updated: May 10, 2021

8.7.5 Established PID Error/NLT Error (Incorrect Finding)

1. Find the corresponding appointment in VistA.

2. Since this is an established patient, identify the PID/CID in the RTC in CPRS. This date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts. The PID is November 21, 2017. This is also an NLT Time-Sensitive Appointment so the **#NLT#** comment will be required in the appointment comment.

3. **The appointment audit would be marked as "Findings" because:**
   - ✗ the PID was transcribed incorrectly
   - ✗ the appointment comment did not include **#NLT#**

4. **Other required elements were correct:**
   - ✓ this was not a Community Care eligible appointment

8.7.6 Community Care (Correct Finding)

1. Look up the patient Consult in CPRS.

```
Current PC Provider:      (b)(6)
Current PC Team:          CO-ST. JAMES PACT 03 *WM*
Current Pat. Status:      Outpatient
UCID:                     589_9477960
Primary Eligibility:      NSC(VERIFIED)
Patient Type:             NSC VETERAN
OEF/OIF:                  NO

Order Information
To Service:               CO-PHYSICAL THERAPY OUTPATIENT FLW-589A4
From Service:             CO-STJ PACT PHONE 3-X
Requesting Provider:      (b)(6)
Service is to be rendered on an OUTPATIENT basis
Place:                    Consultant's choice
Urgency:                  Routine
Clinically Ind. Date:     Aug 20, 2020
Orderable Item:           CO-PHYSICAL THERAPY OUTPATIENT FLW-589A4
Consult:                  Consult Request
Provisional Diagnosis:    Low Back Pain(ICD-10-CM M54.5)
Reason For Request:

Services requested: eval & tx for low back pain   VET WANTS PT IN THE
Facility
   Activity               Date/Time/Zone      Responsible Person   Entered By
-------------------------------------------------------------------------------
  CPRS RELEASED ORDER      08/20/20 15:47       (b)(6)              (b)(6)
  PRINTED TO               08/20/20 15:47
     KAN-PTREHAB6-FLW-
  RECEIVED                 08/20/20 17:35
DST-DST ID: b6d04375-f430-4850-9f9e-da7562bfb53d
CSC-Consult stop code: 205
CSN-Clinical Service: PHYSICAL THERAPY
CST-Consult service type: SPECIALTY CARE
DSW-DST Workflow: NEW PT
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND


CVA-Accept new consult, received during COVID-19 Pandemic
Scheduling prioritized during COVID-19 Pandemic
CV3-COVID-19 Priority 3
As an alternative to a face-to-face appointment:
   VVC-VVC Appointment may be offered to the Veteran

Additional instructions and Comments:
Please schedule Veteran in the CO-PT NEW FLW BRAD/KOZ/LINT AM/PM Clinics for a
60-minute Physical Therapy Initial Evaluation.   Thank you!
ME-May discontinue if Veteran fails to respond to mandated scheduling effort

  SCHEDULED                08/25/20 13:33       (b)(6)              (b)(6)
CO-PT NEW FLW LINT  Consult Appt. on 09/10/20 @ 09:00
CONSULT#9477960


Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
=================================== END ======================================
```

2. Since this is a new patient, identify the PID/CID in the Consult in CPRS. This date should be transcribed exactly, as the appointment was not previously cancelled by patient or was a no-show, and the patient did not fail to respond to scheduling attempts. The PID is August 20, 2020.

3. **The appointment audit would be marked as "Correct" because:**
   - ✔ The appointment was not wait time eligible
   - ✔ The DST was run and saved to the Consult
   - ✔ No other eligibilities were found

4. **Other required elements were correct:**
   - ✔ This appointment was not time-sensitive

Audit Details

Audit Type:	Appointment Audit
Audit Result:	○ Audit Cancelled - Not counted as correct or incorrect. ◉ Correct - No problems found. ○ Findings - Audit resulted in findings.
Audit Findings:	None (Correct) – No Findings. Appointment was scheduled correctly.
Audits Remaining:	1
	Submit Audit

8.7.7 Community Care-No Evidence Other CC Eligibilities (Incorrect Finding)

Audit appointment wait times for appointments, scheduled by the selected Supervisor Group or Scheduler.

Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-PT EST (b)(6)
Scheduler:	▆▆▆▆▆▆
Comment:	PER PT DATE TIME
Type:	SERVICE CONNECTED
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	ESTABLISHED
Patient:	📋 Hover To Show
LAST,FIRST1234:	📋 Hover To Show
Patient SSN:	📋 Hover To Show

Appointment Date Info

Appt Made Date:	09-02-2020
Appt Date:	09-17-2020 13:30:00
PID:	08-28-2020
(Patient Indicated Date)	
PID Difference:	20
(Days between Appointment Date and PID)	
Made Date and Date Difference	15
(Days between Appointment Date and the date the appointment was made)	
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

1. Veteran is not wait time eligible for Community Care because the PID is within the wait time standard of 28 days and a VA appointment was available

2. File entry date=8/28/2020

3. PID=8/28/20

4. Appointment made for 09/17/20

5. **The appointment audit would be marked as "Findings" because:**

    For new patients, other CC eligibilities must be reviewed.

    ✗ For this patient there is no evidence other CC eligibilities were reviewed.

    ✗ DST was not run and saved to the Consult or **#COO#** DT=minutes or DT=minutes was not entered in the appointment comments since the DST was not used.

6. **Other required elements were correct:**

    ✓ The PID was Correct

    ✓ There was a Consult appointment

    ✓ An RTC Order was not needed for this appointment

    ✓ This was not a "Time Sensitive Appointment"

Audit Findings:	**Mandatory**		
	PID		
		☐ PID Not Used or Incorrect	
		☐ No Consult	
		☐ No RTC	
	Time Sensitive		
		☐ #NLT# Entered But Not Used. Appt Sched After PID.	
		☐ "#NLT# not supported" Incorrect.	
		☐ PID Entered Correctly But #NLT# Not Entered	
	Community Care		
		☐ Comments missing #COO# Vet "Opts Out"	
		☐ #COO# Not Supported	
		☐ #COO# Not Selected in DST	
		☑ No Evidence other CC Eligibilities	
	Optional		
	None		
		☐ Insufficient Comments	
Audits Remaining:	1		

Submit Audit

8.7.8 Community Care-#COO# Not Selected in the DST (Incorrect Finding)

1. **The appointment audit would be marked as "Findings" because:**

   ✖ **#COO#** was not entered in the appointment comment.

2. **Other required elements were correct:**

   ✓ The PID was Correct

   ✓ There was a Consult appointment

   ✓ An RTC Order was not needed for this appointment

   ✓ This was not a "Time-sensitive Appointment"

   ✓ Veteran was not wait time eligible

   ✓ Veteran was drive-time eligible

   ✓ Other CC eligibilities were reviewed using DST and "Opt-out" box not selected before DST entry was saved to the Consult

8.8   L1 Audit Report

The BISL Audit Tool offers a variety of reporting tools to assist the auditor and leadership at the local, regional, and national levels to better discern scheduling and auditing practices and make improvements to increase accuracy in scheduling and reliability of appointment wait times.

8.8.1 National Audit Activity Report

This report is used to track scheduling audits completed nationally by VISN and facilities. The audit percent completed is based on the total possible audits that are required to be completed by the scheduler (10) as outlined in VHA Directive 1230, Outpatient Scheduling Processes and Procedures. There are two versions of this report.

- **The National Audit Activity Report "Real-time Report"** continually updates and is the most recent.

- **The National Audit Historical Activity** Report is based on daily updates and is not as dynamic as the Real-time Report. This report is useful when there is a need to see more static baseline data, not affected by continual movement of exemptions, audits, etc.

The denominator or base number of audits to be completed is determined by the number of schedulers who have scheduled an appointment multiplied by 10 (the required number of audits). The numerator is the number of schedulers who have scheduled an appointment. It is important to ensure the Audit Tool is set up correctly and staff who are exempted from the audit are placed in an exempt grouping to ensure accurate accounting. See Section 7.5 "Audit Exemption Grouping" for more details.

To help track the number of audits completed throughout the cycle, there are color coded progress indicators that change each month. The is to be used as a guide and is based on predetermined incremental monthly audit completions.

- **Green** indicates the facility/VISN is on target for the month

- **Yellow** indicates in range for completion

- **Red** indicates that the facility/VISN is on schedule for successful completion of the number of required audits.

Below is a chart of the progress indicators per month.

Cycle 1 - Scheduling Audit Progress Indicators			
October	no color		
November	30%	20 - 29%	< 20%
December	40%	30 - 39%	< 30%
January	50%	40 - 49%	< 40%
February	70%	55 - 69%	< 55
March weeks 1 &2	85%	75 - 84%	< 75%
March week 3	90%	85% - 89%	< 85%
March week 4	100%	No yellow	<100%

Cycle 2 - Scheduling Audit Progress Indicators			
April	no color		
May	30%	20 - 29%	< 20%
June	40%	30 - 39%	< 30%
July	50%	40 - 49%	< 40%
August	70%	55 - 69%	< 55
September weeks 1 &2	85%	75 - 84%	< 75%
September week 3	90%	85% - 89%	< 85%
September week 4	100%	No yellow	<100%

Last Updated: May 10, 2021

The tool offers two views, VISN and medical center. It is defaulted to the VISN and reports the number of appointments made, number of total audits, and the percentage of audits remaining.

- **Parameter settings:** defaulted to the current fiscal year and audit cycle. The data is updated each day and includes information entered from the start of the current cycle.

- **The National Audit Historical Activity Report** captures the final data for each day and is static.

- **The National Audit Activity Real-Time Updates Report** updates continually. The data reviewed is current at the time pulled. The data for the past dates may change, based on the date ranges of the current audits completed in the Real-time Report as it continually updates. The report(s) can be exported to an excel file and other reporting formats.

Cycle Date Range: 10/1/2019 - 11/18/2019 | Data Current Through: 11/17/2019

VISN / Facility	Appointments Made	Total Level 1 Audits	# Schedulers	Level 1 Audits Remaining	Level 1 Audits Percentage Complete
1	344,692	3,866	1,670	11,476	25.15%
2	435,598	2,349	1,536	12,003	15.97%
4	340,600	2,875	1,227	8,939	21.03%
5	232,891	2,045	916	6,318	24.23%
6	481,748	3,427	1,497	10,795	22.98%
7	530,949	5,824	1,610	11,021	27.52%
8	799,497	6,253	2,289	15,127	29.06%
9	339,728	5,174	1,442	9,396	29.75%
10	653,292	3,304	2,243	17,476	15.77%
12	375,304	6,018	1,378	8,043	36.29%
15	294,048	3,833	1,001	5,563	40.79%
16	508,453	13,005	1,763	5,739	65.08%
17	478,159	5,789	1,752	11,109	31.34%
19	345,148	20,098	1,304	537	95.60%
20	285,583	3,375	1,195	9,615	14.61%
21	417,539	8,660	1,793	10,520	35.84%
22	602,681	14,716	2,368	13,831	35.85%
23	357,488	3,265	1,390	9,836	24.69%
National Total	**7,823,398**	**113,876**	**28,329**	**177,344**	**32.58%**

Key:

	>=30% - Audits Complete
	20% -29% - Audits Complete
	< 8% - Audits Complete

Total Audits Completed / # Staff x *10

* # of audits required per scheduler

* Max 10 audits counted per scheduler

VISN View: National Scheduling Audit Activity

8.8.2 National Scheduling Audit Dashboard

This report aggregates the details of the scheduling audits (e.g., accuracy, total appointments, and audits) at a national level and breaks down by facility. It provides a quick glance of overall scheduling accuracy. It can be viewed by staff who schedule as a primary duty (e.g., MSA) and staff who are not primary schedulers. Other parameters include the fiscal year and audit cycle. The report tool can be drilled down to specific national measures.

The default reporting tool highlights the number of appointments made, total audits conducted, total findings, percentage correct, percentage correct excluding clinician (no Consult/no RTC), and percentage findings. Findings refer to national scheduling errors. There may be a difference between the total findings (errors) column and percentage findings because an audit may have more than one error. This report can be drill down to the facility and exported to an excel file and other report types.

A second, more detailed report is available. Above the report, there is a link to the drill down "National Findings Report."

Click here for national findings breakout report.

This breaks down the aggregated report into specific national audit measures/details: Time-Sensitive Appointments, Community Care, and PID. The PID is further detailed into PID Error and No Consult/No RTC Errors. Below is an illustration of the VISN breakout report that can be further drilled down to the medical center level.

VISN / Facility	Appointments Made	Audits	Findings	% Correct	% Correct (Exclude Clinician)	% Audit Findings	Time Sensitive	PID Error	No Consult No RTC	Comments Missing #COO# Vet Opts Out	#COO# Not Supported	#COO# Not Selected in DST	No Evidence Other CC Eligibilities
1	152,017	1,383	228	1181 (85.39%)	1218 (88.07%)	202 (14.61%)	0	165	63	22	4	0	4
2	252,062	501	24	480 (95.81%)	488 (97.41%)	21 (4.19%)	0	13	11	6	0	0	3
4	173,503	780	65	716 (91.79%)	742 (95.13%)	64 (8.21%)	0	38	27	22	2	2	0
5	116,207	1,110	117	997 (89.82%)	1026 (92.43%)	113 (10.18%)	6	78	33	9	0	1	0
6	263,473	1,365	93	1272 (93.19%)	1301 (95.31%)	93 (6.81%)	2	62	29	33	29	1	75
7	274,372	2,821	255	2591 (91.85%)	2631 (93.26%)	230 (8.15%)	2	188	65	52	8	3	6
8	480,575	3,049	260	2807 (92.06%)	2862 (93.87%)	242 (7.94%)	3	187	70	50	11	8	3
9	197,887	2,235	77	2159 (96.60%)	2172 (97.18%)	76 (3.40%)	2	62	13	2	0	0	0
10	320,979	1,438	164	1280 (89.01%)	1316 (91.52%)	158 (10.99%)	3	120	41	19	7	0	11
12	173,812	1,741	309	1445 (83.00%)	1507 (86.56%)	296 (17.00%)	5	231	73	24	5	1	7
15	185,461	2,085	186	1899 (91.08%)	1954 (93.72%)	186 (8.92%)	4	127	55	38	9	5	51
16	264,371	3,233	169	3082 (95.33%)	3133 (96.91%)	151 (4.67%)	5	95	69	67	35	1	0
17	276,405	1,376	118	1263 (91.79%)	1279 (92.95%)	113 (8.21%)	6	91	21	23	3	1	10
19	174,086	2,406	222	2190 (91.02%)	2261 (93.97%)	216 (8.98%)	3	142	77	42	23	3	28
20	119,757	1,206	202	1017 (84.33%)	1052 (87.23%)	189 (15.67%)	2	153	47	29	16	1	4
21	218,899	2,231	186	2045 (91.66%)	2112 (94.67%)	186 (8.34%)	1	118	67	10	4	1	4
22	330,057	3,171	212	2961 (93.38%)	2970 (93.66%)	210 (6.62%)	1	200	11	29	40	0	0
23	220,822	1,455	314	1157 (79.52%)	1314 (90.31%)	298 (20.48%)	2	139	173	47	19	1	11
National Total	4,194,745	33,586	3,201	30542 (90.94%)	31338 (93.31%)	3044 (9.06%)	47	2,209	945	524	215	29	217

National Findings Breakout Report

8.8.3 Scheduling Audit Finding Details Report

This report provides details on scheduling audits performed (e.g., appointment details, audit results, and rescheduled appointments). Detailed information is available in a readable table format that can be exported in excel and other data formats. The report provides a breakdown of the individual scheduling errors made by a staff in a service or section of a service.

- **Parameter settings include:** the medical center, appointment made start date, appointment made end date, service group, supervisor group, scheduler staff name, and the appointment findings you wish to review (e.g., cancelled, correct, optional: local findings, national findings, and pending audit).

- **Elements include:** the audit result, finding type, audit finding, description, service group, supervisor group, audited scheduler's name, audited scheduler's position, audited scheduler's position title, audit location, the patient's name and last four digits of their social security number (SSN), audit appointment made date, audit appointment date, audit desired appointment date, desired date difference from appointment date, create date to preferred date, audit appointment comments, details of the previously scheduled appointment, the patient surrogate ID (SID), appointment SID and Audit ID number.

8.8.4 Appointment List

This report provides an appointment list where the appointment status is not cancelled or no-show for the date specified. It will list any past completed, action required, inpatient or future appointments.

- **Parameter settings include:** VISN and station number and can be broken down to the division level, service line, and stop code levels.

- **Elements include:** facility and appointment details, such as station, division name, clinic group, stop code, clinic location, appointment made date, appointment date and time, wait time from earliest create date, earliest preferred date, create to preferred date, appointment made remarks, appointment length, appointment status, patient SID and appointment SID.

8.8.5 Facility Audit Activity Report

This report is used to track the completed audits by a facility, service, supervisor group, and scheduler. The percentage of audits completed is based on the number of total possible audits completed (10 per scheduler). This is an excellent report that provides both an overview and ability to drill down into audit completion details per individual scheduler.

The data is updated each day and includes information entered from the start of the current cycle. The Facility Audit Historical Activity Report captures the final data for each day and is static. The Facility Audit Activity Real-time Report data is current at the time pulled.

- **NOTE:** the data for the past dates may change in the Real-time Report, based on the date ranges of the current audits completed since this continually updates.

Service Group	Supervisor Group	Staff Name	Appointments Made	Total Audits	# Schedulers	Level 1 Audits Remaining	Level 1 Audits Percentage Complete
⊟A.D. for Patient Care Services	Total	Total	1,095	0	3	30	0.00%
⊟Ancillary Services	Total	Total	1,527	8	4	32	20.00%
⊟Blind Rehab/Optometry Service	Total	Total	363	16	6	38	29.63%
⊟Clinical Health Services	⊟All Employees	PROGRAM SUPPORT ASSISTANT	71	4		6	40.00%
		SUPERVISOR, WARD ADMIN SEC	7	4		3	57.14%
		PROGRAM SUPPORT ASSISTANT	17	4		6	40.00%
		Total	95	12	3	15	44.44%
	Total	Total	95	12	3	15	44.44%

Key:
- ■ >=30% - Audits Complete
- ▨ 20% -29% - Audits Complete
- □ < 8% - Audits Complete

Total Audits Completed / # Staff x *10
* # of audits required per scheduler
* Max 10 audits counted per scheduler

Ability to expand to the group to view staff details

A helpful feature is the breakdown of audits by completed and number of appointments scheduled each month. This is particularly useful for tracking staff who schedule infrequently to ensure appointments scheduled are audited up to the required amount. See illustration below.

Service Group	Supervisor Group	Staff Name	Audits / Appointments October	Audits / Appointments November	Total Appointments	Total Audits	# Schedulers
⊟Ambulatory Care	⊟Ambulatory Care	MEDICAL SUPPORT ASSISTANT	0 / 217	0 / 119	336	0	
		Total	0 / 217	0 / 119	336	0	1
	Total	Total	0 / 217	0 / 119	336	0	1
Total	**Total**	**Total**	**0 / 217**	**0 / 119**	**336**	**0**	**1**

8.8.6 Facility Scheduling Audit Dashboard Report

This report aggregates the details of scheduling audits performed by supervisory staff at a facility level and drills down to each service group and individual scheduler. The user can view aggregated scheduling accuracy details by staff class including, MSA, non-MSA related positions, or both.

The Facility Scheduling Findings Report includes both local and national measures and findings. Optional local findings are optional measures that provide an additional level of scheduling practice insight for education and training purposes at the facility. Auditors and the medical center scheduling business owner should look at the report periodically and note whether there are trends in the types of errors found that may be remedied by additional training or a change in a scheduling process. See illustration on the next page.

Service Group	Appointments Made	% Appt Findings	% Correct	% Correct (Exclude Clinician)	Local Findings	National Findings	Audits Performed	Audits Cancelled
⊞A.D. for Patient Care Services	478	0	0	0			0	0
⊟Ancillary Services	824	0	8 (100.00%)	8 (100.00%)			8	0
All Staff	824	0	8 (100.00%)	8 (100.00%)			8	0
Advanced Medical Support Asst.	53	0	2 (100.00%)	2 (100.00%)	0	0	2	0
ADVANCED MEDICAL SUPPORT ASST	346	0			0	0	2	0
ADVANCED MEDICAL SUPPORT ASST.	387	0	2 (100.00%)	2 (100.00%)	0	0	2	0
ADV MEDICAL SUPPORT ASSISTANT	38	0	2 (100.00%)	2 (100.00%)	0	0	2	0
⊞Blind Rehab/Optometry Service	208	0	0	0	0	0	0	0
⊞Clinical Health Services	43	0	0	0	0	0	0	0
⊞Extended Care Service	1,580	0	62 (100.00%)	62 (100.00%)	0	0	62	0

Annotations on figure: "Expand service group to view schedulers", "% correct that excludes errors made by no RTC and/or No Consult", "Click hyperlinks to view appointment details"

Facility Scheduling Findings Report

8.9   User Access Permissions Dashboard

This report initially provides a high-level view of VISN staff permissions to the following access levels: Access Manager, Appointment Auditor, Grouping Manager, L1 Audit Remover, and L2 Auditor. This report will drill down to the medical center level and provide staff permission level detail for each listed above. Individual staff email account information is provided.

BISL SAT - User Access Permissions Dashboard

VISN / Facility	Access Manager	Appointment Auditor	Grouping Manager	L1 Audit Remover	L2 Auditor	L2 Audit Remover
⊞ VISN 1	66	210	99	14	16	0
⊞ VISN 2	93	191	85	9	38	5
⊞ VISN 4	89	220	84	13	57	8
⊞	45	260	84	6	18	0
⊞	52	174	48	11	17	7
⊞	97	259	65	17	38	5
⊞ VISN 8	69	442	111	2	40	1
⊞ VISN 9	31	226	39	0	39	1
⊞ VISN 10	187	456	211	12	26	3
⊞ VISN 12	92	261	33	7	6	2
⊞ VISN 15	56	17	14	3	9	2
⊞ VISN 16	96	368	206	19	37	16
⊞ VISN 17	96	302	182	16	10	2
⊞ VISN 19	139	277	139	29	7	3
⊞ VISN 20	52	362	180	12	37	6
⊞ VISN 21	80	333	97	12	41	1
⊞ VISN 22	87	472	236	23	49	15
⊞ VISN 23	56	180	42	15	24	5

Annotation: "Drill down to the facility and individual staff level access"

StaPc	Staff Name	Account Email Address	Access Manager	Appointment Auditor	Grouping Manager	L1 Audit Remover	L2 Auditor	L2 Audit Remover
506			YES	NO	NO	NO	NO	NO

Facility drill down includes staff level details

8.10 Site Setup Structure

This report prints the grouping for a facility by the service/section and scheduler staff. It also lists if the staff utilize an Insurance Capture Buffer (ICB). It is recommended to perform monthly validations of the groupings. The report can be exported and requires supervisors provide updates to ensure accuracy.

Parameters include: VISN, Station Number, and Service Group.

Service Group	Supervisor Group	Scheduler
ACOS/EDUCATION	ACOS/EDU	
	ACOS/EDU-EXEMPT	
Ambulatory Care	Ambulatory Care	
	Ambulatory Care Nurse Manager	
	Ambulatory Care-Exempt	

Chapter 9   Level 2 (L2) Audits

9.1   How to Conduct an L2 Audit

The BISL Audit Tool can be found here.

9.2   Setting up L2 Audit Parameters

As a reminder, the VISN will audit the facility L1 Audits or the facility within the VISN will audit each other's L1 Audits. No medical center will audit their own L1 Audits. The VISN Scheduling Business/Audit Lead or designee are to work with the medical centers to outline the L2 Audit process and ensure "just in time feedback" of L1 Auditors.

Each facility must have a minimum of 10 L2 Audits per L1 Auditor completed each cycle. The L2 Audit parameters are to be set to sample a small number of L1 Audits per month. See Section 2.4.2 "L2 Audit Frequency" for a recommended number of L2 Audits to be completed each month.

9.2.1 L2 Audit Parameter Settings:

Setting the L2 Audit date range and additional filters correctly to ensure appointment audit sampling throughout the audit cycle is critical.

When	The Date Column Start, and End Date reflect the monthly sampling period.
Where	Details who is being audited; select L1 Auditors whose audits will be reviewed. NOTE: The L2 Audits are no longer completed "blindly". In cases where there are more than one L2 Auditor responsible for a facility's L1 Audits, the number of L1 Auditors are to be divided among the L1 Auditors.
Additional Filters	Used to target the exact samples needed to meet auditing requirements.
Maximum Sample Size	Limits the total results for the audit sample. – *Practical Application*: If you don't want to audit more than 15 audits, set "Max Sample Size" to 15.
Maximum Sample per Auditor	Limits the total number of audit samplers per L1 Auditor – *Practical Application*: If only auditing two L1 Auditors, set "Max Sample Per L1 Auditor" to 2.

Maximum Completed L2 Audits per Auditor	Total number of L1 auditors with a completed L2 audit.
	   – This setting is increased cumulatively to account for the additional audits performed each month.
	   – The final month of the audit period should reflect the total number of required audits for the cycle.

L2 Audit

L2 Audit Parameters

When?	Where?	Additional Filters

When?

Start Date

2020-12-29

End Date (Inclusive)

2021-01-12

Days In Range

15

Days in date range (1 - 184)

Where?

StaPc

508

L1 Auditor

Any
Mouse, Mickey
Duck, Daisy
Duck, Donald
Doo, Scooby
Smith, John

Additional Filters

Max Sample Size

10

Limit Total Results (1 - 300)

Max Sample Per L1 Auditor

2

Limit Results Per L1 Auditor (1 - 75)

Max Completed Audits Per L1 Auditor

2

Limit Results For L1 Auditors With Completed L2 Audits (1 - 75)

Submit

9.3   L2 Audit Parameter Example

The following is an illustration on how a facility will use the template to set up the audit sampling throughout the cycle when there are more than one L2 Auditors.

Scenario	Value
Number of L1 Auditors	39
Required Number of L2 Audits per Cycle	39 L1 Auditors x 10 L2 Audits = 390 Audits per cycle
Number of L2 Auditors	5
Required Number of Audits per L2 Auditor	390 audits/5 auditors = 78 audits per L2 Auditor

NOTE: At least 10 L2 Audits must be completed _for each_ L1 Auditor by the end of the cycle

Month	L1 Audits	Date Range	Max Sample Size per L2 Auditor	Max Sample Per L1 Auditor	Max Completed Per L1 Auditor
November	2	10/15 - 11/9/2018	(39 x 2) / 5 = 15.6	2	2
December	2	11/12 - 12/7/2018	(39 x 2)/5 = 15.6	2	4
January	1	12/10/2018 - 1/4/2019	(39 x1) /5 = 7.8	1	5
February	1	1/7 - 2/1/2019	(39 x1) /5 = 7.8	1	6
March	2	2/4 - 3/1/2019	(39 x 2)/5 = 15.6	2	8
April	2	3/4 - 3/29/2019	(39 x 2)/5 = 15.6	2	10
	Recommended Audit sample per L1 Auditor	Factor in time for feedback. Do not sample until feedback from the previous audit has been completed	# of L1 auditors X sample audits /# of L2 Auditors. Provides approximate # of audits the L2 Auditor should complete in the month. (total = 78, the number of audits to be conducted per L2 Auditor)	Recommended Audit Sample per L1 Auditor	Cumulative number of audits to have been completed at the end of the month. (= Past month + current month)

9.3.1 Steps for Setting Parameters:

1. Set your L2 Audit parameters by selecting a start/end date, the facility you are auditing, the L1 Auditor or "any" (all L1 Auditors). And your max sample size, max sample per L1 Auditor, and max completed audits per L1 Auditor.

9.4 L2 Audit Examples

9.4.1 Example 1 – L1 Audit Inappropriately Marked as Incorrect (PID Not Used or Incorrect)

1. Review the L1 Audit Appointment information supplied in BISL L2 Audit.

2. Find the Patient/Appointment in VistA or VSE GUI.

3. Find the patient's order/Consult in CPRS.

4. Compare your findings of the appointment to that of the L1 Auditor's finding:

5. The L2 Auditor notes that the PID entered by the scheduler and that of the RTC Order match

6. The L1 Auditor marked this appointment as incorrect, PID not used or incorrect

7. L2 Auditor determines that the L1 Auditor's finding was incorrect.

9.4.2 Example 2 - L1 Audit Inappropriately Marked as Correct (PID Not Used or Incorrect)

1. Review appointment details

2. Find the Patient/Appointment in VISTA or VSE GUI

3. Find the patient's order/ Consult in CPRS

4. Compare your findings of the appointment to that of the L1 Auditor's finding.

5. The L2 Auditor notes that the PID entered by the scheduler and that of the RTC Order do not match. The finding is "PID not used or incorrect."

6. Also, the patient was not wait time eligible, so #COO# is not required in the appointment comments. The finding is #COO# not Supported.

7. The L1 Auditor marked this appointment as correct.

8. L2 Auditor determines that the L1 Auditor's finding was incorrect. See example on next page.

```
Order Details - 94210089;1
>> RTC (b)(6)    1 year
Activity:
10/31/2017 13:53  New Order entered by (b)(6)          (PHYSICIAN (STAF)
     Order Text:       RTC Harocopos 1 year
     Nature of Order:  ELECTRONICALLY ENTERED
     Elec Signature:   (b)(6)          (PHYSICIAN (STAF) on 10/31/2017 13:53
     Clerk Verified:   (b)(6)          (ADVANCED MEDICA) on 10/31/2017 13:56

Current Data:
Treating Specialty:
Ordering Location:         JC-OPHTH EYE (b)(6)
Start Date/Time:           10/31/2017 13:53
Stop Date/Time:
Current Status:            ACTIVE
  Orders that are active or have been accepted by the service for
  processing.  e.g., Dietetic orders are active upon being
  ordered, Pharmacy orders are active when the order is verified,
  Lab orders are active when the sample has been collected,
  Radiology orders are active upon registration.
Order #94210089

Order:
Order:
  RTC Harocopos 1 year
Start Date/Time:           NOW
```

Print   Close

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure	Responsible Group
None (Correct)	Incorrect ▾	None	N/A

Missing L1 Findings

Mandatory

PID
☑ PID Not Used or Incorrect
☐ No Consult
☐ No RTC

L2 Auditor selected the finding, PID not used or incorrect

Time Sensitive
☐ #NLT# Entered But Not Used Appt Sched After PID
☐ "#NLT# not supported" Incorrect
☐ PID Entered Correctly But #NLT# Not Entered

Community Care
☐ Comments missing #COO# Vet "Opts Out"
☑ #COO# Not Supported
☐ #COO# Not Selected in DST
☐ No Evidence other CC Eligibilities

Optional

None
☐ Insufficient Comments

Complete L2 Audit

Audits Remaining: 1   Submit Audit   Cancel Audit

9.4.3   Example 3 – L1 Audit Inappropriately Marked as Incorrect (No Evidence of Other Eligibility)

1. Review appointment details

2. Find the Patient/Appointment in VISTA or VSE GUI

(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)

3. Find the patient's order/ Consult in CPRS

4. Compare your findings of the appointment to that of the L1 Auditor's finding.

5. The L2 Auditor notes that the patient received care by the service in October 2019. This is not a new patient, so only wait time is reviewed. Patient was scheduled within the Community Care Wait Time Standard.

