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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022

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Report Overview

With the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in 2018, veterans have greater choice for health care through VA direct care (provided by VA facilities) or community care (paid for by VA). The VA Office of Inspector General (OIG) initiated this review to assess some of the important aspects of the community care program, in comparison to VA direct care, at the Montana VA Healthcare System (system) for fiscal year 2022 (October 1, 2021, through September 30, 2022). Specifically, the OIG reviewed

- community care utilization for both inpatient and outpatient care;
- the reasons for utilizing community care;
- the quality of care; including
  - timeliness of referral coordination,
  - appointment wait times, and
  - disqualified community providers.[1]

The system, based in Fort Harrison, is part of Veterans Integrated Service Network 19 and provides a range of inpatient and outpatient medical, surgical, and behavioral health services. The system includes a community living center in Miles City and 14 community-based outpatient clinics located throughout Montana.

Inspection Results

Patient Demographics

The patient population consists of 37,362 patients who had an inpatient stay or outpatient visit at the system or through community care paid for by the system during fiscal year 2022. Almost 91 percent of the patient population resided in Montana and roughly 74 percent of those patients lived in rural or highly rural areas.

[1] The term disqualified refers to providers who have had an adverse action taken against them and are ineligible to provide community care to veterans.

Community Care Utilization

VA health care includes both VA direct care (provided at a VA facility) and VA community care (delivered by providers in the community who are paid by VA). The OIG determined the number of patients who utilized only VA direct care, only VA community care, or both VA and community care for primary, mental health, emergency/urgent, and specialty medical care in fiscal year 2022. Among patients who received VA primary care, 98.8 percent did so exclusively through VA direct care. Similarly, 77.5 percent of patients who received VA mental health care did so exclusively through VA direct care. The utilization of specialty care services through only VA direct care or only community care depended on the type of specialty care sought.

The system operates a total of 18 acute care beds and offers inpatient medical and surgical services.[2] Acute inpatient community care accounted for approximately 83 percent of the overall bed-days of care provided in fiscal year 2022.

The OIG also examined the documented reasons for community care referrals made in fiscal year 2022.[3] Most community care referrals were requested due to patients' associated drive times to access needed care.

Quality of Community Care

For the purposes of this report, the OIG assessed certain indicators of quality care: whether the system (1) coordinated the referral processes timely, (2) met timeliness goals for providing quality direct and community care, and (3) used disqualified providers for community care services.

The OIG assessed the timeliness of referral's first action guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to complete any necessary pre-work steps and activate both direct and community care referrals.[4] The OIG found that VA staff acted on approximately 90 and 91 percent of direct and community care referrals, respectively, within two days.

The OIG also assessed the timeliness of appointment setting, guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*. The OIG found that approximately 65 percent of effective (not canceled or discontinued) VA direct care referrals had an associated

[2] "Workload Profile Report," VHA Support Services Center, accessed February 14, 2022, https://vssc.med.va.gov/VSSCMainApp/. (This website is not publicly accessible.) Acute care is defined as "providing or concerned with short-term usually immediate medical care (as for serious illness or traumatic injury)." *Merriam-Webster.com Dictionary*, "acute care," accessed October 10, 2024, https://www.merriam-webster.com/medical/acute%20care.

[3] The terms "consult" and "referral" are used synonymously in this report.

[4] VHA Office of Integrated Veteran Care, "Consult Timeliness" (standard operating procedure), December 15, 2021.

appointment set within seven days and approximately 56 percent of community care referrals had an associated appointment set within 21 days.

The OIG assessed the timeliness of referral completion. VA guidelines give facilities 90 days from the requested date to complete both direct and community care referrals.[5] The OIG found that within 90 days of the requested date, VA staff completed approximately 95 and 48 percent of direct and community care referrals, respectively. This indicates an opportunity to improve the timeliness of referral completion, especially for community care.