6. The L1 Auditor marked this appointment as No Evidence of Other Eligibility.

7. L2 Auditor determines that the L1 Auditor's finding was incorrect. The L1 Audit should have been correct. See example on next page.

L1 Audit Findings

L1 Finding	L2 Review	Reporting Measure	Responsible Group
No Evidence other CC Eligibilities	Incorrect ⌄	Community Care	Scheduler

Missing L1 Findings

Mandatory

PID
- ☐ PID Not Used or Incorrect
- ☐ No Consult
- ☐ No RTC

Time Sensitive
- ☐ #NLT# Entered But Not Used. Appt Sched After PID.
- ☐ "#NLT# not supported" Incorrect.
- ☐ PID Entered Correctly But #NLT# Not Entered

Community Care
- ☐ Comments missing #COO# Vet "Opts Out"
- ☐ #COO# Not Supported
- ☐ #COO# Not Selected in DST
- ☐ No Evidence other CC Eligibilities

Optional

None
- ☐ Insufficient Comments

9.4.4 Example 4 – L1 Audit Finding Is Correct (#COO#)

1. Review appointment details

L1 AuditID 5538081

L1 Audit Appointment Info

SID:	(b)(6)
IEN:	(b)(6)
Location:	CO-BH MHC IND NEUDECKER NEURO
Scheduler:	(b)(6)
Comment:	SPOKE WITH PT TO SCHEDULE #COO#
Non-Count Clinic:	N
Type:	REGULAR
Purpose Of Visit:	SCHEDULED VISIT
Patient Status:	NEW
Patient:	Hover To Show
LAST,FIRST1234:	Hover To Show
Patient SSN:	Hover To Show

L1 Audit Appointment Date Info

Appt Made Date:	04-01-2021
Appt Date:	05-12-2021 11:00:00
PID: (Patient Indicated Date)	03-30-2021
PID Difference: (Days between Appointment Date and PID)	43
Made Date and Date Difference (Days between Appointment Date and the date the appointment was made)	41
Next Available Appointment:	NOT INDICATED TO BE A "NEXT AVA." APPT.

L1 Audit Findings

2. Review appointment details

8. Find the Patient/Appointment in VISTA or VSE GUI

9. Compare your findings of the appointment to that of the L1 Auditor's finding.

10. The L2 Auditor notes that the L1 Audit finding is correct. This appointment was made correctly, and the L1 Auditor finding is correct.

11. The patient was wait time eligible and "Opted Out" of Community Care. The scheduler entered #COO# in the appointment comments correctly

12. L2 Auditor determines that the L1 Auditor's finding was correct. The L1 Audit is Correct. See example on below.

9.5 L2 Audit Reports

The <u>BISL Audit Tool</u> offers a variety of reporting tools to assist the auditor and leadership at the local, regional, and national levels to better discern scheduling and auditing practices to make improvements to increase accuracy in scheduling and reliability of appointment wait times. L2 Audit Reports are located on the <u>BISL Audit Tool</u> along with the <u>L1 Reports and Maintenance Tools</u>.

9.5.1 National L2 Audit Activity Report

This report is used to track L2 Scheduling Audits completed nationally by VISNs and facilities. The audit percent completed is based on the total possible audits that are required to be completed by the L1 Auditor. The minimal requirement is 10 L2 Audits conducted per L1 Auditor.

The denominator or base number of audits to be completed is determined by the number of auditors who have audited an appointment multiplied by 10 (the required number of L2 Audits). The numerator is the number of L2 Audits completed. The L2 Audit is broken down into 2 cycles each year: November through April and May through October (one month behind the L1 cycle). To assist with keeping on track and completing the required L2 Audits, color coded progress indicators that change each month are built into the tool. The green color indicates the site/VISN is on target for the month, yellow indicates in range for completion, and red indicates that the site/VISN is slated for successful completion of the number of required audits. The tool is to be used as a guide and is based on predetermined incremental monthly audit completions.

Below is a chart of the L2 Scheduling Audit progress indicators per month.

Cycle 1 - Level 2 Scheduling Audit Progress Indicators			
November	No Color		
December	30%	20 - 29%	< 20%
January	40%	30 - 39%	< 30%
February	50%	40 - 49%	< 40%
March	70%	55- 69%	<55%
April weeks 1 & 2	85%	75 - 84%	< 75%
April weeks 3	90%	8% - 89%	< 85%
April week 4	100%	No Yellow	< 100%

Cycle 2 - Level 2 Scheduling Audit Progress Indicators			
May	No Color		
June	30%	20 - 29%	< 20%
July	40%	30 - 39%	< 30%
August	50%	40 - 49%	< 40%
September	70%	55- 69%	<55%
October weeks 1 &	85%	75 - 84%	< 75%
October week 3	90%	8% - 89%	< 85%
October week 4	100%	No Yellow	< 100%

The tool offers two views, VISN and medical center. It is defaulted to the VISN and reports the number of L1 Audits and L2 Audits completed, the number of L1 Auditors, and the number and percentage of L2 Audits Remaining. The parameter setting is defaulted to the current fiscal year and audit cycle. The report(s) can be exported to an excel file and other reporting formats.

National L2 Activity Level

VISN / Facility		Level 1 Audits	Level 2 Audits	# Level 1 Auditors	L2 Audits Remaining (% Completion)
1		273	0	12	74 (0.00%)
2		6	0	4	6 (0.00%)
4		399	2	12	71 (2.74%)
5		41	0	2	11 (0.00%)
6		636	0	8	62 (0.00%)
7		398	0	20	144 (0.00%)
8		886	0	34	199 (0.00%)
9		703	0	18	148 (0.00%)
10		152	0	12	87 (0.00%)
12		181	0	7	44 (0.00%)
15		711	3	5	24 (11.11%)
16		1,354	0	30	190 (0.00%)
17		505	0	24	179 (0.00%)
19		3,286	15	68	579 (2.53%)
20		105	0	7	51 (0.00%)
21		865	0	15	121 (0.00%)
22		1,036	1	43	317 (0.31%)
23		30	9	3	10 (47.37%)
National Total		**11,567**	**30**	**324**	**2317 (1.28%)**

VISN View: National Scheduling Audit Activity

9.5.2 National Scheduling L2 Audit Findings

This report aggregates the details of the L2 Audits at a national level and breaks down by facility. It provides a quick glance of overall Audit Accuracy of the L1 Auditors. The report parameters include the fiscal year and audit cycle.

VISN / Facility		L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Correct	% L2 Audits Incorrect
1		815	0	0	0	0
2		508	0	0	0	0
4		2,078	7	3	4 (57.14%)	3 (42.86%)
5		283	0	0	0	0
6		1,880	0	0	0	0
7		2,374	0	0	0	0
8		4,138	2	1	1 (50.00%)	1 (50.00%)
9		1,804	0	0	0	0
10		1,107	9	5	4 (44.44%)	5 (55.56%)
12		1,550	20	13	7 (35.00%)	13 (65.00%)
15		2,090	74	5	69 (93.24%)	5 (6.76%)
16		4,508	16	0	16 (100.00%)	0 (0.00%)
17		2,878	320	11	309 (96.56%)	11 (3.44%)
19		10,655	15	9	6 (40.00%)	9 (60.00%)
20		452	0	0	0	0
21		2,296	0	0	0	0
22		5,261	9	1	8 (88.89%)	1 (11.11%)
23		539	12	4	8 (66.67%)	4 (33.33%)
National Total		**45,216**	**484**	**52**	**432 (89.26%)**	**52 (10.74%)**

Below is the expanded facility view for VISN 17.

	VISN / Facility	L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Correct	% L2 Audits Incorrect
17	(504) AMARILLO HCS	16	0	0	0	0
	(519) WEST TEXAS HCS	25	2	0	2 (100.00%)	0 (0.00%)
	(549) DALLAS VA MEDICAL CENTER	188	0	0	0	0
	(671) AUDIE L. MURPHY MEMORIAL HOSP	593	0	0	0	0
	(674) OLIN E. TEAGUE VET CENTER	1,506	318	11	307 (96.54%)	11 (3.46%)
	(740) HARLINGEN VA CLINIC	280	0	0	0	0
	(756) EL PASO VA HCS	270	0	0	0	0
		2,878	320	11	309 (96.56%)	11 (3.44%)

9.5.3 Facility L2 Audit Activity Report

This report lists the facility L1 Auditors and identifies the percent completed at the time the data was pulled. Additional information provided per L1 Auditor includes the number of L1 Audits completed and L2 Audits completed. Report parameters include the VISN/facility, fiscal year, and the audit cycle.

Level 1 Auditor Name	Level 1 Audits	Level 2 Audits	L2 Audits Remaining (% Completion)
Last name, first name	4	0	4 (0.00%)
	2	0	2 (0.00%)
	4	0	4 (0.00%)
	12	0	10 (0.00%)
	2	0	2 (0.00%)
	4	0	4 (0.00%)
	2	0	2 (0.00%)
	1	0	1 (0.00%)
	2	0	2 (0.00%)
	2	0	2 (0.00%)
	2	0	2 (0.00%)
Facility Auditors Totals	38	0	36 (0.00%)

9.5.4 Facility Scheduling L2 Audit Findings – Audit Dashboard

This report lists each L1 Auditor by name and provides the percentage of accuracy of the L2 Audits conducted. Information includes number of L1 Audited Performed, L2 Audits Completed, L2 Audits Incorrect, Percentage of L2 Audits Incorrect, Percentage of L2 Audits Correct and Local Findings Incorrect. A hyperlink is provided that will drill down to the individual L2 Audit detail.

Level 1 Auditor Name	L1 Audits Performed	L2 Audits Completed	L2 Audits Incorrect	% L2 Audits Incorrect	% L2 Audits Correct	Local Finding Incorrect
	53	1	0	0	1 (100.00%)	0
	13	0	0	0	0	0
	259	1	1	1 (100.00%)	0	0
Total	**325**	**2**	**1**	**1 (50.00%)**	**1 (50.00%)**	**0**

Drill Down – Correct Audit

L2 Audit ID	Sta Pc	L2 Evaluation Code	Reporting Measure	Responsible Group	L1 Audit Finding	L1 National Error	L1 Finding Description	Service Group
1182	542	Correct	None	N/A	None (Correct)	No	No Findings. Appointment was scheduled correctly.	Mental Health Services

Drill Down – Incorrect Audit

L2 Audit ID	Sta Pc	L2 Evaluation Code	Reporting Measure	Responsible Group	L1 Audit Finding	L1 National Error	L1 Finding Description	Service Group
1183	542	Incorrect	None	N/A	None (Correct)	No	No Findings. Appointment was scheduled correctly.	PRIMARY CARE SERVICES
	542	Missing Finding	Choice	Scheduler	Comments missing #COO#. Vet "Opts Out"	Yes	#COO# is not entered in the comments field of VA appointment when the Veteran "Opts Out" of Choice.	PRIMARY CARE SERVICES
	542	Missing Finding	None	Scheduler	Insufficient Comments	No	Scheduler comments do not match documentation or do not identify how they decided entered wait time (PID).	PRIMARY CARE SERVICES

Parameter settings include: medical center, Appointment Made Start Date, Appointment Made End Date, and the appointment findings you wish to review (correct, incorrect, missing findings).

Elements of the drill down include: L2 Audit ID, Sta Pc, L2 Audit Result, Reporting Measure (Finding Type), Responsible Group, L1 Audit Finding, L1 National Error, L1 Finding Description, Service Group, Supervisor Group, Audited Scheduler's Name, Audited Scheduler's Position, Audited Scheduler's Position Title, Audit Location, the Patient's Name and Last 4 of their social security number (SSN), Audit Appointment Made Date, Audit Appointment Date, Audit Desired Appointment Date, Desired Date Difference from Appointment Date, Create Date to Preferred Date, Audit Appointment Comments, L1 Appt Auditor, Start and End Time of the L1 Audit, Start and End Time of L2 Audit, Details of the Previously Scheduled Appointment, the Patient Surrogate ID (SID), Appointment SID and Audit ID Number.

9.5.5 Scheduling L2 Audit Finding Details Report

This report is illustrated above and can be found when drilling down on an L1 Auditor from the facility L2 Audit Findings report or as a standalone report. The standalone report is useful when there is a L1 Auditor of interest to review. Parameters include the: VISN/facility, Appointment Made Start and End Date, L1 Auditor, the Evaluation Code, and National Error Code.

9.5.6 L2 Auditors Monthly Activity Report

This report allows the facility to track which L2 Auditors and how many L2 Audits have been completed for each facility. The report shows the number of completed L2 Audits for each month of the audit cycle selected.

L2 Auditor Name	L2 Audits						Total L2 Audits	#L2 Auditors
	April	May	June	July	August	September		
	10	10	10	10	10	10	60	
	10	10	10	11	10	9	60	
.	10	10	10	10	10	10	60	
Total	30	30	30	31	30	29	180	3

Chapter 10   VHA Scheduling Audits SharePoint and Teams Group

10.1 VHA Scheduling Audit SharePoint

VHA Scheduling Audit CoP SharePoint: https://dvagov.sharepoint.com/sites/VHASchedulingAudits

10.1.1 SharePoint Features:

1. Easily access resources using SharePoint

2. Navigate to other access communities using top toolbar
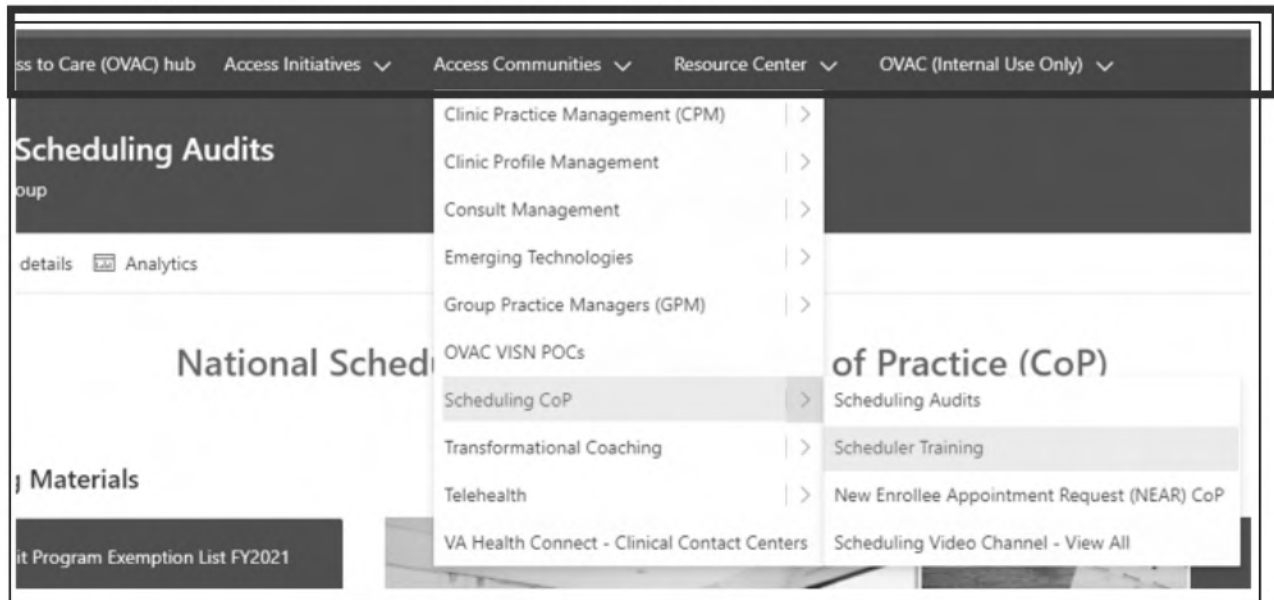
3. Access to Monthly Audit POC Check-in <u>slides and recordings</u>
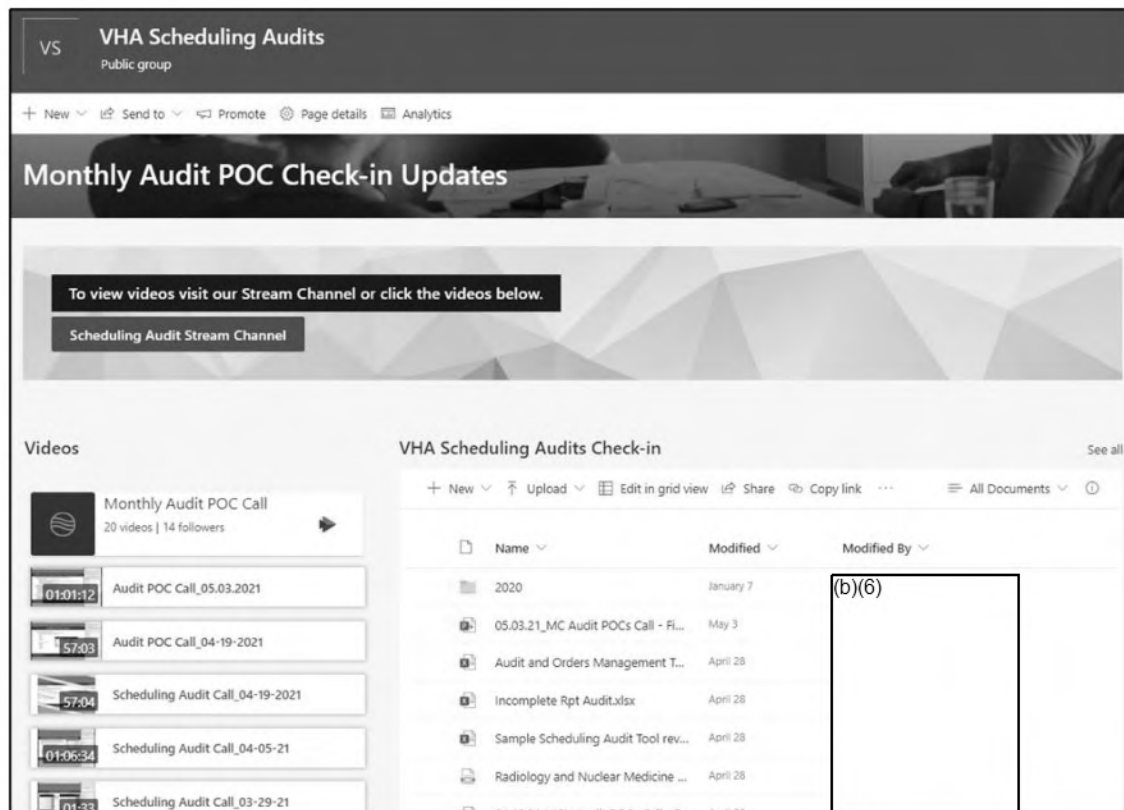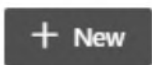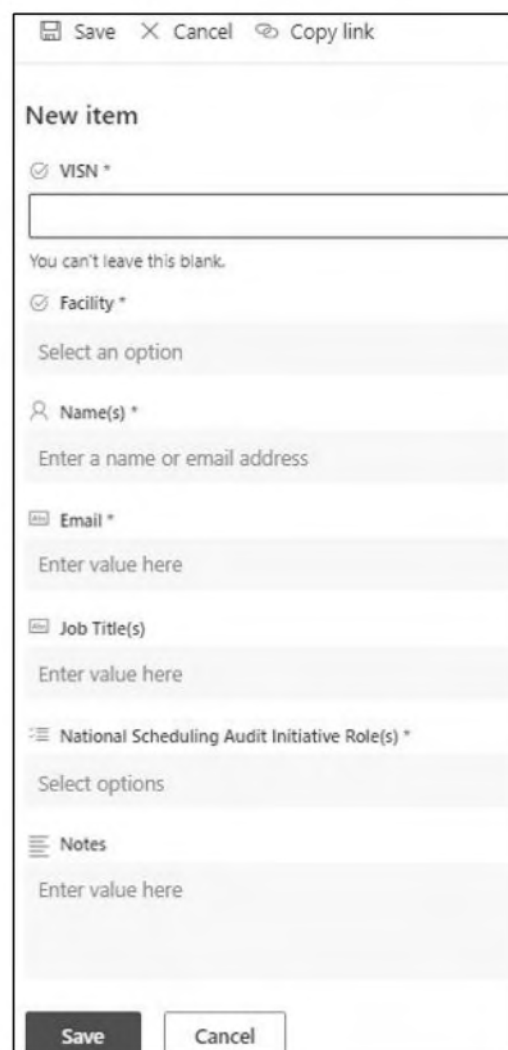
10.1.2 Scheduling Audit Lead Contact List

To help improve transparency and communication for the scheduling community, it is requested that each VISN and medical center periodically review and update their Scheduling Audit and L2 Auditor point of contact information.

− **NOTE:** Please do not submit the names of all your scheduling auditors. Only the Facility Scheduling Audit Lead, L2 Audit Lead, and VISN Scheduling Business/Audit Lead are asked to submit their contact information.

A. *Submit Scheduling Audit Lead Information*

1. Open List:
   1. VISN and Facility Scheduling Audit Lead List
   2. Open L2 Audit Lead Contact List

2. Select

   [+ New]

3. Enter contact information in dialog box and select "**Save**"

10.2 VHA Scheduling Audit Microsoft (MS) Teams Group

10.2.1 MS Teams Features:

Access VHA Scheduling Audit Teams Group here.

1. MS Teams group also functions as a mail group (e.g., "VHA Scheduling Audits" VHASchedulingAudits@DVAGOV.onmicrosoft.com)

2. Easily access resources using Microsoft (MS) Teams group and SharePoint

3. Freely join or leave the group using MS Teams

4. Quickly invite others to join using group link

5. Meeting invites will automatically appear on your calendar after joining and will disappear upon leaving

10.2.2 MS Teams Best Practices

1. Avoid cc'ing the group on personal or facility meeting invitations

2. Reduce "reply-all" chain by emailing OVAC Staff directly or ask questions using "Question and Answers Teams Channel" rather than emailing the entire group
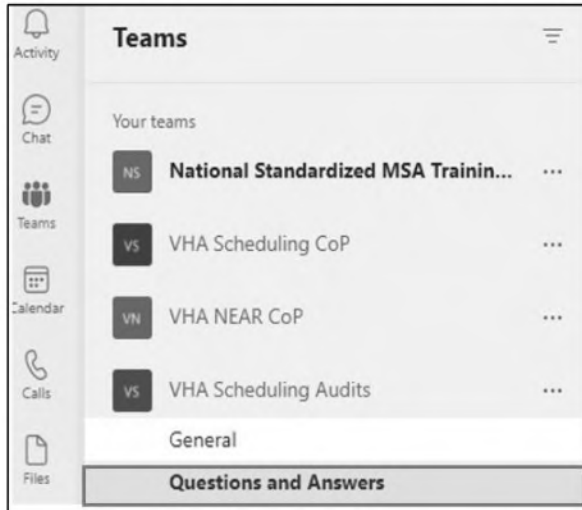
3. Access SharePoint, meeting slides/recordings via Teams Toolbar
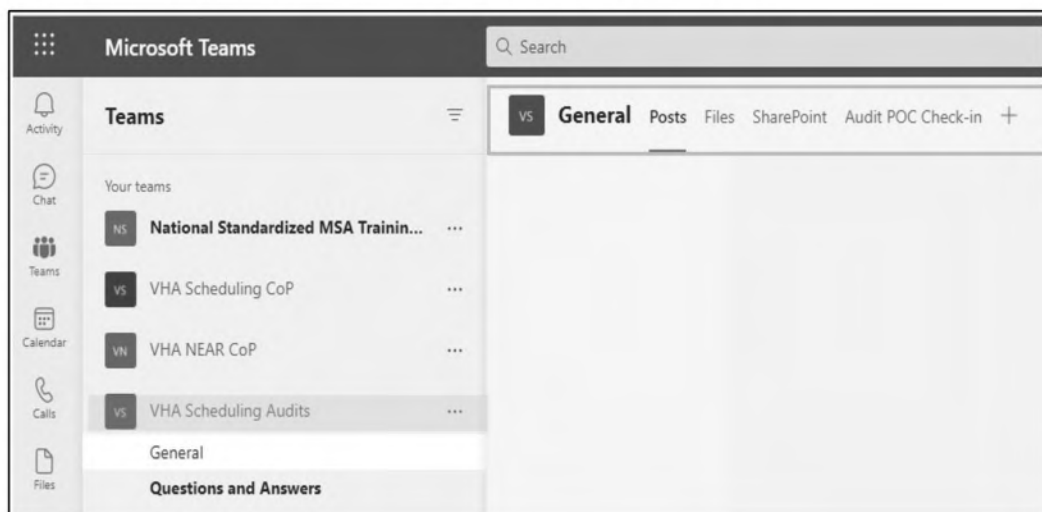
4. Use "Ignore Conversation" feature if stuck on a reply-all chain

5. Use "Stop following Group" feature to stop getting emails sent directly to your inbox

6. Manage group membership

   a. Share the group link to help others join the group in just one click

   b. Leave group using MS Teams if the group no longer applies to your current role

A. *Ignore "Reply All" Emails:*

If you ever get stuck on a "Reply All" chain, keep unwanted replies out of your Inbox using **"Ignore Conversation"** feature. This feature redirects all future messages in email chain from your Inbox to Deleted folder.

Ignore a Conversation:

1. Right click any email in the chain

2. Select "**Ignore Conversation**" All future messages will go directedly to your Deleted folder.

Stop Ignoring a Conversation:

1. In the **Deleted Items** folder, select the conversation that you want to recover, or any message within that conversation.

2. On the **Home** tab, in the **Delete** group, select **Ignore.**

3. Select **Stop Ignoring Conversation**. The conversation will be moved back to your Inbox and future messages will appear in your Inbox.
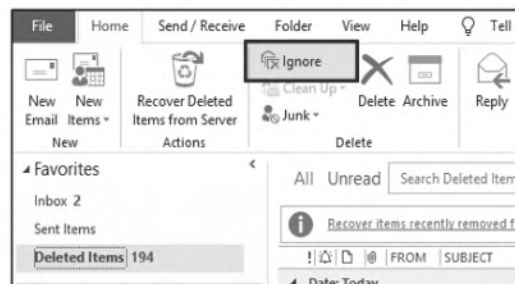
B. *Stop Following the Group*

Continue receiving group emails and meeting invitations without getting emails sent to the group directly to your inbox using the **Stop Following** feature.

— **NOTE:** When you unfollow, you can still view past group emails using the group's shared mailbox (Located under "Groups" in left navigation pane)

Stop Following Method 1: Outlook Desktop Application

1. Select a group from the navigation pane.

2. At the top of the conversations list, select **Following** > **Stop following in Inbox.**
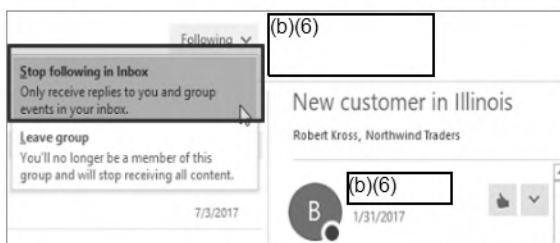
Stop Following Method 2: Outlook Web Application

1. Open Groups tab in Outlook Web at: https://outlook.office365.com/people/group/member/

2. Use left navigation pane and scroll down to "Groups"

3. Select the group you'd like to unfollow.

4. Right click group and click "**Stop following**"
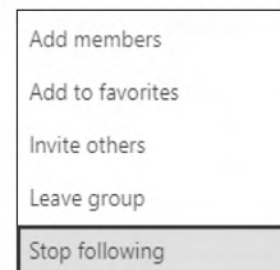
C. *Manage Team Membership*

1. **Join Group**: Click <u>here</u> to join MS Teams Group
2. **Invite Others**: Share <u>team link</u> or "**Add member**" using Teams
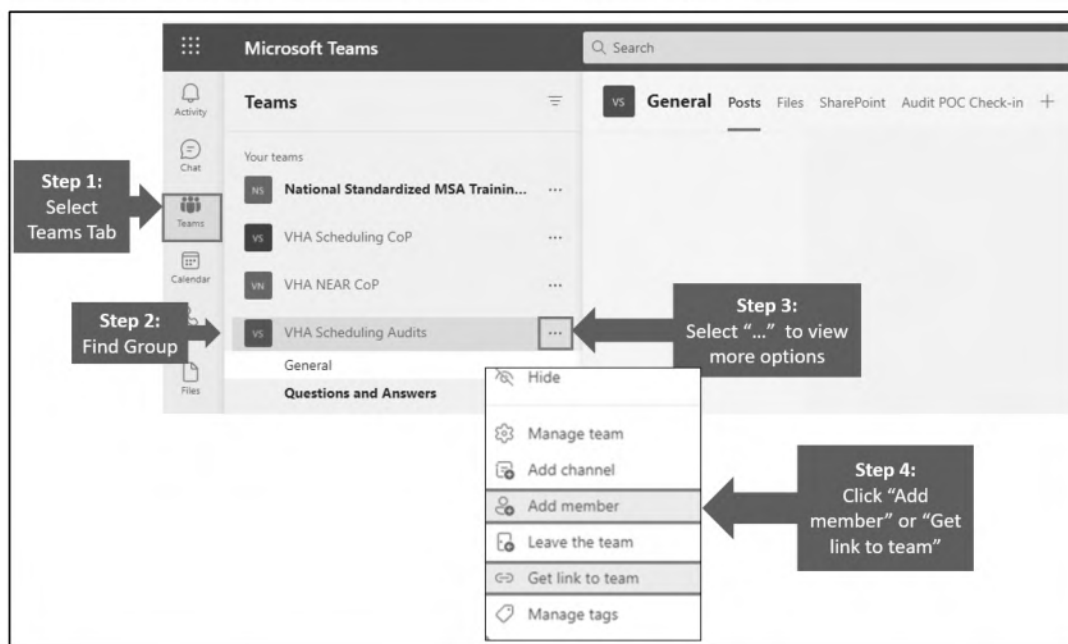
3. **Leave the Team**
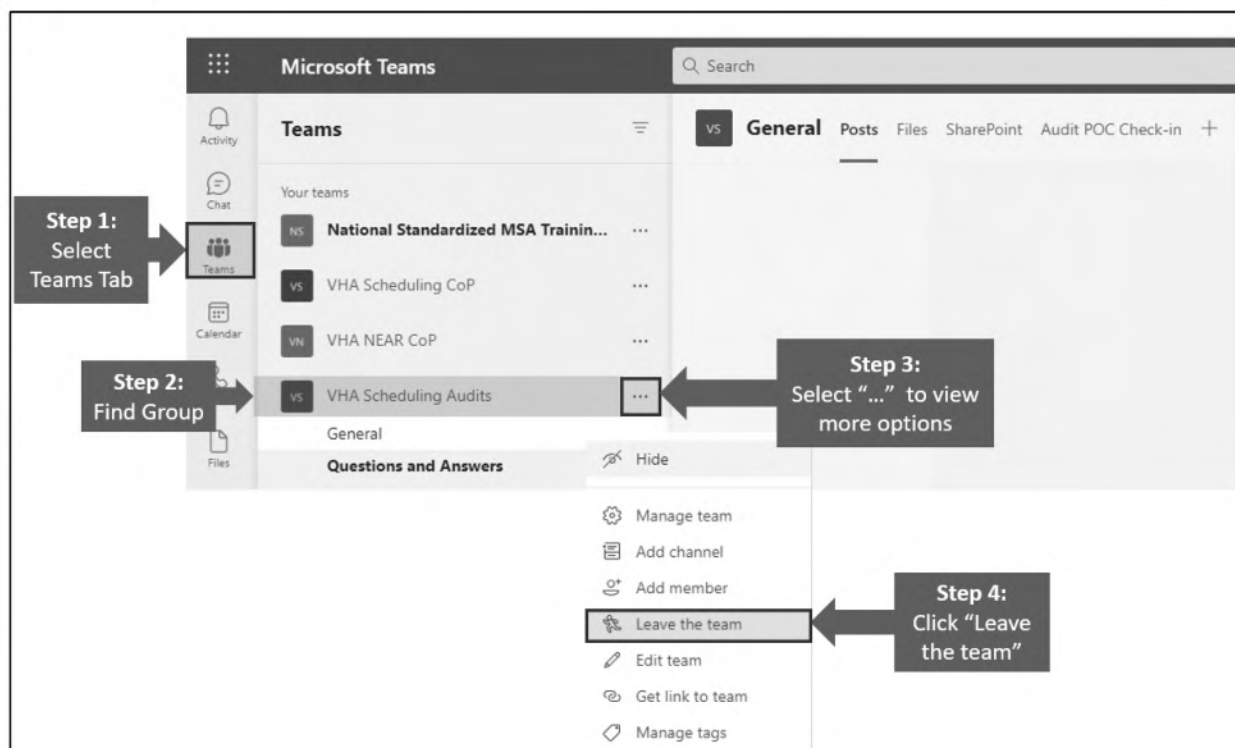
Appendices

Appendix A: National Standardized Scheduling Audit Program Exemptions FY2021

The Access Office is responsible for all elements of VHA Directive 1231 (Outpatient Clinic Practice Management) and VHA Directive 1232.1 (Consult Processes and Procedures). Appointments scheduled from the below listed programs are exempted from audits except. These may change in FY 2021. All other program areas appointments are subject to audit.

1. Diagnostic Imaging
   a. X-Ray (Stop Code 105)
   b. Nuclear Medicine (Stop Code109)
   c. Interventional Radiology Pre-/Post-Procedure Consult (Stop Code 110)
   d. Ultrasound (Stop Code 115)
   e. Radionuclide Therapy (Stop Code 144)
   f. Pharmacology/Physiologic Nuclear Myocardial Perfusion Studies (Stop Code 145)
   g. Radiation Oncology (Stop Code 149)
   h. Computerized Tomography (CT) (Stop Code 150)
   i. Magnetic Resonance Imaging (MRI) (Stop Code151)
   j. Interventional Radiography (Stop Code153)
   k. Vascular Laboratory (Stop Code 421)
   l. Mammogram (Stop Code 703)
2. Employee Occupational Health (Stop Code 999)
3. Compensation and Pension (C&P) (Stop Code 450)
4. DBQ Referral Clinic (Stop Code 443)
5. C&P via Clinical Video Telehealth (CVT) Patient Site (Stop Code 444)
6. C&P via Clinical Video Telehealth (CVT) Provider Site (Stop Code 445)
7. IDES (Integrated Disability and Evaluation System) via Clinical Video Telehealth (CVT) Patient Site (Stop Code 446)
8. IDES (Integrated Disability and Evaluation System) via Clinical Video Telehealth (CVT) Provider Site (Stop Code 447)
9. Integrated Disability Evaluation System Exam (Stop Code 448)
10. Community Care Program
11. Purchased Care Programs
    a. Purchased Skilled Care (POV 70 & 74)
    b. Homemaker Home Health Aide (POV 71)
    c. Outpatient Home Respite (POV 72, 73 & 79)
    d. Contract Adult Day Health Care (Stop Code 191) (POV 76)
    e. Veteran Directed Home & Community Based Care (POV 27)
    f. Program of All Inclusive Care for the Elderly (PACE POV 26)
    g. Purchased Home Hospice (POV 77 & 78)
    h. Community Nursing Home (POV 40, 41, 42, 43, 44)

12. Hospital in Home-HIH (Stop Code 354)
13. Medical Foster Home-MFH (Stop Code 162)
14. Community Residential Care-CRC (Stop Code 121)
15. VA-Adult Day Health Care (Stop Code 190)
16. Home Based Primary Care-HBPC (Stop Codes 118, 156, 157, 170-177)
17. Homeless Programs
    a. Grant and Per Diem Individual (Stop Code 511)
    b. Grant and Per Diem Group (Stop Code 504)
    c. HCHV/HCMI-Individual (Stop Code 529)
    d. HCHV/HCMI Group (Stop Code 508)
    e. HUD-VASH Individual (Stop Code 522)
    f. HUD-VASH Group (Stop Code 507)
    g. VJO Face-to-Face (Stop Code 592)
    h. HCRV Face-to-Face (Stop Code 591)
    i. HVCES-Individual (Stop Code 555)
    j. HVCES-Group (Stop Code 556)
18. Mental Health Programs
    a. Intensive Community Mental Health Recovery Services (ICMHR)
        i. Individual (Stop Code 552)
    b. Residential Treatment Programs
        i. Individual (Stop code 586)
        ii. Group (Stop code 587)
    c. VHA Voc Rehab (formerly TSES)
        i. Individual (Stop codes 207, 208, 213, 222, 568, 568/535, 573, 574)
19. Administrative Stop code 674
20. Preventative Immunization (Secondary stop code 710)
21. Telehealth
    a. Store and Forward Telehealth from Hone-Provider Site (stop code 189)
    b. Store & Forward Telehealth- Provider Site (Not Same Station) (stop code 696)
    c. Clinical Video Telehealth- Provider Site (stop code 645)
    d. Clinical Video Telehealth with Non-VAMC Location- Provider Site (stop code 648)
    e. Clinical Video Telehealth to Home- Provider Site (stop code 679)
    f. Clinical Video Telehealth - Provider Site (Not Same Station) (stop code 693)

    – **NOTE:** The Mental Health Programs listed under #18 are exempt from the scheduling audit. Inpatient and established patients listed are exempt from the scheduling directive requirements in 2020. New patients seen in the outpatient setting will following scheduling directive requirements but are not audited in the BISL tool due to technical issues.

Appendix B: National Standardized Scheduling Audit Resources

Links

Resource	URL
VHA Scheduling Audit SharePoint	https://dvagov.sharepoint.com/sites/VHASchedulingAudits
VHA Scheduling Community of Practice (CoP) SharePoint	https://dvagov.sharepoint.com/sites/VHASchedulingCoP
The Access Office (15ACC) SharePoint	https://dvagov.sharepoint.com/sites/vhaovac
BISL Audit Tool	https://app.cdw.va.gov/BISL_SCHEDAUD/App/#!/home

Community of Practice Calls

Title	Frequency
medical center Audit POC Monthly Check-in	1st Monday of the month at 2pm EST
VISN Audit POCs Monthly Check In	3rd Monday of the month at 2pm EST
Scheduling Community of Practice	4th Tuesday of the month at 3pm EST

Mail Groups

To receive meeting invites and email updates, please join the following groups.

MS Teams Groups		Email
VHA Scheduling CoP	Click **here** to join	(b)(6) @dvagov.onmicrosoft.com
VHA Scheduling Audits	Click **here** to join	(b)(6) @dvagov.onmicrosoft.com

Distribution Groups	Email
VHA OVAC Scheduling CoP	(b)(6) @va.gov
VHA OVAC Scheduling Audit POCS	(b)(6) @va.gov
VHA OVAC Scheduling Audit VISN POCS	(b)(6) @va.gov

Memorandum

**Department of
Veterans Affairs**

Date: July 7, 2020

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

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

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

1. The Office of Veterans Access to Care (OVAC), the Office of Connected Care
and the Office of Community Care (OCC) have partnered to provide guidance for
Outpatient Appointment Scheduling Management Moving Forward Post COVID-
19. The outpatient appointment scheduling procedures includes:
- Clinic profile requirements
- Video to home scheduling
- Community care wait time eligibility for COVID-19 impacted
consults and Return to Clinic (RTC) orders management

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

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

(b)(6)

for
Renee Oshinski

Attachments

COVID-19 Appointment Scheduling Management
VHA Clinical Services Expansion of In-Person Care Delivery

Ensure that scheduling staff and members of the Referral Coordination Team have the necessary knowledge and skill to appropriately execute Updated Attachment C:

- **10N Memorandum Outpatient Appointment Scheduling Management Moving Forward Post COVID-19 dated July 7, 2020**

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

- *At the completion of this training participants will be able to properly manage and schedule VHA outpatient appointments and consults (and refer to community care as appropriate) as the facility navigates through the COVID-19 pandemic and begins to schedule in-person appointments for routine care.*

- *This training will be sectioned out in different parts to increase the understanding and the actions required.*

Choose VA

VA | U.S. Department of Veterans Affairs

1

Key Training Objectives

1. Identify appointment requests (Consult and/or Return to Clinic Order) impacted by COVID- 19 that have the correct documentation supporting an updated PID.

2. Correctly apply:

   a. Community care wait time eligibility standards for COVID-19 impacted appointments when the Patient Indicated Date (PID) **is** updated or **not** updated AND

      ▪ Appropriately forward the appointment request to community care or schedule/reschedule the appointment using the updated PID.

   b. Community care eligibility criteria when their VAMC service or section(s) must halt non-urgent/emergency in-person care, due to an increase in COVID-19 in their community or as otherwise directed by their VAMC and/or VISN Leadership.

Background

- The Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) have partnered to provide consult and appointment scheduling guidance be followed as VA Medical Centers (VAMCs) expand outpatient in-person care delivery beyond face-to-face urgent/emergent visits.

- Each VAMC must have a documented plan for the clinical review and scheduling/rescheduling of Veterans in each Service/Specialty.
    - This plan is to be developed by Service/Section Chiefs and is to be shared with all clinical, scheduling and administrative staff involved in the care of Veterans within the Service/Section.
    - Guidance will apply as each service/section moves forward
        - It is possible that one service may move forward as others are not ready
            - Example: Dermatology moves forward but cardiology does not

Choose VA

VA | U.S. Department of Veterans Affairs

3

Patient Indicated Date

- The PID must be clinically reviewed prior to scheduling/rescheduling.

- Updating of the PID is a clinical decision based on medical needs and not clinic availability nor consideration of community care eligibility.

- The Patient Indicated Date (PID) may be updated in both Consults and Return to Clinic (RTC) Orders by the receiving clinical service when:

  - Scheduling of the appointment or consult was impacted by COVID-19

  - Is clinically appropriate

Choose VA

VA | U.S. Department of Veterans Affairs

4

Patient Indicated Date

- Clinical staff refers to licensed independent providers and may delegated to clinical staff such as RN, LISW, Clinical Pharmacists, etc. on the team based on local policy.

- The original PID is used when rescheduling if there is no documented evidence of a new PID by a clinical staff member.

- The guidance above is a temporary exception to standard policy as outlined in VHA Directives 1230 (2), Scheduling Processes and Procedures and 1232(2), Consult Processes and Procedures.

Consults & Updated PID

- Consults impacted by COVID-19 are strongly encouraged to have an updated PID.

  – Refers to all open/active consults at the time the facility moves forward, regardless of whether the initial appointment was cancelled or not.

- **Clinical Documentation of Updated Consult PIDs**

  – Located in the Consult Comments Section *(no other area is acceptable, i.e. progress notes)*

    - Provider will use Consult Toolbox COVID-19 tab options scheduling instructions

      OR

    - Annotate new PID via Consult "Add Comment" option

Choose VA

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6

Consults & Updated PID

- **Scheduling staff instructions:**
  - Schedule the consults with the properly documented updated PID in VistA Scheduling using the new PID and link the appointment to the consult.
    - Annotate the new PID in the appointment comments: "new PID per Provider, RN, etc."
  - If VistA is not available, use VS GUI (Note, you will be unable to change the PID)
    - When using VS GUI, use the original PID for scheduling and Community Care eligibility.

Consult Application

Scenario:

Mr. McCormick's dermatology appointment was cancelled and not rescheduled due to COVID-19. The dermatology section at the VAMC is now ready to see in-person non-emergent/urgent outpatient appointments. The provider has reviewed the consult and has documented a new PID in the appointment comments and has requested that the MSA schedule this appointment.

- Original PID = 4/20/2020
- Updated PID = 8/14/2020

- **What are the MSA's next steps?**

Consult Application

✓ Look for the updated PID in the Consult comments by designated clinical team member. In this case, the provider.

✓ Negotiate appointment time/date with the patient

✓ Schedule the appointment in VistA using the updated PID date (8/14/2020)

✓ Annotate "New PID per provider" in the appointment comments

✓ Link the appointment to the consult

Follow Up Question

- What if there was no documentation or the documentation was not in the consult comments?

- How is that consult scheduled?

Follow Up Discussion

- If there is no documentation or if the documentation is not in the consult comments (such as a progress note or a sticky note):

  - the PID is not updated in the scheduling package

  - The appointment is scheduled in VS GUI using the original PID and linked to the consult

Updated PID
Return to Clinic Orders/Follow-Up Appointment

- Follow up appointments impacted by COVID- 19 (cancelled and not rescheduled or RTC orders not yet scheduled), are strongly encouraged to have an updated PID by entering a new RTC order.

- **Clinical Documentation of Updated PID**
  - Requires a new RTC order (submitted by provider)
  - Verbal order can not be accepted

Updated PID
Return to Clinic Orders/Follow-Up Appointment

- **Scheduling staff instructions**
  - Negotiate appointment date/time with the patient
  - Schedule the new RTC order
  - Disposition as "Removed/Scheduled-Assigned" in VS GUI
    - Applies to original RTC request or appointment request

"Follow-Up Appointment" Application

Scenario:

Mr. Davis follow up appointment was cancelled and not rescheduled due to COVID-19. The clinician reviewed the appointment and identified a clinically appropriate return date. A new RTC order was entered with an updated PID.

- Appointment request (original PID) was May 20, 2020
- New RTC order PID is September 23, 2020

- **What are the MSA's next steps**?

"Follow-Up" Appointment Application

- Appropriate documentation is a new RTC order.

✓ Negotiate appointment date/time with the patient

✓ MSA schedules the RTC order in VS GUI (PID = 9/23/2020)

✓ MSA dispositions the previous appointment request with the PID 5/20/2020 in VS GUI
  - "Removed/Scheduled-Assigned"

- Note: A new RTC order is entered when the PID is to be updated for RTCs not scheduled due to COVID-19. The "old RTC request" is dispositioned as "Removed/Scheduled-Assigned"

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Follow Up Question

- What if there was not a new RTC order to update the PID and the provider requests the MSA to schedule the follow up appointment that was impacted by COVID-19?

- How is the scheduling handled?

Follow Up Discussion

- If there is not a new RTC order, the MSA will schedule the appointment using the original PID in VS GUI
  - Unscheduled RTC order
  - Appointment request in VS GUI

- Always remember to negotiate the appointment date and time prior to scheduling
  - Note: If the provider has negotiated the follow up date/time with the patient and annotates in the new RTC , the scheduler may use this date/time and should schedule the appointment accordingly.
    - Key is that the appointment date must have been negotiated with the patient
    - Negotiating the appointment date/time with the patient by someone other than the scheduler is not routine practice but acceptable in certain cases.

AWESOME

Community Care Considerations

- When moving forward, the community care wait time standards (WTS) remain the same. Use the updated PID

Primary Care/Mental Health/Non-Institutional Extended Care Services	Specialty Care	Criteria
20 days	28 days	The WTS for community care must be considered if the following applies: 1. The PID on the consult is within 20 or 28 days (based on the type of care being requested) from the file entry date. 2. The appointment within the VA cannot be scheduled within the 20/28 days of the file entry date.

File entry date starts the timeline

No appointment availability

Timeline End

File entry date   PID   20/28 days

Consults & Community Care WTS

- A Veteran is eligible for community care under the Wait Time Standard (WTS):

  – When the original or updated PID is within community care eligibility wait time standards (WTS) and there is **no** appointment availability.

- A Veteran is not wait time eligible for community care:

  – When the original or updated PID assigned is outside of community care WTS.

  – When the original or updated PID is within community care eligibility wait time standards (WTS) and there **is** appointment availability

Application
Consults & Community Care WTS

Scenario:

Dr. [(b)(6)] has updated Ms. Wright PID in the consult comments and requests that the MSA reschedule the consult.

– Old PID March 30, 2020

– Consult File Entry Date March 28, 2020

– New/updated PID is August 10, 2020

• **What are the MSA's next steps**?

Application - Consults & Community Care WTS

- Consult updated PID is appropriately documented
- Important timestamps:
  - File Entry Date (FED) = 3/28/2020
  - Updated PID 10/10/2020

✓ Apply Community Care WTS

Good Job

FED
3/28/2020   20/28 days
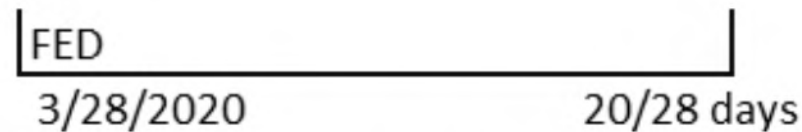
Note: FED = File Entry Date

PID
Date > FED + 20/28 days

Outside the WTS

✓ Schedule an Internal appointment

Note: Other Community Care eligibility criteria may apply

Follow Up Question

- What if the PID is not updated?

- Do we apply the same wait time standards for the original PID?

Follow Up Question - Discussion

- Let's look at the timestamps
  - File Entry Date (FED): 3/28/2020
  - PID: 3/30/2020

- Patient is wait time eligible for community care

FED	PID	
3/28/2020	3/30/2020	20/28 days
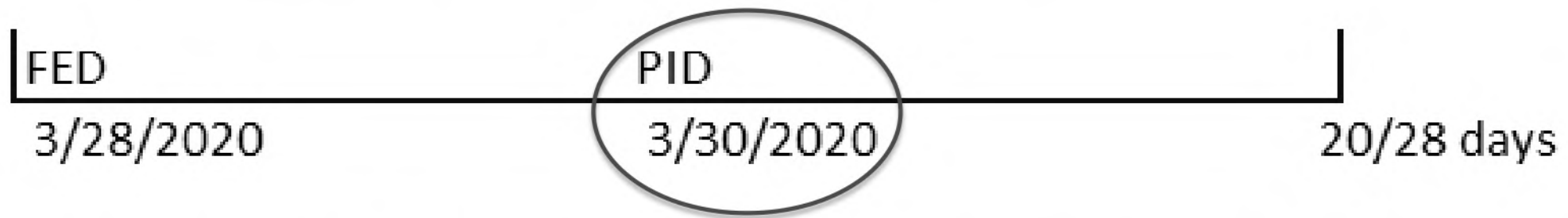
- Reminder – the PID is always clinically reviewed. Updating the PID is a clinical decision based on medical needs and not clinic availability nor consideration of community care eligibility.

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Application
Consults & Community Care WTS

Scenario

An orthopedic consult was submitted (consult file entry date = 5/1/2020). The consult was not determined to be urgent/emergent and was not scheduled. The orthopedic section is now expanding in-person care. The Referral Coordination Team clinical representative reviews the consult and clinical needs with the Veteran, updates the PID via the consult toolbox to 10/1/2020. The MSA on the team has been requested to schedule the appointment.

- **What are the MSA's next steps?**

Consults & Community Care WTS Discussion

- The PID was correctly updated in the consult comments
- Timestamps
  - FED: 5/1/2020
  - Updated PID: 10/1/2020

File Entry Date = FED

FED		PID
5/1/2020	20/28 days	10/1/2020
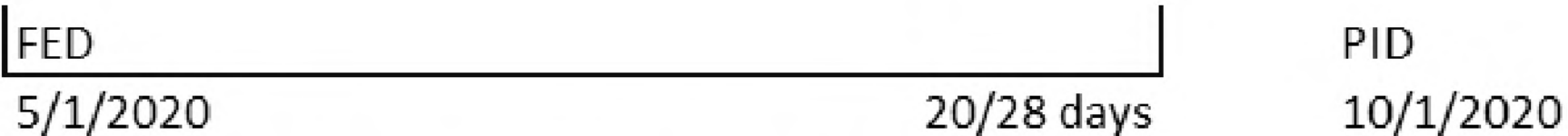
- The patient is not wait time eligible
- The MSA schedules the appointment in VistA and updates the PID. The appointment is linked to the consult

Note: Other Community Care eligibility criteria may apply

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Follow Up Appointments and Community Care WTS

- ## Same Community Care WTS rules apply
  - PID of the appointment request **<u>or</u>** the new RTC order (or current RTC) must be within 20-28 days of the RTC order entry date and **<u>no</u>** Appointment Availability
  - Updating of the PID is a clinical decision based on medical needs and not clinic availability nor consideration of community care eligibility.
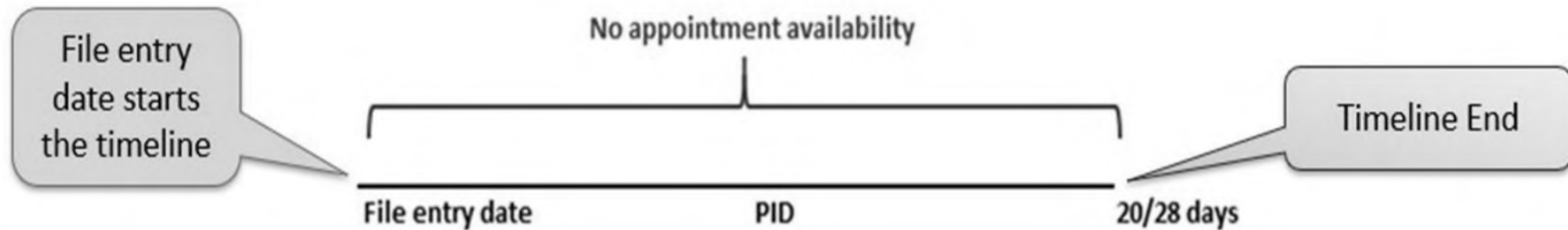
Application - Follow-Up Appointment & Community WTS

Scenario:

Ms. Fields' follow up appointment was cancelled and not rescheduled. Dr. ⬚(b)(6) has reviewed the appointment and has verbally requested that the appointment be rescheduled. A follow-up date was provided but a new RTC was not entered.

- RTC order file entry date (FED): 12/1/2019
- Original PID: 6/1/2020

- **What are the MSA's next steps?**

Application - Follow-Up Appointment & Community WTS Discussion

- A new RTC was not submitted, no updated documentation
- PID is 6/1/2020
- FED is 12/1/2019

File Entry Date = FED

- MSA determines that the PID is outside of the Community Care WTS

FED
12/1/2019   20/28 days

PID
6/1/2020

✓ ACTION: Schedule the appointment in VS GUI using the original PID
  - Following negotiation of the appointment date and time with the patient

  Note: A new RTC was not needed so there is nothing to disposition

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Application - Follow-Up Appointment & Community WTS

Scenario Spin

Dr. [(b)(6)] had a phone conversation with Ms. Fields to check up on her and determined that a follow up appointment was needed. She entered a new RTC order with a PID of 8/16/2020

- Original RTC FED 12/1/2019; PID 6/1/2020
- New RTC Order FED 7/29/2020; PID 8/16/2020

File Entry Date = FED

- **What are the MSA's next steps?**

Application - Follow-Up Appointment & Community WTS Discussion

- An RTC order was placed (new documentation)
- Time Stamps
  - New RTC
    - FED 7/29/2020
    - PID 8/16/2020
    - First available appointment is 8/20/2020

File Entry Date = FED

- MSA determines that patient is NOT eligible for Community Care under WTS


```
                    PID              1st available appointment
 FED
 |                   ◆                        ◆                          |
 7/29/2020        8/16/2020              8/20/2020              20/28 days
```

- ✓ Action: MSA schedules an internal VHA appointment using the new RTC. Disposition the old appointment request (12/1/2019) in VS GUI as Removed/Scheduled-Assigned. Other Community Care eligibility criteria may apply

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Guidance for Community Care Eligibility (COVID-19)

- If at any time a Service/Section must halt non-urgent/emergent in-person care due to an increase in COVID-19 in their community or as otherwise directed by their VAMC and/or VISN leadership, the following applies for community care eligibility
  - Referrals to community care will be based on MISSION Act eligibility
    - Wait time standards (WTS) as discussed earlier
    - Service is not available within the VAMC
      - If the services is not scheduling appointments due to the Pandemic, the service is considered "not available" and therefore the care can be referred to the community if the clinician deems it appropriate.
    - Veteran is being scheduled for an in-person VA appointment and cannot be seen at the VAMC facility.
    - Best Medical Interest (BMI) for the patient based on clinical review

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Virtual Appointments and Community Care Eligibility- COVID 19

- As your facility is moving forward, the following community care eligibility review process would apply for virtual appointment requests
  - Applies to both new and established patients

- The Veteran is being scheduled for a virtual appointment with the VA. i.e. VA Video Connect (VVC), Telehealth (TH), Telephone
  - The facility is not seeing in-person appointments OR the provider prefers to see the patient virtually based on safety considerations

Virtual Appointments and Community Care Eligibility COVID-19

- Schedule the appointment internally unless the Veteran requests to know his/her eligibility
  - If the Veteran requests to know his/her community care eligibility or states he/she is eligible for community care 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 VA and that staff share any COVID-19 related safety considerations and appointment availability in the community.
  - Local market impact on appointment availability & appointment modality options provided by the clinical team, taking into account the safety considerations

- Referrals to community care will be scheduled based on clinical urgency, market availability and safety considerations

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Community Care Eligibility Scenario – Moving Forward

- Mr. Smith saw his primary care provider (PCP) on 7/2/2020 and a consult ordered for endocrinology. The Endocrinology clinic has started to see Veterans for in person appointments other than emergent/urgent.

- The endocrinologist working in conjunction with the Referral Coordination Team (RCT) has determined that the initial appointment can be done via VA Video Connect (VVC).

- The RCT scheduler contacts Mr. Smith to schedule his VVC appointment and reviews the community care eligibility captured when DST was ran as the endocrinology clinic is in the moving forward phase.
  - In this scenario, Mr. Smith is eligible for community care due to drive time and must be offered the option to be seen in the community.
  - Communicating the options within the VA is key in this process and clearly community to Mr. Smith that although he is eligible for community care for drive time, there are options within the VA to provide the care and considering the current COVID-19 Pandemic, we have a VVC appointment options in order to safely render the requested care.

Virtual Care Scenario (COVID-19)

Scenario:

- Ms. Jones saw her PCP on 6/30/2020 and an orthopedic consult for evaluation for her persistent should pain was submitted. *Due to the COVID-19 pandemic the clinic is not scheduling any in person appointments at this time, unless upon clinical review it is determined that an in-person appointment is clinically necessary.*

- Following clinical review it is determined that a VVC appointment is appropriate.
  - Note the clinical member of the referral coordination team (RCT) determined that it was not clinically necessary or safe for Ms. Jones to be seen within the VA during the COVID-19 Pandemic and therefore it is also not safe to refer Ms. Jones to the community as the facility is not in yet seeing in-person visits other than those for urgent/emergent needs

- Ms. Jones turns down the TH appointment and a clinical member of the team determines that an in-person appointment is appropriate.
  - At that time community care eligibility must be reviewed and discussed with Ms. Jones so that Ms. Jones can choose the best option for her on where to get her care.
  - If she is eligible and wants community care, her request must be honored.
  - Note that prior to this decision, the RCT will discuss safety, availability and appointment modality options with the VA with the patient.

Test Your Knowledge

- Patient Indicated Date
  - When can the PID be updated?
  - Who can update the PID?
  - What are the documentation requirements?

Test Your Knowledge

- The PID can be updated on any appointment/consult impacted by COVID19 by the receiving provider or clinical team member.
  - Clinical team member: RN, LISW, Clinical Pharmacists, etc. on the team based on local policy
- Documentation Requirements
  - Consults: Updated PID in the consult comments
  - RTC Orders or appointment requests: New RTC order

Test Your Knowledge

Scenario:

The primary care service is ready to move forward and schedule in-person appointments other than urgent/emergent.

Dr. (b)(6) reviews Mr. Gonzalez's RTC order that was not scheduled due to COVID.   It is clinically determined that the PID is to be updated and a new RTC is ordered reflecting this.

- **What are the MSA's next steps?**

Test Your Knowledge

- Since the provider submitted a new RTC order the MSA:
  - ✓ Schedules the new RTC order following scheduling business rules
  - ✓ Dispositions the "old RTC" order in VS GUI as "Removed/Scheduler Assigned"

Test Your Knowledge

- When do community care wait time standards apply?
- If the PID is updated, does that impact community care wait time eligibility?

Test Your Knowledge

- A patient is eligible for community care wait time standards when:

  - The patient indicated date (PID) is within 20 days (primary care and mental health) or 28 days (specialty care) of the file entry date of the consult or RTC order **and** there is no appointment availability

- If the PID is updated (appropriate documentation), apply the new PID.

No appointment availability

File entry date starts the timeline

Timeline End

| File entry date | PID | 20/28 days |
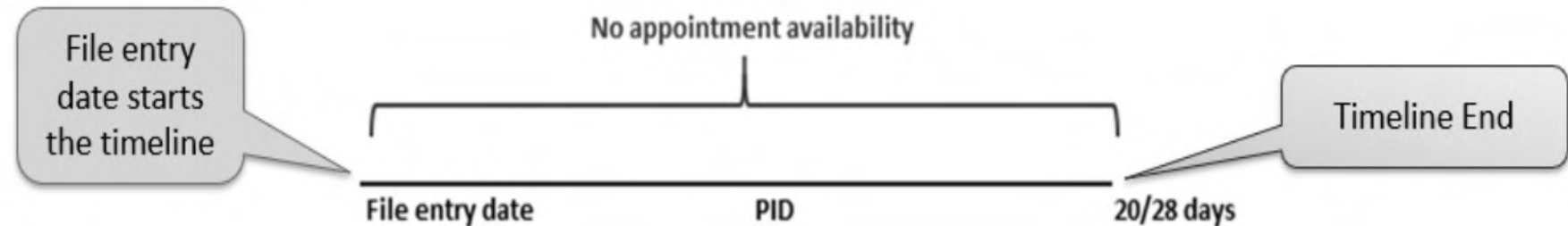
Test Your Knowledge

- What about if the PID was not updated? Same rules?