While reviewing referral completion, the OIG noticed that some completed VA direct care referrals were missing the date the appointment was set. The OIG further analyzed three types of highly specialized VA direct care referrals that generally require appointments. The OIG found that the percent of completed referrals without a scheduled date varied by the location where the referral was ordered. This raises the question whether required consult activity data were entered at all ordering locations within the system.

Veterans become eligible for community care when appointment wait times for VA direct care cannot be met within 20 days of the referral date for primary and mental health care. The OIG found that less than 1 percent of all community care referrals were for primary care and less than 3 percent were for mental health in fiscal year 2022. The OIG found that approximately 39 percent of patients with community care referrals for primary care obtained an appointment within 20 days of the requested date. About 64 percent of patients were given an appointment for mental health within 20 days of the requested date.

Similarly, veterans become eligible for community care for specialty visits when an appointment for VA direct care cannot be made within 28 days from the referral date. The OIG found that approximately 97 percent of all community referrals were for specialty care. OIG analysis indicates that approximately 54 percent of patients received a specialty appointment within 28 days of the requested date.

The OIG also assessed whether providers who were removed from VA employment due to conduct that violated VA policy related to the delivery of safe and appropriate health care, continued to furnish community care to patients. The OIG identified two potentially disqualified former VA providers associated with community care claims paid by the system.

The information presented in this report is intended to provide VA leaders and stakeholders with an overall view of utilization, delivery of timely care, and provider qualifications associated with community care provided through the system. The OIG made five recommendations for improvement to the System Director related to appointment scheduling and documentation, wait times, and provider eligibility designations.

[5] The requested date is the date the clinician, in collaboration with the patient, determines is clinically indicated for future care.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes G and H). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated this review to characterize the impact of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act on patient use of community care. The OIG reviewed patient demographics, utilization, and selected elements of quality of care associated with direct and community care provided through the Montana VA Healthcare System (system). Community care programs enable "eligible Veterans and beneficiaries to receive health care services from providers outside of a VA medical facility."[1] Lawmakers enacted the Veterans Access, Choice, and Accountability Act of 2014, establishing the Veterans Choice Program.[2] This program allowed "eligible Veterans to receive care from non-VA facilities, connecting them to timely and convenient access to health care, instead of waiting for a VA appointment or traveling long distances to a VA facility."[3]

In June 2018, the VA MISSION Act was established to give veterans "better access and greater choice in health care either at VA or a community provider through improved eligibility criteria."[4]

Veterans Health Administration's (VHA's) overall community care expenditures have grown from over $14 billion in fiscal year 2017 to almost $26 billion in fiscal year 2022, the review period.[5] Recognizing that the VA faces distinct challenges in rural areas, the OIG selected the Montana VA Health Care System to assess care utilization and quality provided through the system directly (VA direct care) and through community care purchased by the system in a particularly rural area in fiscal year 2022.

Facility Background

The system, part of Veterans Integrated Service Network (VISN) 19, is located in Fort Harrison, Montana. It provided a range of inpatient and outpatient medical, surgical, and behavioral health

[1] "Veterans Health Administration Office of Integrated Veteran Care," VHA, accessed April 24, 2024, https://vaww.va.gov/communitycare/. (This internal website is not publicly accessible.)

[2] Veterans Access, Choice, and Accountability Act of 2014; Pub. L. No. 113-146, 128 Stat. 1754 (2014).

[3] "Using the Veterans Choice Program," VA, accessed July 9, 2024, https://www.publichealth.va.gov/exposures/publications/oef-oif-ond/post-9-11-vet-fall-2015/veterans-choice-program.asp.

[4] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[5] OIG analysis; Fiscal year 2017 began October 1, 2016, and ended September 30, 2017. Fiscal year 2022 began October 1, 2021, and ended September 30, 2022. These numbers are not adjusted for inflation.

services to over 37,000 patients in fiscal year 2022. The system includes a community living center in Miles City and 14 community-based outpatient clinics throughout Montana.

Scope and Methodology

Data Source

VA Care includes both VA direct care (provided at a VA facility) and VA community care (delivered by providers in the community and paid for by VA). All data analyzed in this report were for fiscal year 2022 and compiled from VA administrative data sources. The OIG utilized VA direct care data that were static as of December 12, 2022, and VA community care data that are dynamic in nature.

Patient Population

The OIG identified the population of patients with an outpatient visit (excluding dental visits), or an inpatient stay during fiscal year 2022.

When average drive time to a VA medical facility for primary care exceeds 30 minutes, or specialty care exceeds 60 minutes, a veteran becomes eligible for community care. Using VA administrative data, the OIG analyzed drive times from each veteran's residence to VA facilities.

Community Care Utilization

Outpatient

The OIG characterized each outpatient visit into one of four medical types (primary care, mental health care, emergency/urgent care, and specialty care), and grouped them into VA direct care visits and community care visits. The OIG further categorized specialty care into cardiology, dermatology, gynecology, ophthalmology, urology, and other specialty visits. The other specialty grouping captured a broad range of visit types from neurology to audiology.

The OIG defines utilization for each of the above medical types as the number of days in which a patient had one or more qualifying outpatient visits through either VA direct care or VA community care during fiscal year 2022. Qualifying outpatient visits exclude visits related to dental care, laboratory tests, dialysis not assisted by a physician, pharmacy, hospice care, homemaker services, adult day care, residential-based care, chaplain services, and other visit types that the OIG determined are often nonclinical in nature, such as the Veterans Justice Outreach and Social Work Services.

The OIG's analysis highlights utilization differences between VA direct care and VA community care. A patient may choose to receive community care over VA direct care for many reasons. The OIG further excluded those visits that do not readily allow for patients to choose between

VA direct care and community care. This results in the exclusion of home-based care and care provided in a homeless shelter or correctional facility.

The OIG also provided a separate analysis of outpatient utilization that includes visits for which the patient cannot readily choose between VA direct care and VA community care in appendix C.

Inpatient

VA Direct Care Inpatient

VA direct care inpatient data contain records for acute inpatient stays, non-acute (short- and long-term) stays, and observation stays. The OIG classified VA direct care inpatient records based on the length of stay and treating specialty at admission:

- Acute inpatient stays—Stays with an acute treating specialty at admission, regardless of the number of days spent in the hospital.
- Non-acute inpatient stays (short- and long-term stays)—Stays with a non-acute treating specialty such as hospice, nursing home, and domiciliary at admission.
- Observation stays—Stays that were less than or equal to 48 hours in which the patient was admitted under observation treating specialty.[6]

For VA acute inpatient stays, the OIG identified the top five most frequently used discharge codes responsible for patient stays.[7]

Community Care Inpatient

The OIG identified acute and non-acute inpatient stays using the bill type codes associated with the claims (see table 1).[8] The OIG excluded stays with the same admission and discharge dates since they are considered observation stays. The OIG also excluded any community care inpatients discharged on October 1, 2021, or admitted on September 30, 2022, from further analysis. For community care acute inpatient stays, the OIG identified the top five most frequently used discharge codes responsible for patient stays.

[6] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, January 13, 2020.

[7] For purposes of this report ICD-10 refers to ICD-10-CM, in which CM references Clinical Modification. According to the Centers for Disease Control and Prevention, "The International Classification of Diseases, Clinical Modification (ICD-CM) is a standardized system used to code diseases and medical conditions (morbidity) data." "Classification of Diseases, Functioning, and Disability," Centers for Disease Control and Prevention National Center on Health Statistics, accessed September 6, 2024, https://www.cdc.gov/nchs/icd/?CDC_AAref_Val=https://www.cdc.gov/nchs/icd/index.htm.

[8] A bill type code is a four-digit code that identifies the type of facility (second digit, e.g., hospital, nursing facility), bill classification (third digit), and frequency (fourth digit). The first digit is always zero.