Test Your Knowledge

- Yes, same rules apply.
  - Consult, use the original PID
  - RTC Order, use the original PID
  - Appointment Request, use the original PID

- Reminder:
  - When the PID is not updated: Schedule in VS GUI, the software will automatically pull the PID *(Scheduling staff cannot change it)* as usual
  - When a consult PID is updated, schedule in VistA

Test Your Knowledge

Scenario:

- The PCP enters a Physical Therapy consult for shoulder pain.

- The receiving service reviews the consult and due to the clinical need, modifies the PID to a later date.

- The original PID was the same date the consult was entered.

- The clinical staff entered in a new PID of 27 days from the entry date.

- **What are the MSA next steps?**

Test Your Knowledge

✓ The scheduler receives the consult to schedule and reviews the consult.

   ▪ Identifies the updated PID in the comments and knows to schedule in VISTA and not VSE.

✓ There isn't an available appointment for 45 days into the future.

   ▪ In this situation the updated PID is within 28 days of the entry date but the appointment date falls well outside the 28 days

✓ The Veteran is Community Care eligible under the wait time standards.

Test Your Knowledge

Scenario:

- PCP enters in a consult for a Veteran to see the newly hired VA Chiropractor.

- The Veteran is going out of town for the next 30 days and requests a VA appointment after he returns.

- The PCP enters in a PID for the VA care of 45 days into the future.

- **What are the MSA's next steps?**

Test Your Knowledge

- The scheduler reviews the consult and contacts the Veteran for scheduling.

- Due to the PID being greater than 28 days from the file entry date, the Veteran is not wait time eligible for Community Care and the scheduler would complete the scheduling process.

*Note: Other Community Care eligibility criteria may apply

References

- Office of Community Care Field Guidebook
  - https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/Site Pages/FGB.aspx
- VS GUI User Guide
  - *https://www.va.gov/vdl/documents/Clinical/Scheduling/VSE_GUI_1 6_User_Guide.pdf*
- Return to Clinic Training Site
  - *https://dvagov.sharepoint.com/sites/vhareturn-to-clinic-rtc?e=1%3A5c6bf5e8f34b4b4d851120fd2e0dd2e0*

Department of Veterans Affairs

Veterans Health Administration

Referral Coordination Initiative Implementation Guidebook

Updated: September 28, 2021

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1 EXECUTIVE SUMMARY

Referral Coordination Initiative Objective

1.1 The Referral Coordination Initiative (RCI) is the Veterans Health Administration's (VHA's) revised process to streamline the referral process. This change shifts the work of multiple clinical staff members to dedicated Referral Coordination Teams (RCTs) of administrative and clinical staff dedicated to RCI.

VHA is committed to improving referral timeliness and empowering Veterans with understanding the full range of their care options. In response to the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act implementation and the ongoing COVID-19 pandemic response, VHA's change to its referral process will improve timely access to care and the overall Veteran experience.

Veteran feedback suggests many prefer to receive internal/direct VA care, regardless of eligibility for community care. The RCT provides every Veteran a complete picture of their care options so he/she can make the most informed care decisions.

Without an improved consult/referral process, the scheduling of referrals will take more time than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community. The terms **consult** and **referral** are used interchangeably throughout the guidebook. The intent is to have RCTs review clinically appropriate care options and community care eligibility (if applicable) with Veterans – then move referrals from a pending/unscheduled status to a scheduled status in a timely manner.

Clinical RCTs will guide Veterans through their full range of care options including internal/direct care in VA and care in the community. All staff should discuss benefits of receiving internal/direct VA care with every Veteran. The ultimate decision regarding where eligible Veterans will receive their care remains with the Veteran. Administrative RCTs then schedule VA or community care appointments based on Veteran eligibility and preference in a timely manner. The goal is to move to scheduled status within three (3) days for internal/direct VA care and three (3) days for community care.

RCTs at each VA medical facility will ensure Veteran care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

- Access to RCT support and comprehensive information about care delivery options including face-to-face care, all available telehealth options and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects eligible Veteran's preference for internal/direct VA care or care in the community

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Purpose of Referral Coordination Initiative Guidebook

1.2 The Referral Coordination Initiative Guidebook is a centralized source of information to support local deployment of RCI. Department of Veterans Affairs Medical Centers (VAMCs) and Veterans Integrated System Networks (VISN) are encouraged to utilize the guidance documents within to tailor strategies locally to improve timeliness and standardize Veteran education on care options both within VHA and in the community. This guide is intended to be used by VHA staff.

Future Updates to Referral Coordination Initiative Guidebook

1.3 The Referral Coordination Initiative Guidebook is a living document that will be updated as frequently as monthly as new guidance and tools are developed to support this work.

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2 REFERRAL COORDINATION INITIATIVE INTRODUCTION

What is Changing and Why?

Understanding the what, why, what is not, benefits and risks of this initiative clarify the reason we are making this change. We developed a change management tool to address these important questions called the Six Essential Questions.

2.1

1) What is Changing?

The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

2) Why is it changing?

VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

3) Why is it changing now?

Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

4) What is not changing?

VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran's needs and life goals – whether that is internal/direct VA care or care in the community. Eligibility standards for community care are not changing.

5) What are the benefits of this change?

RCTs align with VHA's modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

6) What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community.

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Future State

Veterans have more options than ever to receive the best, timely care. RCI's streamlined referral process will empower every Veteran to make more informed care decisions and prevent delays in scheduling critical, high quality care.

2.2 The future state process is illustrated in Figure 1: RCT Process for Referrals.

Veteran Experience *

| Veteran needs care/referred for care | Veteran offered the ability to schedule and RCT appointment prior to leaving | Veteran reviews all care options and eligibilities with clinical RCT | Veteran selects care options including same day appointment if available | Appointment Scheduled |

RCT Process Map *

Referring provider places SC Consult/Order → Veteran selects to schedule an RCT appt prior to leaving → Consult triaged by RCT → Determine Eligibility → Call Veteran to discuss (1) eligibility, (2) value of choosing VA and (3) care options/modalities → Veteran chooses (when applicable) modality of VA or Community Care → Choose's VA → MSA schedules appointment → Internal VHA or CC appt scheduled

Referring provider MSA schedules RCT appointment → RCT initiates appointment

Figure 1: RCT Process for Referrals

Not all consults will result in a scheduled appointment. RCT to assess all care options including E-Consults, testing, medication refills, etc.

A more detailed process map is available for reference.

RCTs will work across Primary Care, Mental Health and Specialty Care Medicine/Surgery services. RCTs will:

- Provide each Veteran with information about all appropriate care options available, including in-person, virtual and telephone.
- Determine Community Care eligibility and secure Veteran appointments when appropriate.
- Coordinate with clinical and administrative staff who have training in both VA in-house and community care scheduling processes to eliminate unnecessary steps and people from the process – making it easier and quicker to schedule.

VHA aspires to achieve scheduling referrals on average within 3 days from time the referral is entered into the Electronic Health Record (File Entry Date) to first scheduled (1st scheduled) for both internal/direct care and community care. This is to assure that Veterans receive timely care regardless of where care is delivered. The Office of Community Care and the RCI team have developed a glidepath of scheduling timeliness milestones for community care that use

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multiple process improvement tools to support VAMC's journey to reach the ultimate aspirational goal of 3 days for both internal/direct and community care scheduling.

Team Composition

2.2.1 The RCT will include dedicated clinical and administrative staff with the capability of coordinating care for internal/direct VA care and community care needs for Veterans. The clinical staff within RCTs should be nurses. Sites may use Doctor of Medicine (MD), Doctor of Osteopathy (DO), nurse practitioner (NP) and/or physician assistant (PA) during the transition to RNs on this team. These team members should be cross-trained to triage internal/direct VA care. Additional responsibilities include:

- Conduct initial triage on all consults/referrals.
- Run the Decision Support Tool (DST) or determine Community Care eligibility through alternative means.
- Call Veteran to review all available care options including internal/direct VA and community care when eligible.
- Document the conversation with the Veteran using the Consult Toolbox (CTB) tab when it is available (currently in production).
- Introduce the Veteran to the administrative staff member of RCT to schedule the appointment.

The **administrative staff** members should be schedulers or the equivalent. The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. Cross-training of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility, services offered and timeliness of care in the community. The RCT must be able to speak to both internal VA and community care options and processes to get 2.3 the patient scheduled in a timely manner.

VAMCs with Limited or No On-site Specialty Care

All VA Medical Centers (VAMC) are required to implement RCI. VAMCs with limited or no on-site specialty care should work with their VISN and VAMC leadership to develop a VISN-level inventory of available services as alternate care options for Veterans who are eligible for Community Care. VAMCs must develop appropriate service-level agreements between VAMCs for appropriate E-Consult reviews and/or in-person/virtual care appointments for Veterans who choose this alternate care option within VA. Reference the VISN Referral Coordination section for more details.

Another option for Veterans who are eligible for Community Care is virtual appointment using VA's Clinical Resource Hubs (CRHs). CRH can provide virtual specialty care to Veterans as an in-house alternative to Community Care.

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Ideal Process for VAMCs with Limited or No On-site Specialty Care

Referring providers will inform the Veteran during his/her initial visit that the RCT will be contacting them within three (3) days to review their eligibilities and available care options, including internal/direct care in VA and in Community Care using available modalities including in-person, virtual and telephone care.

2.3.1

VAMCs must decide whether the RCT will be located at the site originating the referral or at a partner site (either a remote location or another VAMC). If the RCT is at the originating site, the referring provider enters an E-Consult or internal/direct consult. If the RCT is located elsewhere, the referring provider enters an E-Consult or inter-facility consult as appropriate.

In either case, the Veteran will have the option to meet with the RCT or arrange a future meeting with the RCT prior to leaving the referring provider's office. The RCT, regardless of where it is located, follows the RCT Process for Referrals (please review Figure 1: RCT Process for Referrals).

While each facility may develop strategies to address referral coordination, key minimum required strategies include:

- Implement Referral Coordination Teams.
- Eliminate direct entry of community care referrals by referring providers.
- Work with VISNs to establish a network of interfacility consults between VAMCs to support facilities with limited or no on-site specialty care services.
- Offer Veterans the ability to schedule a Clinical RCT appointment at check-out.
- Identify scheduling preferences for all Veterans who choose community care.
- Utilize RCI Clinical and Administrative staff model recommendations to support a dedicated RCT.

2.3.2

What This Means for Veterans

Local RCTs help Veterans make more informed decisions about their care while ensuring their appointments are scheduled in a timely manner for the care they need. RCTs determine all clinical care options and all potential community care eligibilities. VA will continue provide an exceptional experience and deliver high-quality care and serviced – whether the Veteran chooses internal/direct care in VA or care in the community.

With RCI, every referred Veteran can expect:

- A warm handoff from their referring provider's office to an RCT member either in-person, via VA Video Connect, or telephone
- An RCT point of contact to guide them through the referral process and their full care options
- A referral to move from a pending/unscheduled status to a scheduled status within three days for VA care and three days for community care

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What This Means for Staff

In addition to providing a better experience for Veterans, RCI helps VA staff prioritize responsibilities. RCI will unburden referring providers from specialty care specific discussions around referrals and will allow them to focus on internal/direct patient care, initiating the "Choose VA" conversation with Veterans, and identifying future care needs of the Veteran.

2.3.3

Dedicated facility-level RCTs serve as an extension of Primary Care, Mental Health, and Specialty Care providers. They will review and triage referrals and discuss with the Veteran all available options for care locally, virtually, in other VA locations and community care based on eligibility.

RCT will allow Specialists to work at the top of their license, focusing on delivering internal/direct patient care for Veterans. In addition, all referrals going through the RCT/specialty care will eliminate the direct entry of community care consults from referring providers. This provides a more streamlined and thorough approach to the referral process, ensuring Veterans are offered care modalities that best meet their needs

RCI will help maintain funding of specialty care and subsequent resources that allow VA to deliver the highest quality care. RCI aligns with VHA's Modernization and High Reliability Organization efforts through commitment to good financial decisions that best serve Veterans – including decisions that impact VA's on-going ability to fund specialty care services Veterans rely on.

2.4   Support

Trainings, scripts, communications materials, dashboards, change management tools, and field-developed strong practices will be deployed to support this initiative. Further guidance on these materials will be provided in future iterations of this guide, as well as RCT meetings.

This iteration of the guidebook includes guidance on How to Get Started, RCT operations, **Error! Reference source not found.**, Best Medical Interest (BMI) information, DST changes, community care scheduling and examples for strong practices.

The email group for the RCI is ^{(b)(6)} @va.gov.

3 ROLES AND RESPONSIBILITIES OF RCI

It takes a comprehensive and collaborative approach to implement RCTs at both the local and VISN level. We have outlined the general roles and responsibilities of various VISN and local facility staff to give you a better understanding of the RCI's collaborative nature. This list may not be exhaustive of all roles.

Executive Sponsors and Facility/VISN Leadership Support

3.1 Each VAMC and VISN will identify an Executive Sponsor to support the Referral Coordination Initiative. Executive Sponsors are responsible for ensuring their facility and VISN are fully supporting and moving RCI forward. Executive Sponsors remove barriers to improving processes identified by the project team as appropriate.

The Executive Sponsors should be a member of the Executive Leadership Team (ELT). We recommend the VISN Executive Sponsor be the Chief Medical Officer (CMO) (and the Chief Nursing Officer (CNO), if applicable, may also be appointed). We recommend the facility-level Executive Sponsor be the Associate Director for Patient Care Services (ADPCS), Chief of Staff (COS) or Deputy COS.

Process improvement is most effective when leaders:

- Demonstrate effectiveness in clarity of vision, decision making, relationship building, inclusion and conflict management.
- Enhance and cultivate leadership capabilities in project team.
- Empower the organization and teams to think, act, and move as a network.

3.1.1 From planning to post-implementation, the leadership will act as a network and utilize the six essential change management questions to establish accountability.

Facility Executive Sponsors and Leadership

Facility Executive Sponsors serve as the catalyst to promote RCI buy-in and implementation at the facility level. Executive Sponsors oversee the development of a multidisciplinary Implementation Team. Staffing model suggestions are available in the Staffing, Reallocation of Resources, and Productivity Goals Section.

Facility Executive Sponsors' responsibilities include:

- Establish RCT oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 compliance).
- Attend the facility's Referral Coordination recurring meetings.
- Ensure all relevant RCI matters (including progress, implementation updates, barriers, action plans to remove barriers, etc.) are recorded and routed through the facility's governance structure.
- Oversee and develop multidisciplinary RCTs.

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VISN Executive Sponsors and Leadership

VISN Executive Sponsors serve as the catalyst to promote RCI goals and expectations to facility executive leadership team, service chiefs and other leaders as needed to ensure RCI is successfully implemented within the VISN. The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and 3.1.2 development of VISN level teams as appropriate.

VISN Executive Sponsors' responsibilities include:

- Establish VISN RCI oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 Compliance).
- Maximize VA resource utilization within VISN by overseeing resource capacity, efficiency and productivity.

Please review the Funding Referral Coordination Teams

Additional funding will not be provided for this initiative. We expect Executive Sponsors to develop the RCT by leveraging staff already supporting administrative and clinical areas that will benefit from the improved process to address (please review the Staffing, Reallocation of Resources, and Productivity Goals Section). Referral coordination is already being done at most sites, but it may not be coordinated based on the current process. Facilities and VISNs that do not have this staff on hand may need to add additional resources.

3.2 RCT Oversight

RCT oversight is critical to the success of Referral Coordination. Local facilities and VISNs need to oversee the RCI development, implementation and evaluation to ensure RCI progress is moving forward as expected. This can be accomplished through either establishing an RCT Oversight Committee *or* incorporating RCT oversight into an existing committee as a standing agenda/reporting item. Examples of existing committees include (Access Committee, OCC Oversight Council, Consult Steering Committee).

To meet the intent of RCT oversight, the following key stakeholders should be included in the development of a new committee or included in current committee structure:

- Executive Clinical Leadership
- Administrative Officer and/or Chief, Medical Service
- Administrative Officer and/or Chief, Surgical Service
- Administrative Officer and/or Chief, Primary Care Service
- Administrative Officer and/or Chief, Mental Health Service
- Administrative Officer and/or Chief Physical Medicine and Rehabilitation Service
- Administrative Officer and/or Chief, Neurology Service
- Administrative Officer and/or Chief, Strategic Planner
- Administrative Officer and/or Chief, Dental Service
- Administrative Officer and/or Chief, Healthcare Administration Service
- Administrative Officer and/or Chief of Staff or designee

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- Administrative Officer and/or Chief, Community Care
- Group Practice Manager (GPM)

RCT oversight ensures RCI implementation is staying on track. Below are key actions to include in the committee meeting.

- Review, customize, and update charter to include RCT oversight (please review the <u>RCT Oversight Section</u> for 508 compliance)
- Establish regular reporting cadence for RCT implementation/progress.
- Develop a mechanism to track action items and ensure follow-up as suitable to the facility/VISN needs.
- Review key indicators and metrics presented by the implementation team (please review the <u>Data and Measuring Success Section).</u>

RCI Champions

3.3 Referral Coordination Champions are key to the success of RCI. They will drive the development, implementation and evaluation of the RCT. An RCI Champion will be appointed at each facility and at the VISN. We recommend facility Champions be the GPM and the VISN Champion be an RCI Manager and/or Business Implementation Manager (BIM).

3.3.1 Facility Champion

Facility Champion responsibilities include:

- Identify and lead RCI Implementation Team.
- Disseminate information and communication materials to staff.
- Help operationalize the RCTs.
- Identify, address, and report barriers to the Executive Sponsors.
- Track implementation progress and metrics (please review the Data and Measuring Success Section).
3.3.2 - Provide feedback to the local RCI implementation team and VISN RCI Leadership on overall initiative progress and ways to improve implementation moving forward.

VISN Champion

The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and development of VISN level teams as appropriate.

VISN Champion responsibilities include:

- Ensure consistency of RCT functions and use of RCT tools across facilities.
- Disseminate appropriate RCI materials.
- Develop VISN-level triage tools as needed.
- Develop and manage VISN RCT as appropriate.

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Clinicians Related to the Referral Coordination Process

Referring Provider

The referring clinician are the first step in the referral process.

3.4 The referring clinician will:

3.4.1
- Participate with Specialty Care and RCT in the development and/or updating of service agreements.
- Follow established pre-referral guidelines/clinical pathways outlined in the electronic health record prior to entering a consult/referral.
- Enter consults prior to concluding the appointment, where applicable.
- Communicate with patient about the basic referral coordination process.
  - Referring provider enters referral.
  - RCT will review/triage/gather additional information and determine care options available both at VA and in community.
  - RCT will communicate with patient care options and allow Veteran to decide regarding where to schedule.
  - Provide Veteran with the RCT Fact Sheet (coming soon).

Facility Clinical Specialty Care Service

3.4.2
Facility clinical specialty services are responsible for providing subject matter experts to support RCTs. During the early phase of forming RCTs, facility clinical specialty services will work collaboratively with and train the RCT team to understand specialty care needs and services offered. They will build a collaborative relationship so that the RCT is an extension of the specialty service. They maintain ongoing collaboration and manage quality control with RCT clinical staff in the triage/scheduling process.

Facility clinical specialty services responsibilities include:

- Collaborate with RCT and referring providers to develop pre-referral guidelines, clinical pathways, modifications of consult templates as needed, and service agreements.
- Develop clinical triage tool that encompasses the collaborative RCT process (pre-determined clinical and scheduling guidelines utilized by the RCT for consult review, triage, documentation and scheduling).
- Provide specialty service training to the RCT Triage/Scheduling Team on the triage and scheduling of referrals in the designated services (please review the How to Get Started Section).
- Retain the overall responsibility of designated triage and management of referrals that do not easily conform to guidelines.
- Facilitate ongoing collaboration with RCT by working on day-to-day communication regarding triage and scheduling.

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Referral Coordination Team

RCI establishes dedicated local and/or VISN RCTs to manage all consults/referrals. RCTs support the national standardization of how VHA addresses referrals and align with the future deployment of Cerner and efforts to standardize referral templates.

3.5 RCTs serve as the liaison between referring providers and specialty care services. They remove an administrative burden from clinicians, enabling them to spend more time focused on Veteran care by allowing non-Licensed Independent Practitioner (LIP) staff (Registered Nurses (RNs)) to clinically triage consults/referrals. RCTs improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.

Minimal RCT Composition

3.5.1 RCTs are required to be staffed with administrative and clinical support to quickly receive and manage Veteran referrals. The minimal composition will be a clinical team member and an administrative team member. RCT clinical staff guide every Veteran through all internal/direct VA and community care options, and RCT administrative staff then schedule appointments based on individual Veteran eligibility and preference.

Because of RCI's clinical nature, individuals who are licensed and qualified to assess patient's medical conditions either face to face, via telephone, by medical record review, etc., should be identified as the primary RCT coordinator. We highly recommended that an RN serves as the RCT clinical team member. Administrative support with Medical Support Assistant (MSA) staff is critical to the timely scheduling and coordination of appointments.

3.5.2
Clinical RCT Staff

The clinical RCT staff will receive and triage all referrals to the specialty service. This includes referrals both internal and those eligible for community care. **Consults/referrals need to go through the RCT first and should not go directly to community care.**

The RCT clinical staff should ideally be a RN. Sites may use MD/DO/NP/PA during the transition to RNs. They should be cross trained to triage both internal/direct VA and community care referrals.

Clinical RCT's responsibilities include:

- Perform initial triage on all consults.
- Run the DST or determine community care eligibility through alternative means.
- Call every Veteran to review possible options for care including internal/direct VA and community care if eligible.
- Document the conversation with the Veteran using the RCI Consult Toolbox (CTB) tab (currently in production).
- Complete a warm hand-off (defined in RCI Operations) to the Administrative RCT to schedule the appointment.

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The RCT clinical staff uses a triage tool to guide decision making and determining all options of care available based on Veterans clinical need. Once the clinical triage is completed, the Clinical RCT guides the Veteran through their full range of care options based on recommendations from the triage tool. This can include a clinical conversation with the Veteran for complex care needs and options and/or an administrative conversation based on clear direction from the clinical triage note.

As previously mentioned, RCI's streamlined process is collaborative. The Clinical RCT collaborates with the following care team members as needed based on triage training protocols and training:

- Referring provider if additional information is needed
- Specialty providers during the daily triage process
- Veteran to present and discuss all appropriate care delivery options (e.g., telephone, VA Video Connect, traditional Clinical VA Telehealth (CVT), face-to-face, community care) based on referral triage
- Administrative RCT to schedule the Veteran referral appointment in a timely manner
- Community Care handoff when appropriate

Note: Communication and discussion with patients regarding VA care options can occur with both the clinical and Administrative RCT members. This is driven by the clinical nature of the specialty care request and considering the request's complexity or simplicity. To maintain an efficient RCT process, optimization of processes and having the right staff do the right task is essential in utilizing clinical and administrative staff to the full scope of their role. Depending on the specialty and complexity of care requested, it may not always require a Clinical RCT to communicate with patients their options for VA care. Please review the RCT Operations Section for more details.

3.5.3

Administrative RCT Staff

The RCT administrative staff will share with Veterans all their options for care during the scheduling process. This is driven by the RCT clinical plan/instructions documented on the consult. Administrative RCT should be a scheduler, MSA or equivalent.

Administrative RCT responsibilities include:

- Call Veterans to discuss care options and schedule appointments as indicated by the RCT clinical team member documentation.
- Use of DST to determine community care eligibility as appropriate.
- Document scheduling efforts utilizing CTB on the consult/referral.
- Document the discussion of VA wait times vs. community wait times when appropriate.
- Record a Veteran's community preferences, including if a Veteran chooses to self-schedule their community care appointment per Community Care Scheduling Enhancement Memo.
- Analyze the travel distance to select the most appropriate clinic location.
- Send the Veteran's appointment letter.

- Verify the Veteran's contact information.
- Collaborate with RCT clinical team and with facility scheduling staff as needed.
- Ensure a warm and seamless handoff to Community Care when appropriate.
- Develop collaborative communication processes for the local facility RCT to reach out to VISN RCI or assistance.

Additional MSA guidance, including functional statement and competencies templates are linked below:

- MSA Functional Statement Template
- MSA Competencies Template

Clinical Pharmacy Staff

3.5.4 The RCT clinical pharmacy staff should be included in the RCT where possible and partner with the RCT clinician when appropriate to address patient needs.

- For service specific RCTs, the Clinical Pharmacy Services should be considered as a key member of the RCT for the specialty area they are aligned with.
- For centralized RCTs, the Associate Chief of Clinical Pharmacy Services should be considered as an integral member of the RCT specifically to ensure that processes are in place so the RCT clinical nurse is aware and can identify consults where a CPS would be the most appropriate provider to the Veteran.

The CPS should be involved in ensuring processes are in place so the RCT clinical nurse is aware and can identify consults where the CPS would be the most appropriate provider to the Veteran. Specific scenarios for involvement of CPS in RCT are outlined below.

  o **Veteran is referred from primary care for pain management services.** The Pain RCT clinical nurse reviews the chart and determines the Veteran is being referred for medication management of their opioid therapy. The RCT clinical team discusses the care needed involving the CPS and the RCT nurse calls and offers the Veteran an appointment with the CPS for medication optimization. Although this facility had wait times for the pain management physician, the RCT identified a patient where medication management was needed and guided the Veteran to the correct provider to evaluate that care rather than using his wait time eligibility for community care

  o **Veteran, after a recent HF exacerbation, is consulted to the Cardiology service for evaluation and management by their primary care provider.** The Cardiology RCT clinical nurse evaluates the consult and determines the Veterans medication regimen is not optimized. The RCT clinical team discusses the care needed involving the CPS and the RCT nurse calls and offers the Veteran an appointment with the CPS for medication of their heart failure medication regimen. Although this facility had wait times for a cardiologist, the RCT identified a patient where medication management was needed and guided

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the Veteran to the correct provider to evaluate that care rather than using his wait time eligibility for community care

Veteran requiring MH care is referred from primary care for management of depression. The mental health RCT clinical nurse evaluates the consult and determines the Veterans medication regimen is not optimized. The MH service has wait times for mental health due to a current psychiatrist shortage. However, the MH health CPS does have openings on her schedule for the Veteran to be seen. The MH RCT nurse speaks with the Veteran about the role of the CPS as part of the MH team and schedules the Veteran with the MH CPS for evaluation. The Veteran chooses to keep his care in the VA rather than using his wait time eligibility for community care.

Supplemental Role and Responsibilities Materials

3.6
- Example of Oversight Charter (Community Care)
- Example of Oversight Charter (Access and Consult Committee)
- MSA Functional Statement Template
- MSA Competencies Template

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4 HOW TO GET STARTED

Identifying and putting together Referral Coordination Teams at both the local VAMC and VISN takes coordination, collaboration and teamwork! Local facilities and VISNs will work with the National RCI Implementation Teams, using the tools and training that has been provided to date. The facilities use the guidebook in conjunction with the RCI Implementation Checklist to ensure appropriate RCI implementation.

This section will outline steps to get your RCT off the ground. In the event there is VISN RCT structure in place, the local executive sponsors/champions will work collaboratively with VISN RCT to develop consistency between local and VISN RCT (refer to VISN Referral Coordination section).

RCI Implementation Checklist

4.1 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. The checklist was created in collaboration with the Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) and subject matter experts (SMEs) from respective medical centers. The checklist will allow VAMCs to strategically implement RCTs while ensuring that required elements are completed to successfully implement, execute and have oversight of the initiative.

The RCI Implementation Checklist captures high level tasks and sub-tasks, which are broken down by implementation phases. Below is a breakdown of the phases and number of tasks associated with each phase.

Table 1: RCI Implementation Phases and Tasks

RCI Implementation Phase	Number of Tasks
Planning	20
Execution	50
Oversight	14

VAMCs will be tasked with updating their RCI Implementation Checklist bi-weekly on the following site, using the template within the site. Instructions on how to update the checklist can be found here. The VISN RCI Standards and Expectations for Fiscal Year (FY) 21 memo communicates this requirement. The Access Office will be using the information submitted by the VAMCs to track implementation progress.

Watch 'RCI Implementation Checklist Training' here

Additional training and resources to assist with completing the RCI Implementation Checklist can be found here

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Develop the RCI Implementation Team

Select Implementation Team Members

4.2

4.2.1

The RCI Champion will work with facility Executive Sponsors to establish an implementation team. This team is responsible for driving change at the facility in the development and implementation of RCT as outlined in this guidebook. This team meets routinely with an agenda and action items to progress implementation.

Recommended stakeholders are listed below:

- Chief of Staff/Deputy Chief of Staff
- Primary Care
- Mental Health
- Specialty Care
- Community Care
- Nursing
- Clinic Practice Management (CPM) Team
- GPM
- Health Administration Service (HAS)
- Administrative Leads
- Public Affairs Officer (PAO)
- Clinical Application Coordinator (CAC)'s (optional)
- Data Analytics Group (if applicable)

4.2.2

Develop Implementation Plan

The RCI implementation team will develop a facility implementation plan, utilizing the RCI Checklist, Guidebook and National RCI tools and guidance. Below are key actions to follow when developing the implementation plan:

- Review and compare current state at local site and recommended RCT process flow, roles and responsibilities. (Please review the Roles and Responsibilities of RCI
- Conduct a workload analysis and prioritize implementation by service line/specialty.
- Determine the best RCT model to implement for the facility.
- Develop a facility communication/change management plan for respective stakeholders.

4.2.3

- Develop a training plan for the key stakeholders (referring clinicians, RCT, specialty care service).
- Utilize transformational coaches and VISN RCI group at their facilities or VISNs.

Monitor and Communicate

The Champion or CPM team will support ongoing communication between all necessary groups, including facility leadership and VISN RCI leadership. This support includes the following:

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- Establish routine meetings with ELT to provide updates and feedback.
- Attend frequent huddles with RCTs and RCT Oversight Committee to discuss key findings or trends.
- Arrange meetings with Primary and Specialty Care leadership to discuss the collaborative nature of RCT, roles/responsibilities of each area, etc.
- Routine communication with VAMC/VISN RCT Executive Sponsors and Champions to report program progress, risks and issues.
- Collaborate with VISN RCI leadership for consistency throughout VISN, building bridges with other facilities for services not offered locally.

Conduct Workload Analysis

Workload Analysis

4.3 To perform a workload analysis, it is recommended that the implementation team review the
4.3.1 recommended RCT process. A more detailed process map is available.

After reviewing the recommended process map, the implementation team reviews and compares the local processes with the recommended RCT process with subject matter experts. Following the review of local processes, the implementation team performs a gap analysis. The team assesses the differences to identify attributes that are needed to develop a successful RCT. Some questions to consider are listed below.

When evaluating the current state:

- What is happening (volume of referrals leaving VA, which specialties)
- What is the impact (unique patients and consults going to the community, perception of the local VA)
- What is the financial impact to the VA (dollars going to the community)

When developing a future state:

- What should happen at your facility
- When it should happen
- What changes need to be made for it to happen
- Why is it better than the current situation (timeliness of care, patient satisfaction)
- Who will benefit (quality of care, continuity of care, cost of care)

4.4

Share the findings with appropriate stakeholders, capture input and use the information to inform the next steps on the checklist.

Prioritize RCT Implementation by Service Line/Specialty

Evaluation of internal specialty care resources and workload will help the facility determine the prioritization of RCT implementation for specialty care. Facilities are expected to follow the national guidelines/timelines for implementation of services. However, it is important to review a few critical items to determine where the greatest need exists:

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Specialties with:

    a. Access issues/appointments with increased wait times (WT)
    b. The highest overall volume of referrals
    c. The highest community care demand
    d. The longer referral processing times
    e. Significant clinician time spent triaging

1.   f. Increased Veterans with drive time eligibility
    g. The highest volumes of community care referrals with Best Medical Interest (BMI) as the eligibility since beginning use of DST
    h. A strong clinical champion
    i. Strong academic affiliations

2. Modalities of care being offered (i.e., Telehealth, VA Video Connect (VVC), Face to Face, Telephone Clinics)

3. Time providers spend triaging consult (time that could otherwise be used to implement VVC, Telehealth, telephone appointments, procedures, etc.)

4. Specialty care services not offered by the local facility but potentially offered within VISN

5. Gap Analysis that includes staffing and clinical services offered at the facility and across the VISN

6. Patient Self-Referral Direct Schedule (PSDS) Clinics
    a. PSDS is a process where Veterans can call a Specialty Care clinic directly to schedule an appointment for routine care without needing a referral.
    b. If RCT leadership feels that PSDS is resulting in inappropriate referrals into the community and/or irresponsible utilization of care, it is appropriate to halt the direct scheduling and run through RCT.

4.4.1 Update CPRS Consult Menu

The local Computerized Patient Record System (CPRS)/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

1. Work with Specialties and Community Care, Consult Committees, etc., to determine what unavailable services can be offered at the VISN or other VAMCs/the Department of Defense (DoD).
    a. Establish a process for Inter-Facility Consults (IFCs) and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
    b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.

2. Use VISN menu of services to determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. Remove Community Care (CC) referral menu to drive the in-house referral option. There should be very limited referrals available to referring providers in order to promote use of RCT and available internal care options.

3. Establish order menu.

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Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the <u>CPRS Technical Guide</u>).

Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.

4.   Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.

5.   a.   Train providers *before* the menus are setup.

6.   ## Staffing, Reallocation of Resources, and Productivity Goals

4.5   This section will provide guidance on appropriate staffing roles and productivity goals. This guidance provides sites the flexibility to determine the best way to reach these desired outcomes given the structure and staff currently available at one's site and VISN.

Staffing ratios are dependent on the service and how each service utilizes their nursing allocation may alter the ratio. Multiple tools are needed to ensure efficiency of the RCT and will be provided as the guidebook is developed. To be successful, the team needs to have the following information easily accessible: (1) clear triage directions, use of a clinical triage tool (2) internal and external options available and applicable to the Veteran, and (3) simple scheduling instructions.

The RCT will be triaging and dispositioning the referral; informing the Veteran of their internal and external modalities of care options; and scheduling care. The recommended initial RCT triaging productivity target is approximately 25-45 referrals per day per clinical staff member (almost 10,000 referrals per year). Productivity measures may vary depending on the specialty given complexity of some services. For example, clinical triage of Oncology or Cardiology may take longer than Podiatry or Optometry. It is important to take this into account when establishing productivity metrics. Please review the <u>Clinical Triage Recommendation Section</u> below for the formula used to calculate this target. This productivity target is subject to change based on field level data. Changes will be reflected in future guidebook releases.

VAMCs are required to create RCTs that will be responsible for integrating relevant information across specialty services, with an aim to provide Veterans with the best and most timely care options. RCTs at each VA medical facility will ensure Veteran health care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

4.5.1
- Access to RCT support and comprehensive information about care delivery options including face to face care, all available telehealth modalities and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects the Veteran's preference for internal/direct VA care or care in the community (if eligible)

Clinical Triage Recommendation

Strong Practice: Approximately 25-45 referrals per day per clinical staff member or almost 10,000 referrals per year

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Clinical staff can triage incoming referrals, provide scheduling guidance, discuss care options in the service, and be a resource within the service. We recommend looking at the volume of referrals that specialty service receives and assigning approximately 10-25 minutes per referral. Considering there are 510 minutes in an 8 ½ hour day, and 60 minutes are reserved for lunch and breaks throughout the day, there are truly 450 workable minutes throughout the day. This means that we could expect a nurse to handle up to 45 referrals per day or almost 10,000 referrals per year (when factoring in normal leave usage). This formula may be adjusted locally as needed but should be close to this target.

Ideal: 55-60 referrals per day as demonstrated by DoD Integrated Referral Management and Appointing Center (IRMAC) model

For more information on #RCT#, reference RCT Operations Section, subsection #RCT#.

Scheduling Recommendation

4.5.2 Forthcoming in future guidebook versions.

Preliminary information for some specialties is in the How to Get Started Supplemental Materials Section.

Staffing Structure Consideration

4.5.3 The RCT should be made up of administrative and clinical team members. The clinical Full Time Equivalent Employee (FTE) recommendations for RCT members are RNs, PAs, Social Workers (SWs), and/or Advanced Practice Registered Nurse (APRNs)/NPs. Ideally it would be an RN and MSA used to provide frontline care to Veterans (Please review the Minimal RCT Composition Section). The administrative FTE recommendations for RCT members are MSAs, Advanced Medical Support Assistants (AMSAs) and/or other clerical administrative roles such as Licensed Practicing Nurses (LPNs), Health care Technicians (HTs).

To source the RCT member, we highly recommended for facilities to examine FTE utilization and re-allocate staff members first before establishing new FTE if re-allocation examination is inconclusive. When re-allocating, the facility should:

- Evaluate Community Care FTE
- Evaluate current Staff & Specialty Care Case Managers
- Evaluate current Reasonable Accommodation Clinical Staff
4.5.4
- Evaluate RN Staff vs. Inpatient Bed Days of Care (BDOC)/length of stay (LOS)/Occupancy
- Evaluate current Clerical/Admin FTE & Productivity

Alignment / Supervision of the RCT

The alignment and supervision of the RCT will be based on how the facility operates day-to-day. Some recommendations for RCT alignment and supervision are with Specialty Care Services, Clinic Practice Management Team (supervision vs. strong working relationship), or any other existing Care Coordination programs/team.

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Identify Optimal RCT Model

The RCI implementation team should use their workload analysis and current process flows to determine the most appropriate RCT Model. Sites fall into three categories:

4.6

Category 1: They currently have the clinical support/nursing infrastructure in Specialty Care.

Category 2: They are a smaller site with limited Specialty Care, but often send much of their Specialty Care to another VA site.

1.

Category 3: They are somewhere in in-between categories one and two, with limited clinical support/nursing infrastructure in place for Specialty Care they offer.

2.

A description of the most common RCT models with pros and cons are listed in the following

3. sections.

Centralized RCT Model

4.6.1 The Centralized RCT model houses the entire RCT team (administrative and clinical) under the same management structure, but they are built and function as an extension to the specialty care service. For the greatest success of this centralized model, the RCT management team works collaboratively with specialty care leadership team to ensure that the team is trained and functions as an extension of specialty care. This model builds a bridge between RCT and specialty care to ensure accountability and consistency in how VA services are utilized to the full extent.

Table 2: Pros and Cons of Centralized RCT Model

Pros	Cons
- Staff is co-located (physically or virtually), easing burdens on communication and messaging challenges - Consistency in training, processes and functions - Consistency in RCT practice due to singular focus consistent with RCI principles - Improved collaboration between the central team and specialty care services - Ease of determining best use of VISN resources for VISN RCI leadership	- Other services lose existing staff if no additional facility FTE added - Services outside the central team may not share extensive understanding of RCT model to the same extent as centralized RCT staff

If this model is selected, the implementation team should schedule a meeting with facility leadership, including the COS, nurse executive and Specialty care service chiefs to coordinate development, implementation and education of this centralized model. Alignment of RCT under the COS or ADPCS is recommended.

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Service Line/Specialty RCT Model

The Service Line/Specialty RCT model is when the RCT is embedded in the existing service line or specialty and duties are aligned with roles of RCT members.

4.6.2 If this model is chosen, the facility needs to determine who will provide oversight regarding the successful implementation of RCI, given the management structure potentially crosses multiple areas. The facility will need to bring together all key stakeholders to ensure each specialty service RCT is following the processes for admin/clinical functions as outlined in this guidebook. In addition, it is critical that the education of each RCT understand VISN resources available and how to connect with VISN RCI as appropriate.

Table 3: Pros and Cons of the Specialty Line/Specialty RCT Model

Pros	Cons
- Services do not lose any FTE - Minimal/no organizational differences from existing footprint though duties will change	- Additional duties added onto potentially already overburdened staff, RCT may not be the primary focus of the staff member - Potential for decentralized team members to see RCI as "just another duty" - Lack of consistency in practice due to different levels of understanding of the RCI goals - RCT functions under multiple management structures, which often silos teams and processes, making consistency difficult to manage - Difficult to educate every specialty service regarding VISN resource availability

4.7

Form Referral Coordination Team

This section describes how to identify and form the RCT. VAMCs and VISNs have autonomy to staff the RCT based on current staff and specialties available locally. However, facilities must dedicate sufficient staffing to ensure successful RCI implementation across required specialties at their facility.

The composition of this team should follow the minimum composition recommend in the Roles Supporting Referral Coordination Minimal RCT Composition Section. Suggested staffing models can be determined with analysis of your process (Please review the Conduct Workload Analysis Section). The facility implementation team will make recommendations regarding the model that best fits the facility's needs and communicate this to Executive Sponsor.

The RCT will begin supporting our Veterans by triaging referrals and determining the care options available to address their care needs.

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Please review the <u>RCT Operations Section</u> regarding the details of how the RCT will function. Below sections outline tools the RCT must use during the referral triage and scheduling process.

RCT Cross-Training

The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. "cross-training" of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility and services offered. The RCT must be able to speak to both internal VA and community care options and processes to get the patient scheduled in a timely manner.

Required RCT Tools: Consult Toolbox (CTB) and Consult Tracking Management (CTM/CTM+)

4.7.1 *Consult Toolbox (CTB)*

RCT members must be able to forward a consult to community care (<u>section 2.18 in the community care field guidebook</u>) using CTB. TMS course ID: 4562418 is available to train the RCT on how to use CTB. With the release of CTB 2.0 end users will have to capture a community care eligibility reason in order to be able to forward a consult to community care. The following CTB 2.0 TMS Courses are available for CTB 2.0 process specific steps:

- <u>Webinar: Consult Toolbox 2.0 Training Demo</u> TMS Course 4567333
- <u>What's New - Consult Toolbox 2.0 (CTB 2.0)</u> TMS Course 4568812

RCT must also be able to capture patient preferences for community care, including if a Veteran chooses to self-schedule the community appointment. Please review <u>Community Care Scheduling Section</u> and/or (<u>section 2.19 in the community care field guidebook</u>); TMS course ID: 45058 specifically focuses on how to capture preferences.

Consult Tracking Management (CTM/CTM +)

Staff are required to use CTM/CTM + **when it is available**. CTM is being sunset in the beginning of 2022. The benefits of CTM+ include:

- Provides a department/service view of RTCs.
- Displays and updates consult information in real time for both direct/internal and community care consults.
- Integrates with other VistA packages to provide up-to-date information on the same page.
- Creates workflow efficiency by eliminating paper or duplicative systems.
- Provides worklist view ensure every team member had up to data work list for consults they need to process.
- Improves patient satisfaction by providing tools to help ensure timely completion of consults.

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- Monitors user performance and view numerous metrics pertaining to consult aging and bottlenecks.
- Includes consult tracking unique to Community Care workflows.
- Provides efficient, automated tools for tracking and managing RTCs.
- Provides additional features for enhanced progress note management.
- Provides enhanced scheduling features that allow viewing appointments by clinic.

Steps the Implementation team should take to setup CTM+ at the site include:

- Work with DSS on scheduling facility training after CTM+ is approved by the Network Director or Facility director and contract is awarded.
- Train staff on CTM+ and provide information brochure to impacted staff.
- Implement CTM+ in daily operations.

Find more information on technical aspects of CTM and recommendations for procurement. Additionally, any questions not addressed by the resources provided/linked to this guidebook should be directed to Alyssa Tsai (atsai@dssinc.com).

Local Facilitation of RCT Training

4.7.2 RCT training at the local level is crucial for RCT members to familiarize themselves with referring provider groups and more importantly, specialty care groups. The following steps should be followed to ensure the RCT is trained.

1. Identify local training point of contact, who will coordinate and report on training status of RCT to the implementation team.
2. Deploy training from the national RCT team.
    a. Clinical Training for RCT should follow the RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live Section. An example of and RN orientation checklist is linked here and in the How to Get Started Supplemental Materials Section.
    b. Administrative Training for RCT guidance can be found on the National Standardized MSA Training SharePoint.
3. Deploy training from locally developed SOPs to customize the training to your specific VAMC/VISN.
    a. The building of a triage tool for each specialty is a crucial part of RCT Operations Section, it is the tool which directs RCT clinical staff on how to consider a patient in accordance with a specialty. More information on how to build and operate the tool, along with examples, can be found in the RCT Operations Section.
    b. Remember to include education of RCT members on beneficiary travel, special mode travel, and Veteran Transportation Service availability (Disabled American Veterans (DAV), shuttle services, etc.). This can vary by site or VISN.

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RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live

4.7.3 Each Specialty develops and arranges a comprehensive orientation for their designated RCT. If a centralized model is used, Specialty care and RCT management will work together to ensure all elements of RCT development are included. This should include the development of a clinical triage tool (Please review RCT Operations Section for details).

1. RCT reviews Specialty process and materials to thoroughly understand their Specialties and function as an extension or bridge to the Specialty.
   a. Suggested activities:
      i. Overview of the Specialty
         1. Development of clinical triage tool (Please review the RCT Operations Section. List all services, procedures or other care that the Specialty provides
         2. Services work-up orientation (i.e., what needs to be done when certain referrals are received: labs, procedures, other RCT coordination)
      ii. Specialty Care Organizational Chart
      iii. List and define roles of all the Specialty staff (admin, clinical support, physician, etc.)
      iv. Current Clinic Staff schedules (i.e., How is the Specialty covered and operate?)
      v. Current Service Agreements
      vi. Current Referral Triage Process
      vii. Scripted quality talking points (i.e., Why should a Veteran consider this VA specialty care clinic?)
      viii. Note/Referral Templates
      ix. Documentation expectations for the RCT
      x. List of common errors in referrals, and how identify and properly re-disposition to correct Specialty
2. RCT shadows Specialty, developing a working relationship and building a cohesive team.
   a. Administrative and Clinical RCT (admin and clinical) observe current state including referral triage and scheduling process. Example activities include:
      i. Spending time in the specialty clinic with the team understanding clinic functions, services, etc.
      ii. Reviewing consults/referrals with the providers who have historically triaged consults. This provides the Clinical RCT clinical insight and training in how best to clinically triage and disposition referrals using the clinical triage tool.
      iii. Spending time with scheduling team members as appropriate to better understand scheduling and review coordination issues.
3. Specialty, National Program Office, and VISN leadership provide detailed "buffet" Menu of services the VA/VISN offers. The RCT uses this menu to determine the comprehensive range of services the VA offers both locally and at the VISN. RCT is

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completely aware of all options available to Veteran, within VA health care system and community. These options will be offered to the Veteran during the referral process.

    a. Options for care include:
  i. E-Consults
  ii. Local tele-specialty options
  iii. Telephone visits
  iv. VVC
  v. Face to face
  vi. Group visits
  vii. VISN referral options (i.e., VISN menu of services)
  viii. Other regional VA referral options (geographically close, but different VISN)
  ix. National tele-specialty options
  x. Community options
  xi. Other Options

Socialize and Educate Facilities

4.8 Socialization and education of RCI and the newly formed RCTs are critical steps in the implementation process. Ensuring the facility staff understand the critical role that RCT plays in the referral process is central to successful implementation. The RCT serves as a liaison between primary and specialty care, yet they are also an extension of the specialty care service designed to ensure patients are well prepared for their specialty care visit, at VA or in the community. VA is moving to operate more like multispecialty practices, with open lines of communication between different clinics to ensure our Veterans are receiving timely coordinated care. When appropriate, this care can be delivered by VA. When our Veterans will be better served in our communities, we will support that care. Further guidance will be developed to support this change management effort, but initially it is important to make sure these groups understand their roles and the future benefits of this process change.

Ideally facility socialization and education start before the RCT is formed and functioning. The facility Executive Sponsors/Champions and implementation team should lead this effort. Tools to use in the socialization/education process include:

4.9
- Please review the Internal/Staff factsheet and Scripts for Discussing Care Options Section, that are available in this guidebook.
- Executive Sponsors are encouraged to hold town halls or leadership sessions to communicate the importance of this initiative to all staff.

How to Get Started Supplemental Materials

- RCI Implementation Checklist Training
- Limited Specialties Webinar Recording
- How to Build a Triage Tool
- Service Agreement SOP (coming soon)
- Administrative RCT Training

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- NEJM Catalyst Article: The Referral Coordination Team: A Redesign of Specialty Care to Enhance Service Delivery and Value in Sleep Medicine

5 OPTIMIZING REFERRALS

Consult Directive 1232

5.1 The consult directive 1232(2) published August 24, 2016 and associated SOPs (located in the supplemental materials) outline the requirements for the implementation and maintenance of the CPRS Consult application in VHA. Specifically, responsibilities for consult status timelines, responsibilities for sending and receiving services, business rules for consult set up and usage and oversight responsibilities are defined. The policy for the disposition and scheduling of consults for both Mental Health and Non-Mental Health services including provider review and minimal scheduling efforts are defined. The processes for disposition of low-risk consults are also outlined.

Developing Care Coordination/Service Agreements

5.2 A Care Coordination/Service Agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the workflow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; and reviewed or updated as changes are needed or as set forth by local medical center policy. Refer to the Care Coordination/Service Agreement SOP (coming soon).

The assumption should be made that the Chief of Staff has fully endorsed the use of Service Agreements and has relayed that endorsement and expectation of involvement to Service Chiefs. Additionally, GPM and Associate GPMs would be the ideal owners of this process.

The following checklist may be used to assist facilities in the implementation of Care Coordination/Service Agreements:

1. Utilize a standard template including the following elements:
   a. Service Overview
   b. Services Provided
   c. Staffing & Availability
   d. Services Not Provided
   e. Referral Process & Expected Timeliness
   f. Required Referral Information
   g. Criteria for Discharge
   h. Review & Renew Dates
   i. Signatures from Service Chief and Primary Care Chief
   j. Contact Information for Service
   k. Appendices (items the service wants included, but do not fit into the above categories)
2. Assess the current state of Service Agreements.
3. Existing Service Agreements should be:
   a. Transitioned to the standardized template.
   b. Reviewed for accuracy by current Service Chief and/or designee.

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Prioritize Services without Service Agreements based on volume, complexity and costs.

Meet and/or communicate with Service Chief regarding potential stakeholders for the service.

Organize a kick-off meeting with stakeholders to:

4.
5.
6.

    a. Provide objective of Service Agreements.
    b. Develop relationships.
    c. Create an understanding of consensus decision-making with involvement from Primary Care stakeholders.
    d. Assign responsibilities for sections within the Service Agreement.

Coordinate follow-up meetings with stakeholders with an identified deadline for the completion of the initial draft.

Meet and/or communicate with Primary Care Chief regarding potential Primary Care Providers for review of Service Agreements.

7.
8.

    a. Coordinate with assigned Primary Care Providers regarding input required and timeline of review of Service Agreements. A reasonable deadline must be established.

Follow-up with Specialty Service stakeholders on feedback provided from Primary Care.

9.
10.
11.
12.
13.

Coordinate any additional meetings between Specialty Care and Primary Care stakeholders, if needed to come to consensus on Service Agreement.

Obtain signatures on Service Agreement from Service Chief and Primary Care Chief.

Publish Service Agreements to SharePoint.

Educate staff on availability, location and expectations of use of Service Agreements. Consider adding link to Service Agreement within Consult Template.

Refer to examples of Care Coordination/Service Agreements.

5.3

5.3.1

What Makes a Good Consult?

Referring Perspective

A consult template should be developed with the initiating provider, the receiving service, and the patient in mind to promote ease of entry, accuracy of clinical content, and timeliness of completion to ensure that the patient gets the right care at the right time in the right place.

A consult template should reflect a negotiated and mutually agreed-upon understanding of appropriate conditions for referral and necessary work-up prior to referral entry as embodied in the Care Coordination/Service Agreement.

A simple and streamlined consult template enhances communication within patient care teams. The contents of the consult template should be tested for usability to assure efficiency and ease of data entry while minimizing response burden.

The clinician will:

Choose the consult in the CPRS orders tab.
Within the consult, select STAT (within 24 hours) or Routine.

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If appropriate, select a specific procedure or diagnosis within that consult so the specialty knows how to best route it.

Ensure adherence to Care Coordination/Service agreements, ordering any tests required for comprehensive specialty care. A consult template may or may not automatically prompt the clinician to place necessary orders.

3. The consult template should be uncluttered and easy to navigate. Basic requirements for triage and coordination of a consult are:

4.
    a. Indication/clinical history
    b. Reason for request

5.
    c. Does the patient agree to this referral and has patient been told that a member of the Referral Coordination Team will contact him/her?
    d. Indication of patient preferred modality of care (i.e., Video telehealth, E-Consult, Face-to-Face)

Example Consults

5.3.2 The following consult template was developed by Gastroenterology (GI)/OVAC and sent out nationally for a Screening Colonoscopy. It is very simple for the referring provider to fill out, contains information on the patient's other diagnoses and whether the patient has issues with sedation.

Figure 2: Screening Colonoscopy Consult Template

Cardiology Echocardiogram (ECHO) consult which:

- Contains the reason for ordering the ECHO
- Has a data object to pull in the most recent ECHO / Catherization
- Asks for the reason the patient had a previous ECHO

Figure 3: Cardiology ECHO Consult Template

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Update Consult Menu

The local CPRS/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

5.4 Work with Specialties, Community Care, Consult Committees, or other oversight committees, to determine what unavailable services can be offered at the VISN or other VAMCs/DoD.

1.
a. Establish a process for IFC and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.

2. Determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. (More scripting information can be found in the Scripts for Discussing Care Options Section.
a. Remove referrals from the Community Care (CC) referral menu to drive the in-house referral option so those clinics can have a chance to meet the Veteran's clinical needs and only forward to CC if a Veteran is CC eligible and opts-in

3. Establish order menu

4. Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the CPRS Technical Guide).

5. Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.

6. Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.

5.5
a. Train providers *before* the menus are setup.

Optimizing Referrals Supplemental Material

- Consult Processes and Procedures Directive 1232 (2)
- Consult Tips of the Week
- Consult FAQs
- Consult Timeliness SOP (coming soon)
- Consult Business Requirements (coming soon)
- Unable to Schedule SOP (coming soon)
- Minimal Scheduling Effort SOP (coming soon)

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6 VISN REFERRAL COORDINATION

VISN Referral Coordination Program

This section will outline the key strategies to fully engage VISNs in RCI development implementation. VISN Referral Coordination has two elements to consider:

6.1   VISN RCI oversight, guidance and assistance to local facilities that offer limited specialty care
VISN RCT Operations

1.
VISN Oversight and Offering Limited Specialty Care Support

2.
VISN RCI oversight, guidance and assistance to facilities offering limited Specialty Care are
6.2 key to the overall success of referral coordination. VISN RCI leadership should provide a clear understanding and expectation for facilities to incorporate use of VISN resources prior to sending patients to community care. In addition, they will establish consistent standards and processes that will assist and support the local RCT in fully utilizing VISN resources.

VAMCs that do not offer a wide array of Specialty Care services to address Veteran's health needs will require additional coordination. In such situations, the RCT (local or VISN) must look for all VA care options across the VISN to ensure that the patient is offered all internal/direct VA care and community care options available prior to making a decision. VA offers a variety of face to face, telehealth, VA Video options, all of which must be considered and offered to Veterans during the referral coordination process. Ensuring that local facility RCTs have access to a **Error! Reference source not found.** Section and the ability to connect with VISN RCT (if available) to assist in offering the wide array of VA services available will provide Veterans with the best possible options to meet their healthcare needs.

VISN RCI Leadership will:

- Ensure streamlined processes for inter-facility consults (IFCs) and handoffs between facility. Consider use of a "Business Rules" within the VISN to communicate VISN processes and expectations. An example of this is provided (VISN20 Care Routing Business Rules).
- Establish VISN RCT as a hub for the local RCT to assist in the knowledge and use of specialty care resources across the VISN. This will assist in building collaborative relationships between local RCT and VISN resources.
- Collaborate with VISN ICC, CRH and OCC is needed in the development activities of IFC process, Menu of Services, Service Agreements, etc.
- Develop service agreements between primary care, RCT and specialty care services that outline the roles/responsibilities to ensure smooth handoffs across the VISN. Examples of these are in the How to Get Started Supplemental Materials Section.
- Support increased use of Telehealth Options, VA Video Connect (VVC) – offer this to all VISN facilities for services with limited specialists.
- Evaluate the current IFC process and determine how to improve this. Consider future state with Cerner implementation.

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Local and VISN Collaborative Structure

6.2.1 **Figure 4: VISN RCI Collaborative Relationship with Local RCT**

How to Use VISN Resources

Ways to utilize VISN resources include:

- RCTs can use of VISN Menu of Services to ensure all options of care are presented to
6.2.2 patients.
- RCTs can use a VISN Access Dashboard to help facilities determine wait times across the VISN. This will need to be modified in the transition to Cerner.

How to Hand-off Referrals (IFCs) Between Facilities

VISNs should ensure there are clear processes around IFC use (in business rules) between facilities. Include the local RCT in the IFC process to promote collaboration and timely handoffs.

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VISN RCT

6.3 The VISN RCT model centralizes specialty referral triage and scheduling, for a particular specialty. The model allows VISN RCT to search all facilities within the VISN for timely care that best fits the Veteran's needs. This model can be used for specialty services that are scarce or limited within the VISN and/or are complex and require a good working knowledge of VISN-level resources.

A specially trained team of nurses and administrative AMSAs work closely with the Veterans, each other, and the clinical services at each facility to meet the Veteran's needs. This model is a great example of how to provide referral coordination and internal/direct VA services to those facilities who do not provide specialty care service(s) at their local facility. This model has a strong interdisciplinary approach, working daily with providers at the local facilities as an extension of the local facility specialty service. The team uses a VISN Clinical Triage Tool that guides the decision making of the nurse and provides pertinent information for the admin/scheduler regarding what services are offered at each facility.

VISN RCT goals include:

- Optimize the number of Veterans receiving specialty care within the VA network.
- Maximize opportunities for care through alternative care modalities, including VA Video Connect, Telehealth, Phone Clinic and traditional face to face.
- Maximize utilization of existing clinical resources across a VISN.
- Optimize referral triage and appointment schedule process.
- Provide consistency across the VISN utilizing established tools.
- Decrease provider time spent triaging referrals.
- Ensuring patients have accurate information regarding VA and community resources.

6.4 When VISN RCT is established for a specialty across the VISN, local RCT is not needed for that specialty, as the VISN has chosen to provide a VISN approach to referral coordination. VISNs can use this approach for complex specialties and specialties where there are limited resources in the VISN. VISN Referral Coordination acts as the hub while the local facility RCT act as the spoke. The VISN Referral Coordination Hub should establish a routine meeting with the local RCTs to promote and provide open communication, continuity of care, consistency across VISN, collaboration, bridge building and open sharing of services. This will ensure VA is offering Veterans quality and timely care within VA.

Strong Practice/Brief History VISN Care Routing/Referral Coordination

VISN Care Routing was launched in VISN20 in 2014 in response to managing waitlist challenges. The VISN Care Routing Team serves as a central hub to assist facilities in the coordination of complex patients and scarce specialty resource needs, providing consistent communication regarding services available within the VISN. VISN Care Routing Business Rules were developed to ensure all facilities were functioning as an integrated network and to promote seamless and timely transitions of care from facility to facility. Multiple tools have

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been developed to assist in the Care Routing process, including: Access Dashboard, Care Routing Inquiry Process, Cancer Care Interdisciplinary Team and Change in Services Process.

In 2018, VISN20 Care Routing worked with OVAC to pilot the Specialty Care Routing Triage & Scheduling Model, which resulted in the VISN20 Sleep Medicine pilot, based on the DoD Integrated Referral Management & Appointing Center (IRMAC) model.

What started as Care Routing in 2014 has now transitioned as the national Referral Coordination Initiative that can be implemented at local facilities as well as VISN. VISN Referral Coordination is critical to support the local RCT to maximize utilization of specialty care resources across the VISN when local facilities cannot provide the service. This includes utilizing all care modalities (e.g., face to face, Telehealth (CVT and VVC), telephone clinic and E-Consult). VISN RCT can look across the VISN and schedule patients at any facility within the VISN, per patients request. RCI promotes providing Veterans with options for internal/direct care within VA as well as in the community. RCT provides patients with VISN level resources so they can make the best-informed decision for care.

**Referral Coordination Division
Organizational Chart**

6.4.1

Figure 5: Referral Coordination Division Organization Chart

VISN Referral Coordination Roles and Responsibilities

VISN RCT roles and responsibilities mirror those listed in Roles and Responsibilities of RCI Section. However, there are a few slight differences when a VISN RCT is established, which requires coordination and collaboration across multiple facilities.

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VISN Referral Coordination Leadership

Responsible for oversight of RCT triage and scheduling functions for designated services and facilities within VISN, including but not limited to:

- Manage and supervise VISN RCT, ensuring adequate staffing, space, and equipment to meet VHA referral triage timelines.
- Coordinate with local specialty services to implement processes, using a phased approach, in the designated services and facilities.
- Collaborate with local RCT in development of hand offs when appropriate to VISN RCT.
- Collaborate with facility leadership to maintain RCI consistency throughout VISN.