Table 1. Community Care Inpatient Type of Care Included in the Analysis

Type of Inpatient Care	Bill Type Codes
Acute Inpatient	011, 012
Nursing Home	018, 021, 022, 061, 062, 065, 066, 068, 086
Hospice	081, 082

Source: OIG Analysis of bill type codes. "Bill Type Code," Research Data Assistance Center, accessed July 11, 2024, https://resdac.org/cms-data/variables/bill-type-code.

Inpatient Bed-Days

The OIG measured inpatient utilization based on bed-days. The OIG calculated inpatient bed-days from admission date to the discharge date over days that occurred in fiscal year 2022, even if the stay extended beyond the study period.

Reasons for Utilizing Community Care

The OIG used routine outpatient referrals to determine the reasons for utilizing community care.[9] The reasons were classified into the following categories based on the six criteria under the VA MISSION Act that can qualify a veteran to receive community care:[10]

1. Drive Time—Veterans driving to a VA medical facility for at least 30 minutes for primary care, mental health, and noninstitutional services, or driving at least 60 minutes for specialty care services.
2. Grandfathered—Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.
3. Service Not Available—Veterans need a specific type of service that is not available at a VA medical facility.
4. Best Medical Interest—The referring clinician and the veteran determine that it is in the best interest of the veteran to see a community provider.
5. Wait Time—Veterans have to wait for 20 days or more for primary care, mental health care, and noninstitutional extended care services, or 28 days for specialty care from the date of referral request.

[9] The terms "consult" and "referral" are used synonymously.

[10] VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

6. No Full-Service—Veterans live in a US state or territory without a full-service VA facility, which does not apply to the system.

Quality of Care

The OIG assessed timeliness of referral coordination and appointment wait times for routine outpatient referrals. Therefore, referrals for dental, inpatient, geriatric and extended care, e-consults (chart reviews), prosthetics, administrative in nature activities, referrals for which the appointment was expected to occur more than 90 days from the referral date, emergency/urgent care, and laboratory work were excluded (see appendix F). Referrals that were not canceled or discontinued are referred to as effective referrals in this report.

Timeliness of Referral Coordination

The OIG examined direct and community care referrals for routine outpatient care written by system providers during fiscal year 2022. The OIG focused on effective referrals (those that were not canceled or discontinued). For referrals that were canceled or discontinued, the OIG considered the time VA took to cancel the referral and if an appointment should have been scheduled prior to the cancellation.

Timeliness of Referral's First Action

The OIG evaluated timeliness of a referral's first action guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to activate direct and community care referrals.[11] Timeliness of a referral's first action was calculated as the number of days from the date the referral was written to the date the first action was taken.

Timeliness of Appointment Setting

Timeliness of appointment setting was calculated as the number of days from the date the referral was written to the date the appointment was first set. The OIG excluded community care referrals scheduled by the patient and referrals exempted from scheduling requirements, such as those for e-consults, inpatient consults, and clinical procedures.[12]

Additionally, the OIG assessed timeliness of appointment setting, which includes canceled referrals if an appointment should have been scheduled prior to the cancellation.

[11] VHA IVC, "Consult Timeliness" (standard operating procedure), December 15, 2021.

[12] VHA IVC, "Consult Timeliness" (standard operating procedure), December 15, 2021; VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021, was replaced by VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.

Timeliness of Referral Completion

The OIG calculated the number of days from the requested date to the date of completion to evaluate the timeliness of routine outpatient referrals. The requested date is the date the clinician, in collaboration with the veteran, determines is clinically indicated for future care.

Appointment Wait Times

The OIG assessed appointment wait times for routine outpatient referrals. The OIG measured appointment wait time as the days from the requested date to the appointment date. The OIG included effective, routine, outpatient referrals that required an appointment and excluded referrals that are exempt from scheduling requirements. The OIG also excluded community care referrals for which the associated appointment was self-scheduled by the patient.

Disqualified Community Care Providers

The OIG used the VA Human Resources Information System to identify potentially disqualified providers, based on removals utilizing combinations of nature of action code and legal authority code, from the enactment of the VA MISSION Act on June 6, 2018, through the end of fiscal year 2022. VHA clinical providers who had an adverse action, identified using a combination of nature of action codes and legal authority codes, taken against them related to the delivery of safe and appropriate health care are disqualified from providing community care to veterans, and thus should not have any paid community care claims during their disqualification period.[13] The OIG defined the disqualification period as beginning from the date of separation. For cases in which the adverse action was rescinded at a later date, the disqualification period was calculated from the separation date to the rescinded date of the adverse action.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[13] Adverse actions include resignation or retirement, in lieu of involuntary action; removal; termination; or termination during probation period.

Inspection Results

Patient Enrollment Priority and Residency

Patient enrollment priority and residency of the study population in fiscal year 2022 are displayed in the figures below.

Priority Groups

VA defines enrollment as "the acceptance of an eligible Veteran into the VA health care system and assignment to a Priority Group for the purpose of receiving the full medical benefits package as defined in 38 C.F.R. § 17.38." To manage the provision of care, VA assigns veterans to one of eight priority groups when applying for VA health care. Veterans are placed in the highest priority group for which they qualify (see appendix B for priority group definitions).[14] Figure 1 describes the number and percent of patients in the patient population by priority group. VA assigned over 34 percent of the patient population to Priority Group 1, the highest priority group.

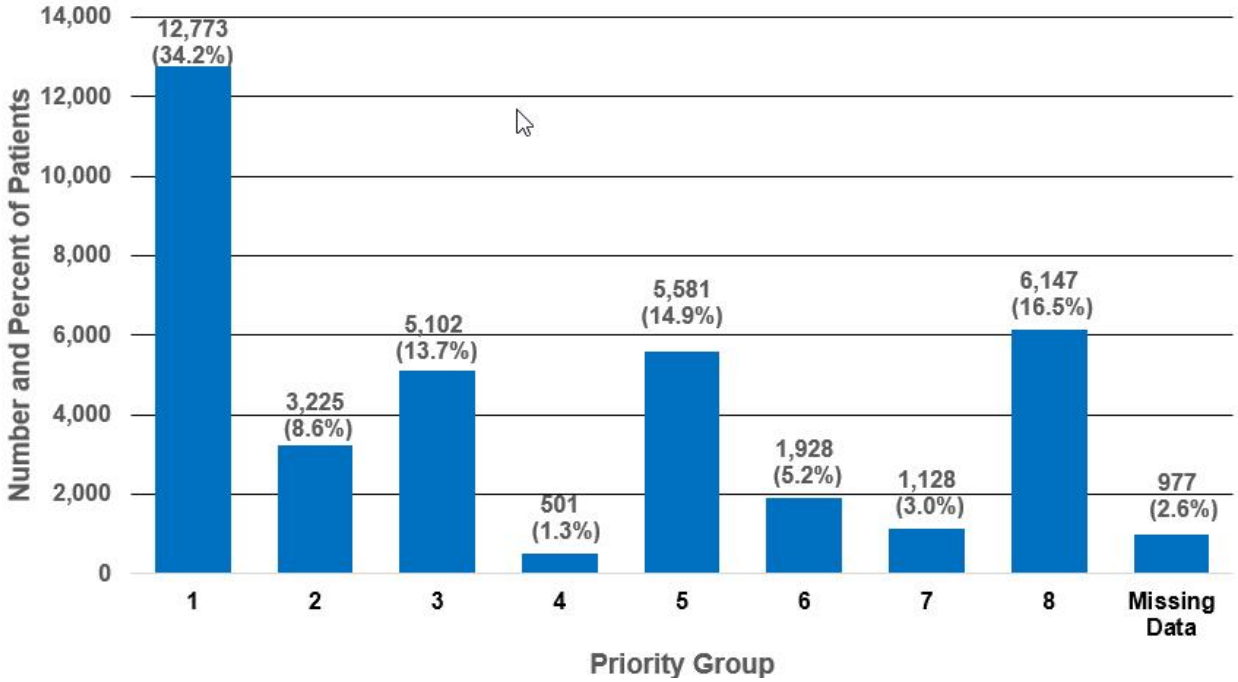

Figure 1. *Number and percent of patients by priority group.*
Source: OIG analysis of VA administrative data.