Facility Leadership

Responsible for collaborating with VISN Referral Coordination Leadership.

Facility Clinical Services

Responsible for collaborating and training the RCT in their specialty clinical services, including:

- Develop pre-referral guidelines/clinical pathways and the RCT triage tool in the designated specialty.
- Provide specialty training to the RCT team to develop them as extension of the service
- Collaborate with VISN Referral Coordination MD and Program Manager providing guidance and oversight when provider input is required.

Designated clinical services retain overall responsibility of triage and management of referrals that do not easily conform to triage guidelines.

VISN Clinical RCT

Responsibilities are the same as local Clinical RCT. However, the VISN Clinical RCT routinely communicates/collaborates with local facility specialty service and other RCT teams as needed to identify VISN resources/services available.

VISN Administrative RCT

Responsibilities and recommended staff (typically an AMSA) are the same as local RCT. However, the VISN Administrative RCT can schedule across multiple VISN facilities to offer 6.5 and schedule internal/direct care within VA whenever possible. They collaborate with community care when the Veteran chooses this VISN option to ensure timely transition and handoff for scheduling.

How to Get Started

This section is like the VAMC in the How to Get Started Section. However, there are a few things to consider when building a VISN RCT. The following steps will help you systematically walk through how to identify and create a VISN RCT.

Assess Need – What Makes Sense at VISN and What Can Stay Local

RCI success relies on identifying the appropriate specialty service to launch VISN Referral Coordination Triage/Scheduling. This requires a "current state" assessment across the VISN of specialty care services.

6.5.1 **Identify Key Stakeholders**

Stakeholders are responsible for strategic planning, reviewing specialty data, decision making and identification of leadership team, steering committee and workgroups.

6.5.2 VISN Level Stakeholders:

- VISN CMO
- VISN BIM
- VISN Primary Care Committee
- VISN Specialty Care Access Team/ICC/Clinical Resource Hub
- VISN Telehealth Coordinator
- VISN Chief Nurse
- VISN Health Administrative Service (HAS) Leadership
- VISN CAC
- VISN Project Manager

Facility Level Stakeholders:

- Facility Chiefs of Staff
- Facility Specialty Care Leadership
- Facility HAS
- Facility Telehealth Coordinator
- Facility Chief Nurse
- Veteran
- Veteran Experience Office (VEO)

6.5.3
- Union Leadership

Complete Current State Assessment

Assess the current state by reviewing the following topics:

- What specialty care services are scarce across the VISN?
- What local RCT's currently exist?
- Where is there a large volume going into community care?
- How much time do providers spend triaging referrals?
- What types of modalities is the service currently using (e.g., telehealth)?
- Data gathering (community care volume, clinic timeliness, provider time triaging)
- Current/upcoming initiatives
- Cerner/electronic health record (EHR)
- MISSION Act

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- On-Demand Appointments
- VA Online Scheduling
  - New Scheduling Software

Develop Business Case

Develop a business case by considering the following:

6.5.4
- What might Referral Coordination do for my VISN?
- How will my VISN support expansion of RCT at the VISN?
- What resources are needed for planning?
- What needs will be met by implementing VISN Referral Coordination?
- How will local RCT and VISN RCT team work together?
- Create a presentation to VISN Clinical Services and Resource Management.

Develop and Plan

6.6 Once VISN RCT concept is approved, we recommend holding a face-to-face Strategic Planning Kickoff Meeting with key stakeholders from VISN and local facilities. A kick-off will not increase buy-in, but it also develops and cultivates working relationships with the team invested in VISN RCT.

6.6.1
Identify VISN Leadership Team

The Leadership Team is responsible for oversight of launching VISN RCT and should include VISN and local facility team members and have no more than 10 individuals. Team should meet weekly initially to discuss implementation timeline, progress of workgroups, identification of barriers and decision making.
6.6.2
Identify VISN Steering Committee or Overseeing Body

The Steering Committee is responsible for guiding decisions related to what specialties are implemented VISN-wide and for the overall guidance on VISN level decision making. This committee can include a larger number of individuals, with everyone ideally involved in the
6.6.3 initial planning sessions. This meeting group should come together monthly to review progress, problem solve barriers and ensure VISN RCT is moving forward.

Identify Individual Workgroups

Individual workgroups are needed to manage the large-scale change and implementation of
6.7 RCT at the VISN level. These groups should be multi-disciplinary with an identified lead and clear workgroup charter with timelines. There is a considerable amount of "pre-work" that must be done prior to launching the VISN RCT. This "pre-work" is assigned to the workgroups listed below. The number of workgroups can be adjusted based on the identified need in your VISN.

Workgroups

Develop clear and concise Workgroup Charters for each group.

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Example of Referral Guidelines Workgroup Charter: Develop clinical pre-referral guidelines and referral templates that clearly communicate to the referring provider what is expected prior to referral. Guidelines will be consistent across the VISN, providing uniformity and consistency for the referral coordination team triaging from site to site.

List of workgroups:

- **Referral Guidelines/Pre-Work Team:** Develop guidelines, referral templates, and clinical triage tool.
- **RCT – Triage and Scheduling Workgroup**: Assemble the VISN RCT team, role of Clinical RCT member, role of Administrative RCT member, documentation of triage, SOPs, etc.
- **Care Delivery/Telehealth Workgroup** (CVT, VVC, Telephone, and Store and Forward): Develop VISN Telehealth Service Agreement (TSA) and support expansion of VVC across facilities.
- **Communications Workgroup:** Identify and develop training tools for local/VISN staff, and market and promote the VISN RCT.
- **Clinical Applications Coordinator (CAC) Workgroup**: CACs are key stakeholders in strategic planning and are part of the workgroups. They must partake in the initial strategic planning and early assessment of what systems/processes are already in place and what needs to be built. Tools requiring CAC involvement include: Referral Guideline Menus, CPRS/EHR Templates, Note Titles, and assigning VISN referral coordination staff as recipients to alerts and Interfacility Consults.
- **Data Workgroup**: Conduct baseline data gathering; ensure metrics are in line with RCI; perform ongoing data management/validation, patient/provider satisfaction, and data quality validation.

6.7.1

Pre-Work

Prework consists of:

- **Pre-referral Guidelines/Clinical Pathways:** The referring provider must follow these guidelines to patient information and required studies/tests *prior* to entering referral. These guidelines are specific to the specialty service that are developed by the Referral Guidelines team and then embedded in the EHR. Consistent guidelines across the VISN for a given specialty provide consistency for the referring providers, referral coordination staff and the receiving specialty service. Depending on where your VISN is with Cerner implementation, you must collaborate with Cerner/EHR team during this phase.
- **Electronic Health Record Referral Templates:** EHR referral templates include auto-populated patient information as well as templated questions prompting the input of pertinent clinical information needed by the triaging clinical team. The Referral Guidelines team developed these templates, which are embedded in CPRS/Cerner. Consistent templates across the VISN ensure consistency for referring providers, referral coordination staff and the receiving specialty service. They should be clear and

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simple but provide enough clinical information for the both the triaging and receiving team. (Note that these will change with Cerner Implementation.)

- **Clinical Triage Tool:** The Clinical Triage Tool contains pre-determined clinical guidelines and scheduling guidelines for clinical and Administrative RCT to use for referral review, triage, documentation and scheduling of care. This is a specialty-specific tool that the Triage Team and Referral Guidelines team build collaboratively. This is a decision-making tool for both the clinical and administrative staff, providing consistency from facility to facility in the triage/scheduling process. This tool takes time to build and can be a "living document" that is edited as the program evolves. Specialty providers throughout the VISN must provide input into this clinically based decision-making tool. RCI has/will provide basic triage tool templates and a "how to build a triage tool."
- **VISN Service Agreement:** This document outlines the expectations of the referring provider, VISN referral coordination team and specialty providers as patients are shared across the continuum of care. The Referral Guidelines team develops the VISN Service Agreement, which provides a common understanding of roles, responsibilities and expectations for sharing patients within a VISN.
- **VISN Telehealth Service Agreement (TSA):** This document is required to initiate Telehealth Services. A VISN-level TSA can be developed for a specialty for consistency across the VISN.

6.8 Develop Performance Monitoring Plan in Line with RCI Expectations

Monitoring the progress of VISN Referral Coordination triage/scheduling is integral to understanding the overall impact that RCT has on the VISN and local facility specialty care programs. RCI success depends on monitoring timeliness of VA care, community care demand and quality of nurse triages. Leadership must identify VISN level data management for the VISN RCT in collaboration and support of the local facility RCT metrics.

Examples of performance monitors include:

- Quality
  - Accuracy of Nurse Triage
  - % Provider Agreement with Nurse Triage
  - % Order/Plan change
  - % Order/Plan deferred to provider
  - Quality should be assessed in two periods: 1) initial training, and 2) continuing review.
    - Initial Training: Initial training may include a higher level of provider oversight in the early phases, which likely includes provider co-signature on triage notes until the providers feel nurses competent to triage independently, per triage tool.
      - Continuing Review: After the initial training period ends, nurses no longer co-sign specialists for review, unless the triage tool

requires it based on patient complexity, but ongoing audit and feedback is essential to maintain triage accuracy and quality.

- Timeliness and Access
  - ○ Time to scheduling contact
  - ○ Time to appointment
- Community Care Demand
  - ○ Community Care Referral volume pre/post VISN RCT
- Provider Time
  - ○ % provider spent triaging referrals
- Patient/Provider Satisfaction
  - ○ Patient perception of timeliness to care
  - ○ Patient perception of knowing next steps in care
  - ○ Patient perception of being treated with respect
  - ○ Provider perception of VISN RCT impact on provider time

Implement and Monitor

6.9 Once the workgroups have completed the pre-work, VISN RCT training should begin. The Communications Workgroup will have identified key stakeholders for training and created training slides for the following example audiences:

- Referring Providers - VISN Primary Care Committee
- Specialty Providers – VISN Specialty Team Committee
- Facility Scheduling
- Community Care
- VISN RCT

VISN RCT functions are very similar to the local RCT. However, the VISN RCT can look across the VISN for specialty care resources that are not available locally and provide patient's with expanded VA options for care. The VISN Clinical RCT has easy access to the specialists within the VISN for clinical inquires and triaging who are readily available to assist local RCT when local services are not offered. The VISN Administrative RCT can schedule at local facilities across the VISN, offering VVC or other appropriate modalities.

6.10 VISN RCI implementation includes routine VISN Referral Coordination meetings, which are led by the VISN RCT manager and include the VISN Referral Coordination representative and Local RCT representative for each facility. These meetings provide a consistent forum for questions, identification of barriers, problem resolution, team building and refining processes across VISN.

Monitor and Improve

Ongoing evaluation of the VISN RCT is critical to the success of this program. The VISN Leadership Team and/or Steering Committee meet regularly to assess VISN RCT's overall impact. This includes routine evaluation of the baseline data as well as ongoing data. The

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routine VISN RCT and local RCT team meetings will provide valuable input on the day-to-day operations of the VISN and local RCT interactions and handoffs of care.

- VISN leadership should identify changes needed to meet goals and objectives.
  - ○ VISN and Local RCTs will likely recommend updates to the triage tool; updates to standard operating procedures; and workflow process improvement.
- Collect data and generate performance reporting.
  - ○ As VISN referral coordination expands, continue to use the RCI Data Portal to publicly guide timeliness of care and community care utilization.

VISN leadership, facility leadership and national RCI leadership communication and reporting is critical to the ongoing success of RCI. There needs to be appropriate overseeing bodies that tie together VISN and local RCT's.

VISN Menu of Services

6.11 ### Definition and Education

6.11.1 A VISN Menu of Services is defined as a document that outlines clinical services available at each facility within the VISN. This includes the specialty (e.g., Cardiology), the subspecialty (e.g., Interventional Cardiology), and the modalities offered (e.g., F2F, VVC, telehealth, or phone). All facilities can use a clear and consistent VISN Menu of Services document during the referral coordination process to ensure VISN resources are offered and used to the fullest extent when the RCT is offering all care options to Veterans.

VISN/facility education about the menu of services is important to ensure the RCT can leverage the full array of services in the VISN for Veteran care. The following slide deck may be used to educate RCTs, specialty care providers, referring providers and facility leadership.

- What is VISN Menu of Services?
- How to use VISN Menu of Services?
- Who can use this tool?
- Where is it located?
- How is it updated? (see feedback loop)
6.11.2 - Who to contact for questions?

Menu of services education presentation is linked here.

How to Build VISN Menu of Services

Developing this tool will require collaboration between the VISN and facilities. Establish a team to lead and develop the VISN Menu of Services. We recommend that you include: VISN ICC Leads (e.g., MH, Specialty, Surgery, and Rehab), VISN/Facility GPMs, VISN Connected Care Lead, VISN CRH, VISN/Facility RCI Leads/Champions, VISN OCC Chief, Clinical Applications Coordinator (CAC), and Data Analysts. VISN ICC leads are a good choice to lead this effort in bringing together medical/surgery specialty care as well as all the other clinical services.

If individual facilities have a Menu of Services for their site only, this can be used to populate the VISN Menu of services utilizing the VISN Menu of Services template. The goal is to have ONE Menu of Services for the entire VISN.

A VISN may currently have a preferred template to capture the Menu of Services which can be used if it meets the intent described in the section above. If there is no template currently available, the RCI team has provided a template which can be used to build and review the VISN Menu of Services.

The following steps should be followed on how to build a VISN Menu of Services, outlined below:

Step 1: Ask and gather from facilities any Menu of Services documents they currently use. Work with clinicians/facilities to develop a list of subspecialities and detailed clinical offerings for each specialty (e.g. instead of ophthalmologist, determine if you have cornea specialists, retina specialists, glaucoma specialists, etc.)
*The following care routing tool can be used to determine what clinics are available for your VISN. Care Routing - Summary - Power BI Report Server (va.gov)

Step 2: VISN Menu of Services workgroup lead will populate Menu of Services worksheet with each specialty and subspecialty and facility name based on any facility specific current Menu of Services document.
        *Recommended template for VISN Menu of Services is linked here.

Step 3: Educate GPMs across the VISN about the intent of what is needed, why it is needed, and when it should be returned to the VISN.

Step 4: Send ExtraView (EV)/Suspense to each facility within the VISN and allow 3 weeks to complete. Instruct each facility to complete their list of specialties, subspecialties, and modalities offered for these services. The following language was used on the VISN 7 EV:

As discussed during the VISN7 GPM Bi-Monthly call, 2/24/2021, as part of the National Referral Coordination Initiative, Network Offices are required to develop an inventory of clinical services within their VISN.

Attached to this EV is a spreadsheet with two tabs (one for surgical services and one for medicine services). VISN7 network office is requesting that each site completes all services on each tab. Facilities should respond either "yes" or "no" to whether you offer these services and then which modalities you offer them in (e.g. F2F, VVC, TELE). An example of a response would be like this "Yes – F2F/VVC/TELE".

This request is due back to the network office by 3/12/2021.

For any questions related to this EV, please contact {insert POC email} or via phone at {insert POC telephone number}.

Step 5: VISN Menu of Services workgroup lead will compile all information submitted by facilities into a single spreadsheet and make corrections as needed.

Step 6: Post the VISN Menu of Services to a common location easily accessible to front line staff and RCT. Ensure staff have appropriate access to the document. Send completed Menu of Services spreadsheet to [(b)(6)]@va.gov.

Updating Menu of Services

The VISN Menu of Services will be a living document. The VISN Menu of Services development team will be responsible for updating and making sure the content is current. When a facility has a change in services, it impacts the supply and demand balance across the VISN, thus accurate reporting and tracking of services is critical.

6.11.9

The feedback process for the RCT/Facility to communicate change of services to the VISN is outlined below:

Utilize when your facility has a change in services offered

Accessed through local VISN SharePoint

Received and Reviewed by VISN RCI Champion (or designee) and oversight committee

Allows for collaboration between VISN and local facilities to ensure uninterrupted and timely care for Veterans

Change in Services Process

Preferably the facility with the change in service should provide the feedback. However, the referring site or specialty care can submit the change in service form.

The form should be stored on the local VISN SharePoint. We recommend the form includes the following fields for change in service request:

- Site of change
    - Name, Role of RCT member, E-mail
    - VISN/Site
    - Specialty/Service
    - Date
- Receiving Site:
    - Who reported the change in service?
        - Name, Role, E-mail
    - Date

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- o Detail:
  - Service
  - Subspecialty
  - i.e. Provider for x subspecialty resigned 2 weeks ago. No replacement available.

An example of the form is linked here.

The local supervisor should be notified of the change in service.

The VISN RCI Champion and Oversight committee will:

- receive and review the submission for accuracy

- update the Menu of Services as required

- evaluate other potential options for care in the VISN

- communicate changes to local facility leadership and RCTs throughout the VISN

We recommend the Menu of Services to be reviewed and updated quarterly (four times a year) at a minimum while making it a standing agenda item (e.g. RCI Oversight Committee, Specialty ICC Health Care Delivery Committee Meeting, Executive Leadership Committee). Additionally, teams should update services offered on an ad hoc and/or rolling basis if it is determined between reporting periods that specialty availability has changed.

6.12   VISN Referral Coordination Supplemental Materials

- Example of VISN Service Line Agreement
- Example of VISN Telehealth Service Agreement
- How to Build a VISN Triage Tool
- Example of Referral Coordination Business Rules – V20

7 RCT OPERATIONS

RCT operates within the RCI framework and provides resources for a standardized approach to receive, triage, review and gather clinical information in the health record; to identify barriers to scheduling the referral; and talking to Veteran's about their care options.

The process map below depicts the recommended RCT operations process from RCT receipt of consult/referral all the way through RCT conversation and scheduling decision with the Veteran.


Figure 6: RCT Operations Process Map

Receive/Review Consult/Referral

7.1   The Clinical RCT initially receives the consult/referral to determine the urgency/appropriateness of the referral and potential care options.

Initial assessment of the consult/referral includes:

- Referral reason clearly stated and was routed to the correct specialty.
- Referral is not a duplicate.
- Referral contains appropriate pre-work.

It the referral is not appropriate for the RCT based on the above elements, the RCT may disposition the referral in various ways. Each way should be documented in the referral for tracking purposes. The most common ways are listed below.

- Convert referral to E-Consult.
- Provide a return to clinic order if patient already established in specialty.
- Forward the referral to the correct specialty service, documenting the reason for forwarding.

7.2
- Reach out to referring provider for clarifying information needed.

7.2.1
- Cancel referral clearly documenting reason for cancellation.

Clinical Triage

Overview

RCT's clinical triage of the consult/referral ensures that all clinical information is clear and available in the medical record when the patient is seen in VA's specialty care or in the community. RCT promotes efficiency by ensuring Veteran health care is accessible, convenient, and delivered in a timely manner. Part of this work includes ensuring proper pre-work and clinical information is available once the referral appointment is made.

When triaging specialty care referrals, RCTs conduct a medical chart review to gather clinical information and determine the most appropriate level of care for the Veteran. First, the EHR will alert RCT clinical team members to the specialty care consult. Work with your local CAC on how to setup automatic alerts for CPRS. For alerts in the Cerner platform, the RCT will need to create their worklist such that they will be the first to receive all referrals for their specialty. The Clinical RCT uses an approved triage tool for consistency in the clinical triage and scheduling process. Instructions how to create and use the triage tool are in the Clinical Triage Tool Section.

The Clinical RCT member should use the COVID-19 CTB priority tabs to capture the appropriate referral priority for scheduling purposes (mandatory use for priority 1 and 2). The use of the #RCT# is in addition to the clinical triage comments and use of COVID-19 CTB priority tab. Also refer to Prioritization for Consultations Procedures and Appointments.

Specialty care services often require medical testing prior to a medical visit. Since each facility and specialty has unique testing requirements and availability, it will be up to each specialty service to determine which tests are essential to complete prior to a medical visit. In addition, each specialty service will determine how recent the testing should be and whether the Veteran would need new testing prior to an appointment. This information should be listed in the triage tool. The RCT will document the triage actions on the consult/referral utilizing a template and/or CTB that will provide a clear and consistent summary of the triage, conversation with the Veteran and the plan/next steps for the patient.

7.2.2 Medical Record Review

The Clinical RCT uses the clinical triage tool in the medical record review process to track what clinical information is needed during the triage process. Upon receipt of the referral, the Clinical RCT first determines the urgency of the consult/referral and if testing has been completed in the EHR. If testing is not indicated as complete in CPRS/Cerner, the RCT should search in Vista imaging, Radnet or in the Joint Longitudinal Viewer (JLV) to see if the Veteran had testing in the community or at another VA/DoD location. If there is incomplete information on the consult/referral, the Clinical RCT may need to reach out to the referring provider for additional information.

7.2.3 During the review of medical records, the Clinical RCT can determine complex coordination needs, barriers to care coordination and community care eligibility to understand the Veteran's best available care options.

High Risk and Complex Veteran Considerations

High Risk Veterans can be defined in a multitude of ways, including having one or more of the following characteristics: high intensity medical management, suicide risk, homelessness, frequent ER user, polypharmacy, frequent PCP visits, frequent admissions, and medication non-adherence. Find further information regarding the CAN Score and the Patient Care Assessment System (PCAS) with the supplemental material on High Risk and Complex Patients.

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Eligibility

7.2.4 Veteran Community Care eligibility criteria became effective June 6th, 2019 under the VA MISSION Act of 2018. Find key aspects of community care eligibility and the six eligibility criteria can be found in the MISSION Act factsheet. All Veterans should be offered VA care options regardless of community care eligibility, so they have a choice in where they receive care.

Tools to Use (Required and Optional)

7.2.5
- The Consult Toolbox (CTB) should be used by the RCT to forward consults to community care as well as capture Veterans preferences. Refer to Community Care field guidebook for instructions on how to use CTB.
  - RCT members must be able to forward a consult to community care (section 2.18 in the community care field guidebook) using CTB. RCT must also be able to capture patient preferences for community care (in the community care field guidebook).
- The Consult Tracking Manager (CTM/CTM +) must be included in daily RCT operations when it is available. Refer to the How to Get Started Section to determine if your VISN has CTM and review information on how to setup CTM locally.

Documentation

7.2.6
The Clinical RCT responsible for triage completes the RCT brief templated note in the consult with a clear plan for the next step. This keeps it all in one place, so when the patient/referral arrives to their appointment, all the information is on the referral string. The consult should be dispositioned (scheduled, forwarded, cancelled or completed) within three business days (excludes weekends but not holidays). The Consult Timeliness SOP is coming soon.

Documentation of clinical triage provides transparency in the medical record as outlined above. Documentation occurs in the consult/referral itself to promote clarity and ease of finding information relative to the consult/referral. We recommended that the RCT use a standardized note template/format directly on the consult and/or via CTB.

Example of RCT Triage Template:

- Patient referred for X (reason for referral):
- Pre-work and/or diagnostic studies completed and/or available in CPRS/JLV/Vista Imaging:
- Special Considerations:
- Patient discussion:
- Plan:
- Patient Preferences: (if patient chooses community care) [capture in CTB]
  - Provider Preference
  - Day of week and time of day
  - Scheduling preference (i.e., self-schedule or VA schedule)

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Find more information on <u>general guidance on why to disposition a referral can be viewed</u>.

#RCT#

7.2.7 The Referral Coordination Initiative Project team has worked to develop a RCT User Role within Consult Toolbox (CTB) 2.0 to allow for appropriate tracking of consults reviewed by the clinical members of the Referral Coordination Teams (RCTs) within the facilities. The RCT User role within CTB 2.0 is tentatively scheduled to be released date late October 2021; therefore, an interim process has been developed in order to appropriately monitor consults that are reviewed by the clinical member of the RCT.

Clinical and Administrative RCT members will capture a #RCT# comment on the consult following the process below:

Upon receiving a consult or when adding a comment based on clinical review, the clinical or administrative member of the RCT will add a #RCT# comment that the consult was addressed by a clinical RCT member. The preferred process is for the clinical member of the RCT to capture the #RCT# comment; however, in the instances where the clinical member has reviewed the consult and the comment was not added, the administrative member of the RCT should add the #RCT# comment to the consult as an added comment.

(CTB Version 1.9.0078)

**Figure 7: Add #RCT# Comment to Consult**

Figure 8: Receive Consult with #RCT# Comment

- The #RCT# comment can be added in CPRS either as an additional comment on the consult or when the consult is received and reviewed by the clinical RCT member.

- Note the administrative member on the team can also add the comment, once it is confirmed that the clinical RCT member reviewed the consult.

Use of #RCT# Comment Reminders

- It is important to note, the use of the #RCT# comment is only for consult tracking purposes. Appropriate consult review and documentation actions must still take place as outlined in the Operation Chapter of the RCI Guidebook, section titled "Documentation."

- The comment must be captured only after the clinical member of the RCT has reviewed the consult for clinical purposes. The comment can be added by either the clinical or administrative RCT member. Per the current process, the clinical member of the RCT will review the consult for clinical appropriateness and provide scheduling guidance to the administrative staff within the team.

- The #RCT# comment does not need to be a standalone comment and can be part of other comments added. The key is to ensure that the #RCT# comment is captured as part of the comment entered.

- The Clinical RCT member should still use the COVID-19 CTB priority tab to capture the appropriate referral priority for scheduling purposes. The use of the #RCT# comment is in addition to the clinical triage comments and use of COVID-19 CTB priority tab.

Below is the guidance for the recommended process steps for capturing the #RCT# comment on a consult reviewed by an RCT clinical member:

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#RCT# Process

CLINICAL RCT

1   Receives and performs initial triage on consult / referral

2   Inputs #RCT# in comments after clinical review

3   Discusses care options and applicable community care eligibility with Veteran
     ☀   Veteran chooses care location and modality

4   Warmly hands off consult / referral to administrative RCT member

ADMINISTRATIVE RCT

5   Receives consult / referral after it has been clinically reviewed to schedule appropriate appointments

6   *(If needed)* Adds #RCT# to comments if clinical review was completed and #RCT# was not documented

Choose VA   VA | U.S. Department of Veterans Affairs   6

Figure 9: #RCT# Guidance

A report has been created in the <u>RCI Dashboard</u> to capture the number of consults with a #RCT# comment added for appropriate monitoring.

7.2.8

Clinical Triage Tool

A clinical triage tool is a pre-determined clinical and scheduling guideline used by RCT for consult review, triage, documentation and scheduling. It is built collaboratively with specialty providers, referral coordination nurses and administrative team and provides a clinical algorithm for nurse decision making in determining appropriate care routing modalities. This triage tool also includes scheduling guidelines and scripting for administrative staff when scheduling appointments. This tool is not part of the EHR; RCT uses this tool for decision making and routing of care.

Reasons to use a triage tool include:

- Allows nurses to clinically triage consults/referrals based on an approved MD algorithm (triage tool).

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- Allows specialty providers to re-direct their time to things only a provider can do (e.g., clinic visits, procedures, and VVC).
- Provides consistency in the referral and scheduling process – everyone using the same document.
- Provides clear expectation of documentation in the record summarizing referral triage, plan and scheduling.

Creating a triage tool is a collaborative process that includes physicians, nurses and admin staff. Details about how to build a triage tool "how to slides" and a "base triage tool" examples are linked here and in the Supplemental Materials Section.

Example triage tools by specialty:

- Cardiology VA
- Gastroenterology IRMAC
- Sleep Medicine VA
- General Surgery IRMAC
- Cancer IRMAC
- Cancer/Oncology VA
- Hem-Oncology IRMAC
- Pulmonary IRMAC
- Dermatology VA

7.3 Contact Veteran

Once the clinical triage of the consult is completed, Clinical RCT can **hand it off to the Administrative RCT to call** the Veteran and schedule. The conversation with the Veteran to discuss VA options for care can happen both with the clinical and Administrative RCT. Each facility determines the workflow and who best to have the conversations. Regardless of who has the conversation, it must happen; patients must be given an option for internal/direct VA care vs. Community Care (when eligible); and staff clearly documents the discussion in the EHR.

Contacting the Veteran and offering internal/direct VA care options is critical. We need to ensure that patients have all care options available to them whether internal/directly in VA or community care, and ultimately, they have a choice. If they are eligible for community care, we cannot assume they will choose that based on distance or wait time measures. They make the final choice once all options presented to them.

If a facility does not offer a specialty, the local RCT needs to discuss internal/direct VA care options within the VISN, as the service may be offered via Telehealth or VVC. A Menu of Services Example can be found in the Virtual Care Supplemental Materials Section.

We have provided scripting to help facilities with Veteran conversations to ensure the right conversations are happening and documented clearly in the EHR. Please review Scripts for Discussing Care Options Section to guide you through the process.

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Determining Who Should Contact the Veteran

If the Clinical RCT contacts the Veteran

7.3.1 During the clinical triage of the consult/referral, Clinical RCT may need to call patient to gather additional clinical information and discuss care options for the high risk and more complex specialties. This allows the Clinical RCT to address any clinical questions the patient may have as well as thoroughly explain VA resources both locally and across the VISN that would best meet the patient's needs. The Clinical RCT will then hand off the scheduling activities to the MSA once the patient has decided on VA or community care. Examples of high-risk specialties that would likely require a phone call from the Clinical RCT include Oncology, Neurosurgery, complex Cardiology, etc.

If the Administrative RCT Contacts the Veteran

The Administrative RCT will call patient to offer VA options for care and/or community care options *when* the Clinical RCT determine it is appropriate, based on clinical complexity requested. This should be documented by the Clinical RCT on the consult/referral triage summary directing the MSA to call patient. This process will decrease the number of phone calls the patient receives as they will get one phone call from MSA providing both VA/Community Care Options AND the ability to schedule during the same phone call. Example of this could be a referral for some of the lower risk specialties such as Podiatry, Optometry, Audiology, Physical Therapy, Primary Care.

Handoffs between Clinical and Administrative RCT

There are multiple options for handoffs between the clinical and administrative RCT to begin the scheduling process. A warm handoff is considered to be an immediate handoff between two parties via phone or IM. Warm handoffs are is considered to be ideal, however, depending on local processes, smooth and timely handoffs can be accomplished in the following ways:

- Alert system in the EHR consult/referral system (i.e., via CTB).
- Transfer call to MSA while patient is on the phone.
- Enter or forward consult/referral to community care when this option is selected.
- STAT Referrals (internal/community care) requires a telephone conversation to for handoff and disposition.

Teams/Skype and other messaging systems can be used for informal hand-offs in addition to formal hand-offs listed above.

7.3.2 During the discussion with the patient, the RCT needs to communicate VA resources that patients may need with scheduling their appointments, such as transportation options. See below for guidance relative to transportation services.

Solutions for Transportation

RCTs identify their local and VISN opportunities for transportation needs of Veterans when seeking to keep this care within VA's health care system and mitigate and/or reduce travel expenses.

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RCTs collaborate with their local Beneficiary Travel point of contact(s) to pinpoint what modes of transportation are available to your VAMCs.

Several national programs within the Veterans Transportation Program (VTP) offer transportation assistance to Veterans obtaining health care at VAMCs or an outpatient clinic across the country. When a Veteran does not have any other means of transportation, they are eligible for VTS transportation.

RCTs should check with their local Beneficiary Travel Office for additional guidance regarding Veteran's eligibility requirement (see below) and other travel benefits that may be available within their respective VISN and/or Network.

Administrative Eligibility for Beneficiary Travel

Description	Travel for SC Care Only	Travel for Any Care
Veterans rated 30% or more service-connected		●
Veterans rated less than 30% service-connected	●	
Veterans who receive a VA pension		●
Veterans whose income does not exceed the maximum annual VA pension rate		●
Veterans traveling in relation to a Compensation and Pension (C&P) Examination	<C&P Exam only>	
Veterans in certain emergency situations		●
Certain non-veterans when related to care of a 30% or more SC Veteran (caregivers, attendants, donors, and other claimants subject to current regulatory guidelines)		●
Certain non-veterans when related to care of a less than 30% SC Veteran	●	

Figure 10: Administrative Eligibility for Beneficiary Travel

Veterans Transportation Program

1.
2.
3.   VA's VTP offers Veterans many travel solutions to and from their VA health care facilities. This program offers these services at little or no costs to eligible Veterans through the following services:

Beneficiary Travel (BT)
Veterans Transportation Service (VTS)
Highly Rural Transportation Grants (HRTG)

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7.3.2.1.1 Veterans Transportation Service

VTS provides safe and reliable transportation to Veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments. VTS also partners with service providers in local communities to serve Veterans' transportation needs. Partners include:

Veteran Service Organizations (VSOs)
Local and national non-profit groups
Federal, state and local transportation services

1. Find a VTS location near you. (Find a VTS location near you.)
2.
3. *7.3.2.1.2   Beneficiary Travel*

The BT program reimburses eligible Veterans for costs incurred while traveling to and from VA health care facilities. The BT program may also provide pre-approved transportation solutions and arrange special mode transportation (SMT) at the request of VA. Veterans may be eligible for common carrier transportation (such as bus, taxi, airline or train) under certain conditions. All BeneTravel eligible veterans must have a referral confirming a Medical need for wheelchair or common carrier transports.

7.3.2.1.3   Highly Rural Transportation Grants

HRTGs provide grants to VSOs and State Veteran Service Agencies. The grantees provide transportation services to Veterans seeking VA and non-VA approved care in highly rural areas. These grants are available in counties that have fewer than seven people per square mile. HRTGs are specific to VISNs if needed.

Learn more about the HRTG program and VA's grants program. (Learn more about the HRTG program and VA's grants program.)

7.4

Coordinate/Schedule

Once internal/direct VA care and Community Care options have been discussed with the patient and they have decided, it is time to begin coordination of scheduling. There will be documentation on the consult/referral from the Clinical RCT providing direction to the [1]Administrative RCT regarding scheduling.

There are basically three options for scheduling:

Local VA facility
   a. Administrative RCT will review the scheduling instructions documented by the Clinical RCT to determine the next steps in scheduling.
   b. Administrative RCT reviews/establishes appointment modality (face to face (F2F), VVC, etc.) per triage tool and/or Clinical RCT documentation/direction.
       i. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note

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requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    c. Administrative RCT reviews/establishes Veteran scheduling preferences for internal/direct VA care (provider, date, time, location).

    d. Administrative RCT calls to schedule appointment (refer to contact Veteran and scripting sections).

    e. Administrative RCT documents all scheduling activities on the consult/referral via CTB.

2. Another facility within the VISN.

    a. Clinical RCT forwards the consult to the preferred VA facility/service via the IFC process.

    b. Receiving VA facility/service Clinical RCT reviews the consult, annotates consult priority and applies scheduling process listed in the Local VA facility section.

3. Community Care – If a patient has opted to use their community care eligibility after being presented all options, the RCT must gather and document the following information during the patient discussion in order to streamline community care scheduling. MEMO Community Care Scheduling Enhancements.

    a. RCT must also capture patient preferences using the CTB for community care, reference Veteran Community Care Scheduling Preferences Section and/or (section 2.9-2.12 in the community care field guidebook).

        1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    b. RCT members should forward a consult to community care (section 2.18 in the community care field guidebook) using CTB.

7.5 RCT Promising Practices

Strong practices have emerged over the past two years for RCT development and implementation. We have local and VISN level strong practices that you can refer to as you implement RCT at your facility/VISN. Please refer to Promising Practices Section on the RCI SharePoint details.

7.6 RCT Operations Supplemental Material

- Eligibility Factsheet
- Referral Disposition Instructions
- Care Assessment Need Information
- Special Consideration Solutions Table
- Veterans Transportation Service Information
- HRTG Program and Grants Information
- Referral Triage Tools

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8 SCRIPTS FOR DISCUSSING CARE OPTIONS

The scripting provided is a reference for RCTs to discuss referral care options with Veterans. These scripts will be revised and expanded based on user feedback. The scripts are guidelines. Veterans should know their options include appointment slots across the VISN. VAMCs/VISNs have authority to standardize messaging based on services available and care modalities that meet their Veterans' care needs.

Referring Provider Scripting

Veteran Has No Specific Questions

8.1 The referring provider needs to inform the Veteran on what to expect for referral coordination
8.1.1 next steps.

Referring provider script: "Mr./Ms. (*Veteran's name*), I will place a referral for (*specialty*) service and a member of the Specialty Referral Coordination Team will contact (*add facility specifics on who/how the Veteran will be reached*) you to discuss options available to you in the VA and in the community. You can then decide what option is best for you. Your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

8.1.2 Veteran Requests Community Care Referral Based on Eligibility

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care. Our goal is to inform you of all your health care options. I will place a referral for your specialty care and a member of our Referral Coordination Team will contact you to discuss all options available to you in the VA and in the community. This allows you to decide what option is best for you. In my opinion, your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, keep that in mind when making your appointment. Can I answer any more questions for you at this time?"

8.1.3 Veteran Requests Community Care Referral Based on Best Medical Interest

Referring provider script: "Best medical interest takes into consideration several eligibility criteria that examines medical hardship. This will determine if you are eligible to receive community care. Based on these criteria, I see that you (*do/do not*) meet the best medical interest eligibility criteria." (*State reason based upon nature or simplicity of service; frequency of service; need for an attendant; potential improved continuity of services; or travel difficulty*).

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care based upon best medical interest criteria. I will place a referral for (*specialty*) service. We have a member of the Specialty Referral Coordination Team here at (*facility name*) who will review your referral and determine what testing or level of care you may need. The Referral Coordinator {*add facility specifics on who/how the Veteran will be reached*) will contact you to

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discuss options available to you in the VA and in the community. Then you can decide what is best for you. Your appointment (*is/is not*) urgent, and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

Referral Coordination Team: Administrative and Clinical Scripting Framework

8.2

1.
2.

Greet and deliver individualized script to Veteran.
Inform Veteran of all options available to the Veteran.
  a. Recommendation(s) from Provider
       i. Clinically appropriate modality
      ii. Clinically appropriate timeline
     iii. Recommendation to receive care in VA vs Community
  b. Availability of VA appointments (in local or VISN)
       i. Telehealth at a VA clinic, community telehealth access point or at home, IFC, DoD
      ii. Travel: Bene-Travel, VTS, DAV etc.
  c. If Veteran is eligible for Community Care
       i. Expectation of Wait Times
      ii. Possible locations and associated drive times
     iii. Veteran scheduling preferences (location, time, date, provider) including if the Veteran chooses to self-schedule

3. Capture Veteran input of available options.
4. Veteran and RCT agree upon disposition.

8.3

Referral Coordination Team: Administrative and Clinical Scripting

8.3.1 Prior to contacting Veteran, team member runs DST to check eligibilities.

1. **Administrative RCT or Staff with Scheduling Keys – Veteran Engagement**

2. "Good Morning/Afternoon, my name is (*staff member name)* and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"

3. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We reviewed the request and want to schedule you for an appointment. We have a variety of options for this appointment including (*offer modalities identified in the consult*), and you (*are/are not*) eligible to be seen in the community. The dates and times we have available are (*dates/times for the modality*)."

4. **If Veteran elects to schedule with VA:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name, date/time, via face-to-face visit/Telehealth*). I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you? Thank you for choosing VA for your health care provider. Have a great day!"
    Scripts for Community Care Eligibility for Community Care with Veteran

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a. **Veteran is not eligible to be seen in the community**: "I am sorry Mr./Mrs. (*name*), but at this time you do not meet the eligibility requirements (*state requirement*) for community care. However, we are happy to schedule an appointment for you at the VA and can do this right away. Once the appointment is made, I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you?

b. **Veteran is eligible to be seen in the community**: "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*). However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our number one priority, and we can assist with either option you choose. How would you like to proceed today?"

    i. **Veteran elects to schedule VA Face to Face appointment:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. Thank you for choosing VA for your health care. Have a great day!"

    ii. **Veteran elects to schedule VA telehealth appointment:** "Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."

        1. **Into the home:** [Administrative RCT obtains/updates email field] "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. For your video visit, you will choose a private location such as home or work to meet over video with your VA Provider using secure, encrypted technology on your internet-connected smartphone, tablet or computer. A member from the specialty or a telehealth coordinator will contact you for a test call before your (*specialty*) appointment."

2. **Into a community telehealth access point:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit in the private room at (*Walmart/VFW/other*) an attendant will be on site to securely connect you to a virtual provider."

3. **Into the virtual clinic:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit, a VA technician will use modern technology to do an exam or connect you to a virtual provider."

iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file and will then send your information to the Community Care staff. They will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.3.2 **Clinical RCT or Administrative RCT Do Not Have Scheduling Keys – Veteran Engagement**

1. "Good Morning/Afternoon, my name is (*staff member name*), and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"

2. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We have reviewed the request and want to schedule you for an appointment. We can see you at the VA Medical Center as soon as (*date, time, via F2F visit/Telehealth*), and you (*are/are not*) eligible to be seen in the community."

3. **If Veteran opts to schedule with VA:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. Thank you for choosing VA for your health care. Have a great day!"

   a. **Veteran is eligible to be seen in the community:** "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*) date. However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our

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number one priority, and we can assist with either option you choose. How would you like to proceed today?"

    i. **Veteran elects to schedule VA Face to Face appointment:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. After the appointment is made, a letter will be mailed to you as a reminder of your appointment date and time. Thank you for choosing VA for your health care."

    ii. **Veteran elects to schedule VA Telehealth appointment:** "Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have a smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."

        1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

    iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file. I will then send your information to the Community Care staff who will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.4

Referring Provider or RCT Team: Veteran Needs Can Be Addressed via E-Consult

Referring Provider/Referral Coordinator Script: "Mr./Ms. (*Veteran's name*). This is (*Provider name, or Referral Coordinator calling for Provider name*). A referral for (*specialty*) service was placed and (*specialty provider*) contacted me. After review of your information, we feel we can treat you without you having to visit the specialty clinic. We recommend the following (*treatment plan*)."

8.5

MISSION Act Information

Current Mission Act Information and Scripting:

- Mission Act General Information
- Eligibility FAQs
- Call Handling and Documentation

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Veteran Does Not Answer the Phone

Scripts for answering machine messages will be included in future releases of the guide. VAMCs and VISNs will need to identify how Veterans can best reach the RCT. It is recommended the Veteran's PACT be the initial point of contact provided if a telephone number is needed so as not to add another phone to monitor.

8.6

9 DATA AND MEASURING SUCCESS

Impact Measures

9.1 Initial anecdotal feedback from RCTs, Patient Advocates and providers should be collected by the Executive Sponsors to assess immediate impact. The purpose of the initiative is to improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.

To measure success, VHA will be monitoring the following RCI outcome measures:

Table 4: RCI Key Performance Indicators

Focus Area	Measure	Goal
Decrease consult scheduling time	Consult Scheduling Timeliness - Average days from File Entry Date (FED) to first scheduled by first scheduled date	• Aspirational goal of 3 days for both Internal/Direct Care and Community Care
Improve Veteran satisfaction	VSignals (Community Care survey)	Increase percentage of respondents with "agreement" score
Ensuring Veterans understand their full range of care options	Percent of Veterans engaging with RCT (metric in development)	90% of referrals reviewed by RCT
Maintain VA's ability to fund internal/direct VA specialty care services	• Community Care cost • Referral Volumes for internal/direct VA vs community care • Understanding population of Veterans who Choose VA (metric in development)	Intended to be used for VISN/VAMC leadership to identify possible resources

9.2

Analyzing Data to Monitor Progress

Data that can be used to monitor progress includes those listed under How to Get Started and Operational Measures.

How to Get Started:

- VA and Community Care Referral Trends (see example in next section about how to use this data to choose which specialties to start with)
- Understanding Changes in CC Volume (by Consult title)
- Understanding Changes in VA Volume (by Stop Code)

Operational Measures:

- Community Care Eligibility Distribution

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- Improving Timeliness: Referral Cycle Time
- Increasing Care Options: Face-to-face, E-Consults, Virtual, Telephone, Interfacility, etc.

The RCI Data Portal provides links to reports that support management of RCI access principles by providing a consolidated view of internal and Community Care measures in the same visuals. The Implementation Team should thoroughly analyze report results to determine the effectiveness and efficiency of current operations and reporting reliability. The implementation team should also analyze trends to observe reporting result changes over time and to determine the root causes behind inadequate performance.

Supplement detailed reports are currently available for both internal/direct and community care referral management individually. This data portal will evolve as new data measures become available. RCI Data Supplement is in development to provide data definitions and additional training. For guidance on Community Care specific reports, review Chapter 6 of the OCC Field Guidebook.

Each facility should take a multi-disciplinary approach to selecting which specialties to incorporate into the RCT first. Considerations include specialties with highest overall volume of consults, highest community care demand and longer consult processing times. Additionally, facilities can consider specialties that may already be operating with an RCT-like process, specialties with a strong clinical champion, or specialties with strong academic affiliations.

Below is an example of how to look at the data if you would like to focus on specialties that have the highest community care demand.

How to Determine Specialties with the Highest Demand
4.
    Step 1: Identify yearly referral volume by specialty (Internal & Community Care)
       a. Access the RCI Data Portal
         i. Select Volume by Specialty
         ii. Filter data for latest Fiscal Year and facility
         iii. Sort data largest to smallest
            1. All Internal VA Referral Volume by Service/Stop Code
            2. All Community Care Referrals volume by consult title
         iv. Use the Data to develop Staffing Plans
            1. Prioritize specialty services by Referral Volume (Community Care, Internal, or Community + Internal)
5.
6.
            2. Identify Total Referral Volume (Community Care + Internal) and divide annual volume by 10,000 to identify approximate FTE required to timely and appropriate address referrals.
               a. Example: 17,000 VA Cardiology Referrals + 3,000 Community Care Referrals = 20,000 divided by 10,000, which shows 2.0 FTE required
    Step 2: Prioritize specialties that have the highest rate of referral to community care
    Step 3: Using audience from How to Get Started Section to identify appropriate staffing

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Data and Measuring Success Supplemental Material

- RCI-Power BI-Dashboard
- RCI Data Portal
- Data Portal Supplement

9.3
- OCC Field Guidebook - Chapter 6
- Recording: VSSC Office Hours 030221 RCI Dashboard Presentation

10 APPROPRIATE USE OF DECISION SUPPORT TOOL (DST)

NOTE: *Consult Toolbox Version 2.0 combines the Decision Support Tool (DST) and the Consult Toolbox (CTB) as one web-based tool integrated within CPRS. The equivalent of the DST is built directly into the CTB Version 2.0 and the below still applies using the CC Eligibility (DST) tab in the workflows.*

In the new process, the referring provider is not required to use DST but may choose to render a Veteran Community Care eligible under MISSION ACT authority of Best Medical Interest (BMI) eligibility and document the reason if they feel there is a strong clinical indication. Specialty clinics or RCT utilize this tool when determining where the Veteran is eligible to seek care. The RCT will take more ownership of making this determination if the DST was not previously run by the referring provider. The primary care team must still determine primary care community care eligibility before including provider, nurse and scheduler when scheduling primary care appointments.

DST will allow the RCT to view relevant data within the existing CPRS consult order workflow. This helps guide the conversation with the Veteran to decide if a consult should be referred to the local VA facility, a near-by VA facility via Inter-Facility Consults (IFC), or to a community provider by providing information about the following:

1. Veteran's static community care eligibility (hardship, living in a state without a full-service VA or grandfathered into community care from the legacy Choice program) for accessing care in the community
2.
3. Drive time standards and drive time eligibility associated with the requested consult service. Average wait times for the requested clinical service at VA facilities near the Veteran's place of residence and average wait times for community care appointments (note that average wait times may not be used to determine wait time eligibility)
4. Veteran's stated preference for community care (Opt-in/Out or To Be Determined/Deferred)

It is important to note, with CTB 2.0 a consult cannot be forwarded to community care without
10.1community care eligibility captured using CTB.
1.

DST Checklist for RCT

2. The RCT must be familiar with E-Consult and Telehealth protocols as well as access to the face-to-face clinic grids and Telehealth schedules to determine the appropriate options available when having a conversation with the Veteran about his/her care choices.
Community Care Eligibility
   a. If none exists, consider what the best method is to meet the Veteran/referring provider's needs including overbooking an appointment based on local protocols.
   b. Ensure to review the specific clinic where the patient is to be scheduled using VSE or VistA appointment packet in order to determine the next available

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appointment and to consider community care wait time eligibility. If the Veteran is eligible for community care based on wait time, the consult must be forwarded to community care using the CTB.

Best Medical Interest (BMI)

3.

a. If the referring provider entered a referral and used DST to render the veteran community care eligible based on best medical interest, the RCT should still review with the veteran ways in which the veterans care needs might be met within the VA including an E- consult, telehealth or face-to-face visit. If the veteran chooses to receive his/her care within VA, the appointment is made and #COO # is placed in the comment section of the appointment. If the veteran opts into community care, scheduling preferences are obtained and documented using the CTB. Offer the Veteran the opportunity to self-schedule and to select a specific provider using the community provider locator (CPL). Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.

b. If the referring provider entered a referral and placed considerations for BMI in the body of the referral but did NOT use the DST to render the Veteran CC eligible based on BMI, RCT determines if the care requested can be addressed via an E-Consult, Telehealth, or a face to face visit. Supporting documentation should be available in the body of the consult to support the need for the episodic medical hardship/BMI.

i. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult and inform the Veteran of the pending recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document. If the Veteran's care needs can be addressed by a face to face visit within the wait time standard, the appointment is made.

ii. If care cannot be addressed via E-Consult or Telehealth, review the referral with the Veteran, discussing the available care options within VA as well as care in the community. If the clinician reviewing the consult agrees that based on the considerations for BMI noted by the referring/ordering provider in the body of the consult and their own judgement that it is in the Veteran's best medical interest to seek care in the community, the Veteran is given the option for community care. The Veteran's decision is captured on the consult along with the Veteran's community care scheduling preferences. The Veteran is informed that these preferences will be used to schedule the community appointment. Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.

4.

Drive Time – Can the care need be addressed via an E-Consult or is Telehealth a viable option?

a. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending

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recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document opt-in/out decision in the Consult Toolbox (CTB). If the Veteran opts out, schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.

    i. If care cannot be addressed via E-Consult or Telehealth, discuss transportation options to receive internal/direct VA care.

    ii. If none are acceptable, capture the Veteran's scheduling preferences in CTB and forward to community care using CTB and choose Drive Time as the forwarding reason.

5. Wait Time – Is there local guidance for the scheduler to consider an overbook?

    a. If yes, scheduler should book the Veteran in clinic according to the local overbook guidance within the wait time standard. If the overbook request is denied or is for after the wait time standard, the Veteran is still eligible for community care.

6. Wait Time – Can the Veteran/referring provider's needs be met via an E-Consult or Telehealth?

    a. If yes, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending recommendations from the specialist. For telehealth options, discuss with the Veteran and document opt-in/out decision in the CTB. Schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.

    b. If no, capture the Veteran's scheduling preferences in the CTB and forward to Community Care using CTB and choose Wait Time as the forwarding reason.

10.2   Best Medical Interest General Information

It is important to keep the following information regarding BMI in mind while making the BMI determination:

- BMI is **not** required and should only be recommended when there is a true medical hardship for the requested episode of care rendering the Veteran eligible to receive care in the community.
- BMI is **not** to be used for Veteran or provider preference or convenience.
- BMI is a MISSION Act eligibility.

If a referring provider believes that BMI should be utilized for a true medical hardship and documents this in the DST, it does **not** mean the Veteran must receive their care in the community. Once RCT reviews the referral, the Veteran should make an informed choice to either remain with VA for his/her care or utilize community care based on his/her BMI eligibility as well as other factors such as other modality options or appointment availability.

10.3   Types of BMI

There are two types of BMI: Episodic Medical Hardship and General Hardship.

Episodic Medical Hardship (labelled "BMI-Per Episode of Care" in CTB) is only for a single, specific episode of care.

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2.

    a. The referring or primary care provider is not required to run DST unless he or she has determined BMI is clinically appropriate for a true medical hardship. The referral would then be routed to the RCT to review the referral with the Veteran including the BMI request. The referring or primary care provider can only capture BMI using DST (CC Eligibility (DST) tab in CTB 2.0) at the time of entering the referral. DST will not allow end users to capture the BMI eligibility on a signed referral.

    b. When the referring or primary care provider recommends BMI be considered without running DST, he or she should document this in the body of the referral with justification. **This is not considered a true BMI eligibility** but rather a suggestion that the RCT or specialty provider would consider when discussing care options with the Veteran.

General Hardship (labelled "BMI-Hardship" in CTB) can be either for six months or one year, depending on the Veteran need, for all care referred to the community.

    a. General Hardship BMI is determined via a Community Care-Hardship Determination referral placed by VA provider and reviewed by the facility Chief of Staff or designee. If hardship determination is approved, community care or VA referrals must be placed as appropriate for all subsequent care needs for the approved length of time.

    b. Just because a Veteran has an approved hardship eligibility, it does **not** mean the Veteran must have all their care in the community. The Veteran has the option to have some (or all) of their care at the VA for each referral placed. If the DST has **not** been run to place BMI or there are no BMI considerations within the body of the referral from the referring provider, the Clinical RCT can discuss with the Veteran if there is a reason for BMI. The Clinical RCT would need to document the justification via added comment on the referral. Once that is done, the LIP from the RCT team, if applicable, or VA provider, would need to provide their concurrence as an added comment on the referral that BMI is appropriate. Once that has occurred, the RCT can forward the referral to Community Care, using the appropriate community care eligibility reason using the CTB, at the time of forwarding the consult to community care.

10.4

BMI Definitions

Within the DST, there is a **required** free text box under each BMI option for referring provider to document the justification for choosing the specific BMI option. This should be documented upon the referral entry.

Please note that BMI eligibility cannot be determined/captured by an administrative staff member. With CTB 2.0 only the provider and nurse user role will be able to capture the BMI eligibility determination. In CTB 2.0, the end user making the BMI eligibility determination can use the pre-populated drop down to capture the specific BMI eligibility reason.

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

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- **Frequency of Service:** To be considered if the frequency of the requested care is often enough to be a medical or clinical burden to the Veteran to have to travel to the nearest VA to receive. Examples include physical therapy, chemotherapy, and radiation therapy.
- **Need for an Attendant:** To be considered when an attendant is required for a specific episode of care. An attendant is any person who provides required aid and/or physical assistance to the Veteran, for a Veteran to travel to a VA medical facility for hospital care or medical services. The provider must consider the care/procedure being requested and/or the Veteran's medical condition when determining the need for an attendant. This definition is consistent with the definition of this term in VA's beneficiary travel regulation (see 38 CFR 70.2.), but that definition at § 70.2 is dependent on separate eligibility under the Beneficiary Travel program.
- **Potential for Improved Continuity of Care:** To be considered if the requested service were to occur in VA it would disrupt an established treatment plan with a community provider who delivers stable, consistent care to the Veteran during a specific episode of care. Examples could be: Recent surgery or active chemotherapy. A Veteran who had a knee replacement two years ago or who is previously established with a community provider and wants follow-up with their community provider would require a new referral with a new determination of BMI eligibility for a new episode of care if medically indicated.
- **Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 mins for PC and MH and 60 mins for SC) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (e.g., Social Work Service (SWS) referral) when making this determination.

10.5

Supplemental Materials

- Office of Community Care Field Guidebook (FGB)
- Consult Forwarding Procedures, FGB Chapter 2, subsection 2.18

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11 COMMUNITY CARE SCHEDULING

When the RCT determines that the Veteran is eligible for and opts in for community care, the RCT *must* ensure the information listed in this section is documented in the consult before the consult is forwarded to community care. For consults/ that are directly ordered to community care (for services not offered in the VA facility), the PACT or RCT front-line staff will ensure that Veteran preferences identified below are documented at the time the Veteran checks out of the internal, VA appointment. Ensuring this information is documented will support expedited scheduling of the community appointment for the Veteran and avoid unnecessary Veteran contacts.

Community Care Referral Checklist

Prior to the consult being forwarded to community care, the RCT will review the consult for
11.1 completeness and document the following information in the consult:

Capture clear documentation of the community care eligibility either using the DST or using CTB and selecting the correct forwarding reason.
1.
Ensure a clinical review was completed and documented by either an MD, NP, PA or DO or
2. RCT/Specialty Care RN under direction of one of the above.
Consider a standard episode of care (SEOC) and, if appropriate, select using CTB's
3. "authorizations tab." The CC Eligibility (DST) tab is used in CTB 2.0. (This step can be delegated to the facility community care office.)
4. Capture clear documentation of the clinical need by the referring provider.
5.
Capture the Veteran's community care appointment scheduling preferences to include preferred provider or "no preferred provider", day of the week or "any", and time of day or "any" using CTB unless the Veteran decides to self-schedule. If so, only preferred provider
6. is needed.
Inform the Veteran that these preferences will be used to schedule his/her community appointment.

11.2

Veteran Community Care Scheduling Preferences

Capturing a Veteran's community care scheduling preferences is mandated to expedite appointment coordination. Multiple attempts to contact the Veteran delay community care scheduling. Capturing preferences prior to check-out or before the consult is forwarded to community care minimizes delays and ensures the Veteran receives timely care in the community.

Capturing Veterans preferences for community care scheduling occurs after the Veteran's eligibility has been verified and the Veteran has opted-in for community care services.

Capturing scheduling preferences will be completed for all community care consults regardless of who is doing the scheduling (VA or Contractor) or how the Veteran prefers to be scheduled. When an eligible Veteran opts into community care, scheduling staff *must* capture the

Veteran's scheduling preferences as shown in CTB. Additional guidance can be found in the OCC Field Guidebook, Chapter 2, subsection 2.19.

Staff members who are responsible for consult management such as the RCT will document the Veteran's community care scheduling preferences in the following scenarios:

- When the Veteran is eligible and opts into community care after discussing the options offered internal/directly within VA, the RCT will capture Veteran community care scheduling preferences for the following scenarios 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

When a Veteran is eligible for community care due to wait time and opts in, the VAMC staff member who forwards the internal consult to community care should place the date of the next available internal VA appointment on the consult/referral prior to forwarding to community care.

Types of Preference Information to Capture

11.2 Scheduling staff *must* capture the following information for Veteran preferences for scheduling community care appointments (the minimum information required is bolded unless the Veteran chooses to self-schedule in which case only the community provider preference (or "no preferred provider") is required):

1. **Community Provider Preference (or "no preferred provider")**
2. **Day of the Week (or "any")**
3.
4. **Time of Day (or "any")**
5. **Scheduling Preference (VA or Veteran self-scheduling)**
6. Communication Preference (text, phone, email, standard mail, MHV Secure Messaging) Mileage Veteran is willing to travel

Each Veteran *must* be informed that this information will be used to schedule the appointment
11.2.2 with the preferences provided this information *must* be documented and agreed upon by the patient to not be considered blind scheduling.

Accessing the Consult Toolbox to Capture Scheduling Preferences

Frontline staff and RCT *must* use the VA Community Provider Locator (CPL) tool must be used to identify the preferred provider.

Facility community care staff *must* continue to use Provider Profile Management System (PPMS). For contingency purposes, staff (not including facility community care staff) may use the VA.gov Facility Locator to identify the preferred provider. If the Veteran does not have a preferred provider, the staff must select "no preferred provider" using the CTB.

Staff can capture Veteran community care scheduling preferences using either the Community Care Functions or Scheduler Options within the Consult Toolbox (CTB). In CTB V2.0, staff can also enter community care scheduling preferences using the available CTB 2.0 process flows.

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The staff member will need to speak to the Veteran prior to entering the scheduling preferences in the CTB. The staff member will need to know the method in which the patient will be scheduled to complete the preference. Methods include VA scheduling, or Veteran self-scheduling (VSS).

It is important to note that community care scheduling preferences must be captured prior to forwarding the consult to community care. The following report can be used to monitor compliance of this process: Power BI (powerbigov.us)

Figure 11: Community Care Functions

Figure 12: Scheduler Options

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(CTB Version 2.0)

Figure 13: Community Care Workflow Provider Preferences

Figure 14: Scheduler Options for Patient Preferences Add Comment / Receive Consult Workflows

Figure 15: Scheduler Options for Patient Preferences Forward Consult Workflow

11.2

Figure 16: Scheduler Options for Patient Preferences Forward Consult Workflow

Entering Veteran Preferences

(CTB Version 1.9.0078)

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Select the "MSA PT Contact" tab and complete the "Veterans Preferred Provider Information" section using the drop-down menu. If a Veteran chooses to self-schedule, only the preferred provider is required.

Step 1: Check "Update record with above information" box
Step 2: Select "OK" at the bottom of the window

Figure 17: MSA Patient Contact Tab

(CTB Version 2.0)

Select the "Patient Preferences tab" tab and complete the Patient Preferences and the "Veterans Preferred Provider" section using the available options and the CPL. If a Veteran chooses to self-schedule the day/time preferences are not required.

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

Figure 18: Scheduler Options for Patient Preferences Add Comment / Receive Consult Workflows

Options for Community Care Scheduling

11.3
Veterans will have the two options to determine how their community care appointment will be scheduled: VA Scheduling and Veteran Self-Scheduling. Veteran preference for scheduling will be documented using the guidance identified in the <u>OCC Field Guidebook, Chapter 2, subsection 2.19</u>.