[14] VHA Directive 1601A.01(3), *Registration and Enrollment*, July 7, 2020, amended April 4, 2024.

States of Residence

The OIG identified the patient population of 37,362 veterans who received medical care from the system during fiscal year 2022. Although the system provided care for patients from every state but Vermont, almost 91 percent of the patient population reported residing in Montana (see figure 2). Less than 8 percent of patients reported living further away than an adjacent state.

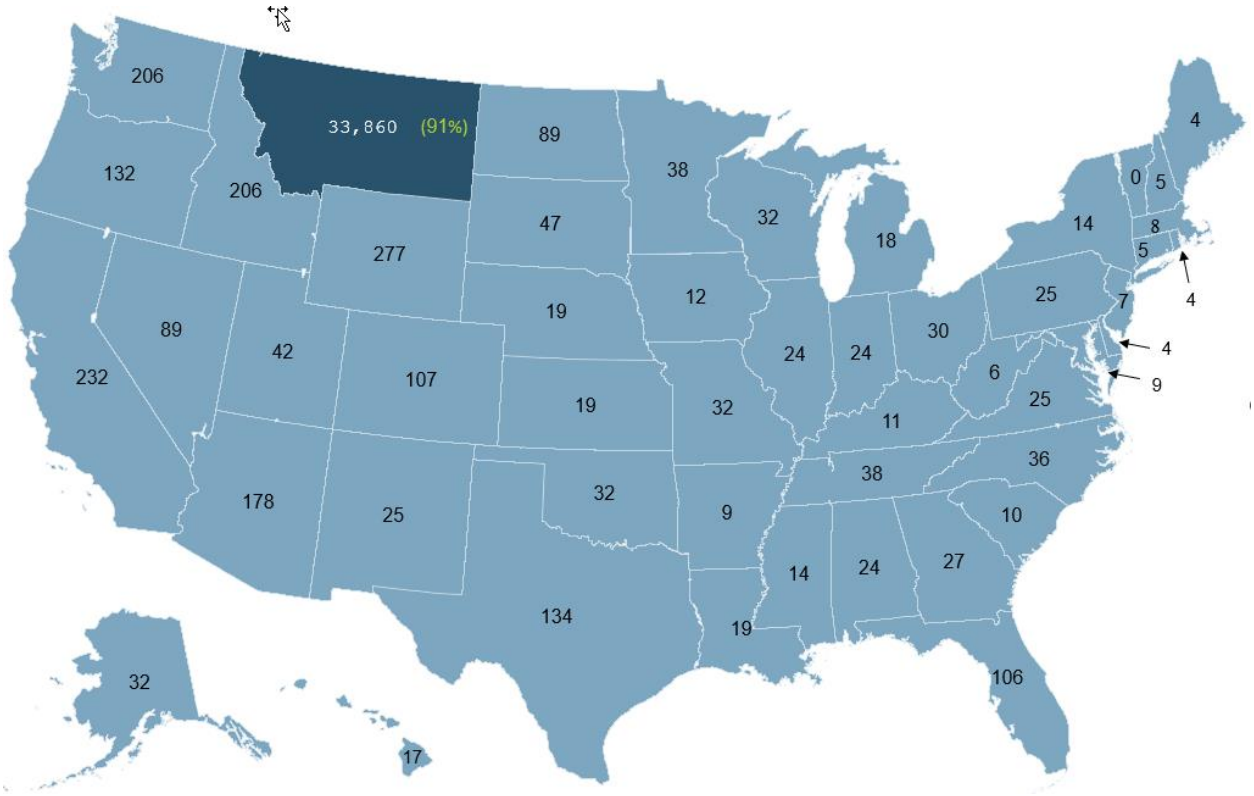

Figure 2. *States of residence for fiscal year 2022 Montana VA Healthcare System patients.*
Source: OIG analysis of VA administrative data.