11.3.1
VA Scheduling

VA will schedule the community appointment on behalf of the Veteran using the community
11.3.2 care scheduling preferences documented by RCT.

Veteran Self-Scheduling

The Veteran may elect to self-schedule his/her own appointment.

VSS begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider. The Veteran can provide this preference to self-schedule to the clinic Medical Support Assistant (MSA), RCT or the facility community care staff. The community care VSS 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 the CTB Consult Review Tab.

Additionally, RCT *must* use the VA Community Provider Locator (CPL) in CPRS to identify Veteran's preferred provider and to ensure the preferred provider is in network.

It is important to note for care that is available within VA, the Veteran's preference to self-schedule for community care should be captured after an RCT member has discussed all care

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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. If the preferred in-network provider is known, the Veteran may also elect to wait three days to call the provider to schedule prior to receiving the letter in the mail.

In addition, the front-line staff or RCT *must* clearly communicate to the Veteran that he/she *must* contact the facility community care office to inform them of the appointment date/time for documentation purposes in a timely manner. More information is in the OCC Field Guidebook, Chapter 3, subsection 3.16.

Note that self-scheduling may not be appropriate for some Veterans with active Behavioral Patient Disruptive Flag (BPDF), based on the Veteran's individual needs. If the Veteran has an active BBDF, elevate the request 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 a community provider. DBC Chair contact information can be found at: Workplace Violence Prevention Program (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 OCC Field Guidebook, Chapter 3, subsection 3.15. "How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran."

11.4   Community Care Scheduling Supplemental Material

- The Office of Community Care Field Guidebook (FGB)
- Policy Appendix

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12 USE OF ELECTRONIC CONSULTS (E-CONSULTS)

Recently updated reimbursement rules have expanded payment for non-synchronous care such as Electronic Consults (E-Consult). While some Veterans prefer in-person visits and some types of services will require in-person visits, the availability of electronic records supports wider access to specialists' expertise without the necessity of a face-to-face patient visit. Electronic record review and consultation can spare Veterans unnecessary travel and provide them convenient access to specialty care.

The Office of Specialty Care Transformation developed the E-Consult initiative to improve access to specialty care for Veterans and their primary care providers. E-Consults allows referring providers to request review of the record, obtain interpretation of the information, and receive recommendations. They also allow the specialist to receive workload credit for non-face-to-face visits done by chart review.

What is an E-Consult?

12.1 E-Consults are referrals designed for Veteran/provider questions about advice for diagnostic and therapeutic issues. They can also be used to better prepare a Veteran for a face-to-face visit by arranging for the completion of necessary tests in advance of the visit with a specialist.

E-Consults should be completed within three business days (excluding weekends but not holidays) of the File Entry Date. Learn more about the process in the E-Consult Guidebook Version 3.

E-Consults are a kind of asynchronous care sometimes referred to as "chart only consult" or "virtual consult." Within VA, an E-Consult does not require direct communication (phone or written) with the referring provider and can be completed just through a review of the chart and
12.2 a written note. E-Consults are also considered one subset of asynchronous care.

All Sites Should Promote E-Consults as an Avenue of Care

To optimize Veteran choice and improve access to care, all specialties should provide E-Consults. This requires the local site to develop a referral process in CPRS with note titles and encounter locations that include "E-Consult" to be tracked appropriately. Veterans are not billed for copay. Workload is tracked as described below. We strongly encourage specialty care services to consider active consult management, identifying face-to-face requests that can be completed as an E-Consult and vice versa.

All services within the medical center should receive communication about any new E-Consult opportunity. Staff should promote E-Consults as a rapid, efficient way to obtain documented diagnostic or management recommendations without a face-to-face visit. Examples of good outcomes should be marketed to all services to promote use of E consults. Staff should promote E-Consults in Care Coordination agreements between Primary and Specialty Care Services.

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Advantages of E-Consults

12.3 A consultant's review of the records can take place without structured scheduling, allowing the consultant flexibility to complete tasks at a convenient time. Because the Veteran does not need to travel, the inconvenience and costs of scheduling and arranging transportation are eliminated. While support staff may, at times, expedite requests from the referring provider or the specialist, when compared to a traditional consultation, the burden on support staff is generally reduced. Consults can be completed without the delay of scheduling and the response time to the consultation can be much less than in a traditional consultation. Consultants whose expertise is highly specialized may be accessible from long distances for those Veterans who cannot travel to/from medical centers.

E-Consults Take Time to Perform

12.4 Providers who perform E consults should have time to perform referrals using the most efficient approach that limits impact on face-to-face clinic time. Section Chiefs and Service Chiefs are responsible for assessing productivity and assigning the appropriate amount of allocated time for all asynchronous care, including E-Consults. Data on individual productivity will continue to guide those individuals in accomplishing their goals. Section productivity can be assessed based on total clinical workload: clinic, ward or inpatient referral coverage, procedures, test interpretation (electrocardiograms (EKGs), pulmonary function tests (PFTs), telephone or tele-video visits and E-Consults. Clinical care in any form should be used to maximize access based upon the need of the Veteran. Clinicians should be reassured that productivity for completing E-Consults is comparable to performing face-to-face visits and is based on the time spent completing the consultation as opposed to care complexity with office-based Evaluation and Management (E&M) codes. Please refer to the Electronic Consult Implementation Guide for additional information and implementation guidance.

12.5

Use of E-Consult Supplemental Materials

- E-Consult Guidebook Version 3

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13 TELEHEATH / VIRTUAL CARE

MISSION Act and Telehealth

13.1 The MISSION Act established "Anywhere to Anywhere" telehealth across state lines and from off-site locations to a Veteran's home or community. Through Telehealth, VA has an unprecedented opportunity to grow and to meet Veterans where they are with continuity, convenience, and excellence. Providers should invite Veterans to consider care by Telehealth for several reasons, including its ability to provide overall continuity of care, a Veteran-centric option within VA, and a more convenient option for care, often with reduced travel requirements.

Per the MISSION Act, the below verbiage from the preamble applies when determining community care eligibility when the appointment being offered is considered Telehealth. "The proposed rule stated that if the VA is able to furnish a covered veteran with care or services through telehealth, and the veteran accepts the use of this modality for care, VA would determine that is was able to furnish such care or services in a manner that complies with designated access standards. We received one comment that urged VA to ensure that the option for the Veteran to have face-to-face care would be maintained if the Veteran did not choose the telehealth modality. We do not make changes based on this comment. As stated in the preamble of the proposed rule, VA will not require a veteran to accept the use of telehealth for the purpose of meeting VA's designated access standards." Review specific guidance from the law. Select the Final Rule document and search the word telehealth. Review the Office of Community Care Field Guidebook for additional guidance about eligibility requirements for unique scenarios such as a Veteran who choosing telehealth and then requires an in-person visit.

13.2

What Kinds of Telehealth Appointments Exist at VA?

Synchronous (Clinical Video Telehealth or VA Video Connect into the home/non-VA site), Asynchronous (Store and Forward Telehealth) and Remote Patient Monitoring (Home Telehealth) are telehealth services offered at VA.

VA leads the Nation in telehealth, with options in more than 50 specialties. Service lines consider what care is appropriately delivered by Telehealth by clinical judgement and via guidance from Specialty Telehealth Operational Manuals. Specialty expert consultation by telehealth for select conditions is available through a network of National and VISN based Telehealth Hubs. Inpatient telehealth services include tele-hospitalist, tele-ICU, tele-stroke, and other programs.

Telehealth clinics must be set up in VistA to correctly capture workload. At this time, telehealth services into the home are not associated with a patient co-pay.

Increasingly, VA providers will have the skills to offer Veterans clinical care by telehealth. Video telehealth expansion into the home and non-VA sites of care began in 2018 for Primary Care and Mental Health and expanded to Specialty Care in 2019. All VHA ambulatory healthcare

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professionals are expected to have completed at least one video visit into the home or non-VA site, by end of FY2021. Expansion of asynchronous care in eye care, dermatology and sleep is underway. VISN Clinical Resource Hubs offer services in Primary Care, Mental Health and increasingly Specialty Care.

Advantages of Telehealth

13.3

Telehealth, and virtual care in general (mobile applications, secure messaging, remote patient monitoring) should be promoted as an option for Veterans to choose VA, decrease travel time or travel cost, and increase convenience and comfort (for Veterans not wishing to receive care in a medical facility). There is high Veteran satisfaction with Telehealth Services at VA on par with in-person care. To date, the literature on Telehealth suggests equivalence in clinical outcomes, experiences and improved continuity of care.

In the management of rare/specialized clinical conditions, telehealth may be the best option for Veterans who have few (or no) options for care in the community. During disasters or emergencies when facilities experience closures and appointment cancellations resulting in a potential surge of increased eligibility for community care, prioritizing appointment rescheduling to include virtual care supported by facility based, VISN based or national providers can mitigate access challenges during the period of the disaster/emergency.

Since the location of the remote provider is flexible, VA can optimize capacity by recruiting providers in areas where it is relatively easy to do so and match this available capacity to demand elsewhere in the VISN. Clinical capacity for Telehealth may be available through Telehealth providers located in front-line clinics within the healthcare system, or within the VISN Clinical Resource Hub. Facility leadership is encouraged to identify underutilized FTEE for telehealth (Productivity and Staffing Guidance for Specialty Provider Group Practice VHA 1065(1) linked here) Services from providers outside the VISN may be arranged by an MOU and/or cost-transfer.

13.4

Applicable National Data Sources

- VSSC Connected Care Reports
- Appointment Data Cube now includes wait time and encounters for telehealth appointments in addition to in-person appointments. VSSC Appointment Cube
- CVT SFT Data cubes for information on Telehealth Data or historical usage, who/what CBOCs currently use. VSSC CVT SFT Cube
- Provider productivity cubes for evaluation of who may have capacity at your site to start or expand provider side offering of telehealth in your specialty VSSC Provider Productivity Cube
- Community Care data to review what services are being provided in the community. VSSC Community Care Cube
- Virtual Care Scorecards

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How to Increase Awareness with Veterans and Staff

A key to increasing use of virtual care throughout the health care system is to make both Veterans and staff aware of how it works, when it is appropriate to use and that the Veteran will still be receiving the top quality of care that they receive throughout other modalities. Using tools such as VEText, Secure Messaging, and social media for outreach efforts are recommended.

13.5

Promising practices and data to support their process. A summary of these practice may be viewed on the Connected Care Messaging Blog.

Scheduling with Virtual Care

In VA, there are multiple options for scheduling telehealth. The Telehealth Scheduling Tool Matrix outlines all scheduling platforms and when they are appropriate to use for scheduling. The Office of Connected Care is continuing to work on making the scheduling process streamlined with in person visits. Currently the main platform for scheduling VVC is Virtual Care Manager. Review additional information about Virtual Care Manager and scheduling specific information on VA Video Connect for Schedulers.

13.6

Scheduling Training Requirements

13.6.1

All schedulers need to follow OVAC Scheduler Requirements as laid out in VHA Directive 1230 including virtual care scheduling requirements. A Specialty Care Department of Veterans Affairs Video Connect Expansion Memo (VIEWS# 03400841) from August 25, 2020 was sent to the field requiring schedulers mastering the most recent VVC Scheduler training and schedulers are required to have scheduled VVC appointment. The trainings and can be found on TMS, training module #41309.

13.6.2

Understanding Where Virtual Care Is Available in VA Network

To optimally inform the Veteran, the RCT needs to know where virtual care is available across the network. Currently the VHA is in progress of creating an efficient national database however there are ways to gather the applicable information. Below are examples of how sites are sharing this information across their healthcare systems in the interim. Consider using the following practices to understand where virtual care is available across their VISN.

- Create a VISN SharePoint were all information is been posted and shared
- Grant Access to local SharePoint for staff and leadership
- Hold Telehealth Leadership weekly meetings
- Hold a VISN while Telehealth Strategic Planning call
- Hold weekly meetings with Leadership including front office and ACOS
- Connect with the SAIL workgroup, NDPP, Nursing Executive council and Medical Executive Council
- Participate in PACT Huddles and departmental staff meetings
- Distribute local flyer across the facility with all the Telehealth modalities and services offered.

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- Work in collaboration with patient advocate team, patient centered care team and Wholehealth team to share Telehealth information across the facility
- Create a spreadsheet by site to show who is offering what about Telehealth at each facility.

Specialty Specific Guidance on How to Start and Expand

13.7 Through virtual care Telehealth is well suited to provide care for the majority of outpatient clinic visits through Synchronous Telehealth/Clinical Video telehealth (CVT), CVT to home (VVC), and other Virtual Care options including Asynchronous Store and Forward Telehealth (SFT) or E- Referrals. Expansion of Virtual Care offerings is the appropriate step for many services and for patients to bring the right care to the right place at the right time. This following seven specialty sprint focus areas gives recommendations on evaluation and expansion of Virtual Care offerings to be implemented in conjunction with the Referral Coordination Teams (RCT). Each specialty focus area includes the following sections specific to that specialty

- Services to consider for E-Consults
- Services to consider for telehealth
- What the Veteran & Provider can expect when using telehealth
- Recommended care pathways
- Staffing recommendations for telehealth
- FY2020 Usage facts
- Current promising practices
- Resources & innovative approaches needed to continue to expand virtual care

In the Field Guides, you will also find a Telehealth Supplement if one exists. The supplement includes use cases and set up for telehealth. Select and view guidance specific to your specialty on the Telehealth website.

Figure 19: Telehealth Specialty Menu

13.7.1 Steps to Start Expansion

1. Review telehealth utilization, wait time and Community Care data to determine best specialty in which to expand.

2. Contact your Facility Telehealth Coordinator (FTC) and RCT review telehealth data and community care cost data, see where telehealth is offered at CBOCs see where you can expand, consider VISN CRH level approach.

3. See what the highest community care utilization is for your service(s) and plan how to include virtual health offering, prioritize where to start and with what service based on data.

4. Include RCI team at local facilities to make aware of current telehealth options for service(s) and expansion of service(s)/offering let it be known *which* CBOCs offer Telehealth currently.

5. Discuss pathway with RCI team for offering patients telehealth, (e.g., what does that look), use of telehealth admin scheduling referrals, how does RCT involve telehealth option up front and aware to offer this first to patients.
   a. Examples:
      i. Identify CBOCs in your VISN that do not offer TeleDermatology or face to face Dermatology care.
      ii. Evaluate the staffing at the CBOCs and if there is a TCT trained in TeleDermatology, if not have the FTC take steps to have the TCT at the CBOC trained in TeleDermatology.
      iii. Assess that the CBOC has the equipment for TeleDermatology, a hand-held point and shoot camera with dermascopy attachment is recommended, cost is around $2000.00 per unit.

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iv. Follow telehealth specialty supplement for referral and clinic set up for go live of new TeleDermatology service offering.

Market to patients and providers.

Virtual Care Supplemental Materials

6.

13.8

- Telehealth Website
- Telehealth Expansion - VHA Telehealth Services Intranet (va.gov)
- Specialty VA Video Connect Expansion VSSC Report
- Inclusion for Specialty Care Service Lines
- Facility Executive Leadership VA Video Connect Checklist
- Example of VISN Menu of Services
- Example of VISN Telehealth Service Agreement

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14   CHANGE MANAGEMENT

This section of the guidebook will reference Prosci® tools and techniques to support RCI. Prosci® Change Management focuses on managing the people side of change with research-based processes, tools and techniques to achieve the required business results. Every organizational change ultimately has individual impacts—the tens, hundreds or thousands of employees who have to do their jobs differently when they adopt the solution. This is the role of change management.

On October 22nd, 2019, VHA approved an Executive Decision Memo that recognized Prosci® as VHA's current methodology for Change Management. Organizations that integrate Change Management into their project management delivery are six times more likely to successfully reach their program/project objectives. Change management is the use of an organized framework that helps to guide individuals through the change process. According to Prosci research, "the results and outcomes of changes are tied to individual employees doing their jobs differently. A perfectly designed process cannot improve performance until employees follow it. A perfectly designed technology adds no value to the organization until employees use it. Perfectly defined job roles won't deliver results until employees fulfill them. Employee adoption and usage are the bridge between a great solution and ultimate results" (Top Contributors to Change Management Success, Prosci®, 2016).

14.1   Three States of Change

Change is about moving to a future state while change management is about supporting individual employees impacted by the change during their transitions—from their current state to their future state.

There are three states of change: current state, transition state, and future state. The current state is how things are done today. The transition state is how to move from current to future. 14.1.The future state is how things will be done tomorrow.

Why is Change Management Important?

It is important to understand VHA's future state is actually the collection of many individual future states.
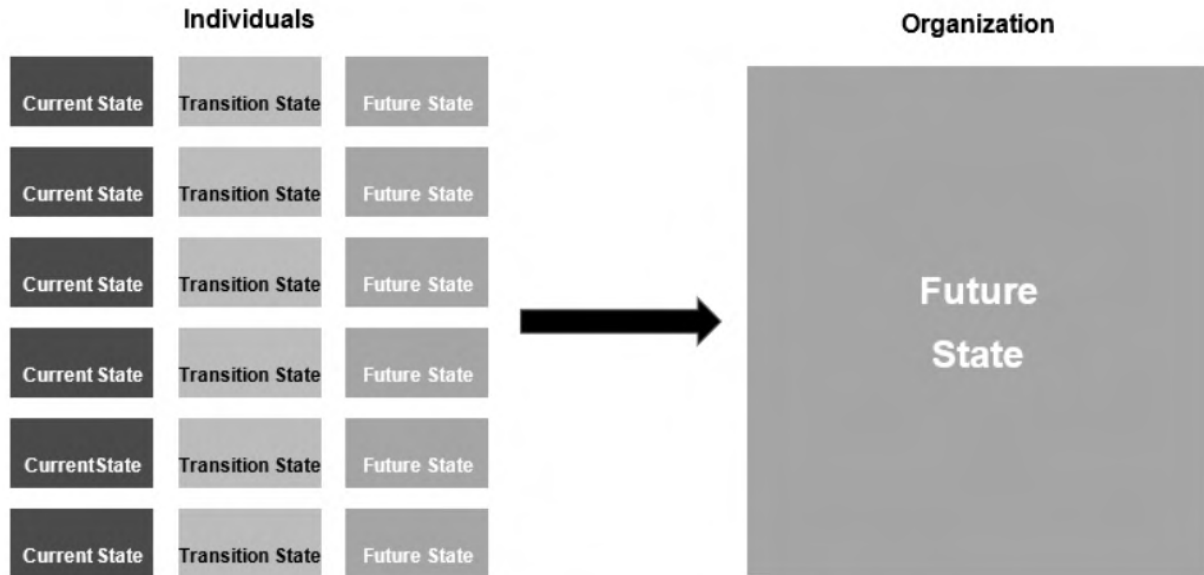
Figure 20: Change Management States of Change

Change management increases organizational outcomes to achieve desired results by driving individual adoption and usage. In order to drive individual adoption and usage, facilities must enable success by supporting each individual through his/her personal change journey. With excellent change management, employees:

- Adopt changes faster, more completely and more proficiently.
- Stay engaged in the organization during disruptive change.
- Understand why the change is happening.
- Have the time and tools to get on board and feel heard and supported.

14.2

Change Management Framework

ADKAR is a change management framework for understanding change at an individual level (Hiatt, Jeffrey. ADKAR. A Model for Change in Business, Government and our Community, 2006). Every change that occurs in a system is dependent on individuals making individual changes. Applying ADKAR framework can assist organizations in successful change by understanding the elements necessary for change results to be recognized. ADKAR presents in five stages that individuals go through when making a change.

- A in ADKAR stands for Awareness. For change to occur, the individual needs to have awareness of the need for change and the nature of the change.
- D stands for Desire. The individual must have the desire to support the change, participate, and engage in the change.
- K stands for Knowledge. The individual should have knowledge on how to change and on how to implement the new skills and behaviors.
- A stands for Ability. The individual should have the ability to implement the change and demonstrate performance.

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- R stands for Reinforcement. The individual needs reinforcement to sustain the change and build a culture and competence around change.

For sustainable change to occur in a system or organization, individuals must reach the level of Ability. The elements of ADKAR are sequential, requiring individuals to move through each stage successfully.

SmartChange Toolkit

VHA's National Center for Organizational Development SmartChange Toolkit provides simple, powerful tools to make change easier at all levels of the organization. This toolkit consists of 6 steps to help organizations think through and support the 'people side' of change. You can access the SmartChange Toolkit to gain a better understanding and best practices for each step. This guidebook provides a summary of all six steps with an intended focus on Step 1.

14.3

Step 1 – Define Success

14.3.1 In any change scenario, organizations should be able to answer the basics – starting with what's changing, why a change is needed, and what happens if we don't change. When you start with the Six Essential Questions, you'll get clear on what's changing, why, and what success looks like. The process of answering the Six Essential Questions gets people on the same page. Once the answers are in place, you have the cornerstone for key change messages.

Beyond informing communications, Six Essential Questions can:

- Help a leader decide if it is the right change to implement.
- Help a leader understand the change more fully so they can better lead others.
- Help a leadership coalition or project group come to consensus on the key reasons for the change and facilitate buy-in.
- Identify when you need to seek out more information to better understand the change.
- Initiate discussions with key leaders to discuss alternatives to the change and/or fully understand implementation options.

14.3.2

Step 2 – Strengthen Your Foundation

14.3.3 Once the reasons for change and expected benefits are clear, it's time to examine and strengthen your foundation. Change success depends on a balance of technical decisions and actions that help people adopt and use the solution as intended. By measuring the Foundations for Change, you'll get a snapshot of your project's health, and a good sense of which elements need the most attention.

Step 3 – Prepare Sponsors

Benchmarking studies repeatedly show the number one predictor of change success is active and visible sponsorship. Using the Preparing Sponsors tool, you'll identify the coalition needed to support your change, and discover how best to facilitate their success in these critical roles.

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Step 4 – Understand Individual Change

When you understand individual change, you can decode the mystery (and relieve the frustration) of organizational change. By applying Prosci's ADKAR® model, you can easily see where to focus your efforts, avoiding the common change management error of scheduling the "right" tactic at the wrong time.

14.3.4

Step 5 – Engage Impacted Groups

You know how change happens at an individual level (that's ADKAR!) – now it's time to shift your focus to engage groups affected by change. Resistance to change is normal and should

14.3.5 be expected. Managing that resistance, however, depends on knowing several things: how the change impacts different groups, their readiness for change and their context for change. By using the Engaging Groups tool, you'll gain insight into what support is needed by whom and when.

Step 6 – Pull it Together: Your Change Strategy

14.3.6 You've assessed your change from several key perspectives, and now it's time to put it all together to make sense of the bigger picture.   Whether you are a team of one leading a change in your workgroup, or responsible for a much larger change in your organization, this SmartChange Snapshot is a great way to capture the next actions to best drive the people side of change for the results you want and need.

14.4   Change Management Resources

There are many VHA change management resources available to assist with change success. We encourage all levels of the organization to become familiar with the following resources:

- VHA NCOD SmartChange Toolkit
- Best Practice Tip Sheet for Communications
- Best Practice Tip Sheet for Engaging Managers
- Sponsorship Roles
- Actions that drive ADKAR – Senior Leaders, Mid Managers/Supervisors, Individual level
- Plan for Sustainment: 3 Key Sustainment Elements
- Prosci Portal – VHA employees can create a Prosci account by using their VA email to register.

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15 ACRONYMS AND GLOSSARY

Table 5: Acronym List

Abbreviations	Meaning
ADPCS	Associate Director for Patient Care Services
AMSA	Advanced Medical Support Assistant
APRN	Advanced Practice Registered Nurse
BDOC	Bed Days of Care
BIM	Business Implementation Manager
BMI	Best Medical Interest
BPDF	Behavioral Patient Disruptive Flag
BT	Beneficiary Travel
CAC	Clinical Applications Coordinator
CC	Community Care
CITC	Care in the Community
CMO	Chief Medical Officer
COO	Community Opt-Out
COR	Contracting Officer's Representative
COS	Chief of Staff
CPL	Community Provider Locator
CPM	Clinic Practice Management
CPRS	Computerized Patient Record System
CRH	Clinical Resource Hub
CTB	Consult Toolbox
CTM	Consult Tracking Manager
CVT	Clinical VA Telehealth
DAV	Disabled American Veterans
DBC	Disruptive Behavior Committee
DO	Doctor of Osteopathy
DoD	Department of Defense
DSS	Decision Support System
DST	Decision Support Tool
E-Consult	E-Consult Electronic Consultation
ECHO	Echocardiogram
EHR	Electronic Health Record
EKG	Electrocardiogram
ELT	Executive Leadership Team
FBG	Field Guidebook
FTC	Facility Telehealth Coordinator
FTE	Full Time Equivalent Employee

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F2F	Face to face
GEC	Geriatrics and Extended Care
GI	Gastroenterology
GPM	Group Practice Manager
HAS	Health Administrative Services
HCS	Health Care System
HOC	Health care Operations Center
HRTG	Highly Rural Transportation Grants
HT	Health care Technicians
ICC	Integrated Clinical Community
IFC	Inter-Facility Consult
IRMAC	Integrated Referral Management and Appointing Center
JOC	Joint Operations Center
JLV	Joint Longitudinal Viewer
LIP	Licensed Independent Practitioner
LOS	Length of Stay
LPN	Licensed Practicing Nurses
MD	Doctor of Medicine
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
MSA	Medical Support Assistant
NP	Nurse Practitioner
OCC	Office of Community Care
OCC	Office of Connected Care
OVAC	Office of Veterans Access to Care
PA	Physician Assistant
PACT	Patient Aligned Care Team
PAO	Public Affairs Officer
PFTs	Pulmonary Function Tests
PPMS	Provider Profile Management System
PSDS	Patient Self-Referral Direct Scheduling
RCI	Referral Coordination Initiative
RCT	Referral Coordination Team
RN	Registered Nurse
SFT	Asynchronous Store and Forward Telehealth
SMT	Special Mode Transportation
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SW	Social Worker
SWS	Social Work Service

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TH	Telehealth
TPA	Third Party Administrator
VA	Department of Veterans Affairs
VAMC	Veteran Affairs Medical Center
VCCPE	Veterans Community Care Program Eligibility
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
VEO	Veteran Experience Office
VSO	Veteran Service Organization
VSS	Veteran Self-Scheduling
VSSC	Veterans Health Administration Support Service Center
VTP	Veterans Transportation Program
VTS	Veterans Transportation Service
VVC	VA Video Connect
WT	Wait time
WVPP	Workplace Violence Prevention Program

16 DOCUMENT HISTORY LOG

The Referral Coordination Initiative (RCI) Guidebook is a living document that will be updated to reflect new solutions and strategies. Below is the Document History Log of changes.

Document Type (Baseline/Revision)	Document Revision	Effective Date	Description
Baseline	V3.0	03/10/2021	Version 3 release of the Referral Coordination Initiative Guidebook.
Revision	V3.1	7/23/2021	Revision including addition of Consult Toolbox (CTB) 2.0 guidance. 4.7 – update to existing content 7.2 - update to existing content 10 - update to existing content 10.1- update to existing content 10.3 - update to existing content 10.4 - update to existing content 11.1 - update to existing content 11.2 - update to existing content
Revision	V3.2	9/21/2021	Revision including addition of Clinical Pharmacy Role on RCT, Menu of Services, and MSA Guidance 3.5.3 –update to existing content 3.5.4 – new content 3.6 – update to existing content 6.11 – new content 6.12 – update to existing content

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17 APPENDIX A – RCT SIX ESSENTIAL QUESTIONS

What is changing?

17.1 The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

Why is it changing?

17.2 VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

Why is it changing now?

17.3 Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

What is not changing?

17.4 VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran's needs and life goals – whether that is in-house VA care or care in the community. Eligibility standards for community care are not changing.

17.5

What are the benefits of this change?

17.6 RCTs align with VHA's modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive in-house VA care may instead be referred to care in the community.

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18 APPENDIX B – COMMUNICATION MATERIALS

Table 6: Communication Materials

Communication Material	SharePoint Link
Veteran Fact Sheet	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/RCI%20External%20Communications%20Documents/External%20Veteran%20Fact%20Sheet%20Final%20022321.pdf
Internal Staff Fact Sheet	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/RCI%20Internal%20Communications%20Documents/RCI%20Internal%20Fact%20Sheet%20Final.pdf

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Table 7: Policy Materials

Policy Material	Link	Issue Date	End Date
Community Care Scheduling Enhancements Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Community%20Care/Scheduling/Community%20Care%20Scheduling%20Enhancements%20VIEWS%20%2303771730.pdf?csf=1&web=1&e=tcWdTA	10/28/2020	10/31/2022
National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065 – COVID-19 Upgrades Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Announcements/National%20Deployment%20of%20Consult%20Toolbox%201.9.0063%20and%201.9.0065%E2%80%93%20COVID-19%20Upgrades%20(VIEWS%23%2002748457)%20signed.pdf?csf=1&web=1&e=MF6jcA	05/18/2020	
Changes to Consult/Referral Management during COVID-19 Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Conditions%20-%20Flu%20%20etc/COVID19/Changes%20to%20Consult%20Referral%20Management%20during%20COVID-19%20.pdf?csf=1&web=1&e=PNHS3P	09/13/2020	
RCI Memo: Veterans Integrated Service Network (VISN) Referral Coordination Initiative (RCI) Standards and Expectations for Fiscal Year (FY) 21	https://dvagov.sharepoint.com/:b:/r/sites/ReferralCoordinationInit/RCI%20Resource%20Documents/03122021%20--%204723515%20%20S%26D%20Memo%20%20031221%20--%20Veterans%20Integratedg%20Service%20Network%20(VISN)%20Referral%20Coordination%20Initiative%20(RCI)%20Standards%20and%20Expectations%20for%20Fiscal%20Year%20(FY)%2021_.pdf?csf=1&web=1&e=7KHoE2		
Prioritization for Consultations Procedures and Appointments	https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NA/ACAO/ConsultManagement/SitePages/Consult%20Toolbox.aspx	N/A	N/A
Consult Processes and Procedures Directive 1232 (2)	https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3230	06/28/2019	N/A
CPRS Technical Guide	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/Guidebook%20Supporting%20Documents/RCI%20Technical%20Guide%202%202%202021%20RW%20%202%205%202021%20cp%20v1.pdf	N/A	N/A

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E-Consult Guidebook Version 3	https://dvagov.sharepoint.com/:b:/r/sites/vhaovac/cpm/Shared%20Documents/Guidebooks/E-Consult%20Guide%20Book%20V%203.0.pdf?csf=1&web=1&e=WbAagT	N/A	N/A
Office of Community Care Field Guidebook (FGB)	https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx	N/A	N/A
Service Agreement SOP	Coming Soon	N/A	N/A
Unable to Schedule SOP	Coming Soon	N/A	N/A
Minimal Scheduling Effort SOP	Coming Soon	N/A	N/A

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