Community Care Utilization

Outpatient

VA Care includes both VA direct care (provided at a VA facility) and VA community care (paid by VA). The OIG determined the number of patients who utilized only VA direct care, only VA community care, or both VA direct care and VA community care for primary, mental health, emergency/urgent care, and specialty medical care in fiscal year 2022. Although most primary care patients (98.8 percent) and mental health care patients (77.5 percent) utilized only VA direct

care services, the majority of patients (77.8 percent) who sought emergency/urgent care did so through community care.[15]

The utilization of specialty care services through only direct or only community care depended on the type of specialty care sought. For example, more patients received cardiology and dermatology services only through community care, while more women received gynecology services through the system (see table 2).

Table 2. Patients Receiving Outpatient Care by Medical Care Type

Medical Care Type	Number (%) of Patients with ONLY VA Direct Care Visit-Days	Number (%) of Patients with ONLY Community Care Visit-Days	Number (%) of Patients with Both VA Direct Care and Community Care Visit-Days	Total Patients
Primary Care	**29,056 (98.8)**	**212 (0.7)**	**136 (0.5)**	**29,404**
Mental Health	**5,929 (77.5)**	**784 (10.2)**	**939 (12.3)**	**7,652**
Emergency/Urgent Care	**1,870 (17.3)**	**8,396 (77.8)**	**521 (4.8)**	**10,787**
All Specialties*	**5,690 (20.1)**	**9,547 (33.8)**	**13,008 (46.1)**	**28,245**
Cardiology	996 (18.9)	3,544 (67.3)	723 (13.7)	5,263
Dermatology	799 (38.4)	1,225 (58.9)	55 (2.6)	2,079
Gynecology	287 (71)	91 (22.5)	26 (6.4)	404
Ophthalmology	2,469 (45.5)	2,740 (50.5)	216 (4)	5,425
Urology	1,126 (46.8)	1,144 (47.5)	138 (5.7)	2,408
Other specialties	6,297 (23.6)	9,342 (34.9)	11,095 (41.5)	26,734

Source: OIG analysis of VA administrative data.
Note: Table data reflect only visits for patients who could choose either the VA or community care and who had at least one visit by medical care type. Each row of table 5 is calculated independently, so comparisons across rows must be done carefully. For example, there are 6,297 patients whose visits to other specialties (i.e., other than cardiology, dermatology, gynecology, ophthalmology, and urology) were only through VA direct care. If one of those patients also had a community care visit to a cardiologist, then that patient would not be included in the 5,690 patients whose visits to specialists were only through VA direct care, because the All Specialties row includes both cardiology and any specialty in Other Specialties.
**Five selected specialties are disaggregated from All Specialties.*

The OIG reviewed utilization based on outpatient visit-days. VA direct care provides most primary and mental health care services but relies heavily on VA community care for

[15] The OIG defines a visit-day as a day in which the patient received care in one of the listed medical care types. If a patient received care in multiple medical types on the same day, then the patient is counted as having a visit-day in each of the medical-type categories. While there are only 413,581 distinct patient visit-days, allowing for multiple medical types on the same calendar day means that there were 434,742 total patient visit-days.

emergency/urgent and specialty services. VA community care specialists provided over half (61.8 percent) of the outpatient specialty visit-days in fiscal year 2022 (see table 6). Overall, direct and community care comprised approximately 56 and 44 percent of all outpatient visit-days, respectively (see table 3).

Table 3. Outpatient Utilization by Direct and Community Care

Medical Care Type	VA Direct Care Visit-Days	Visit-Days by Medical Care Type (%)	Community Care Visit-Days	Visit-Days by Medical Care Type (%)
Primary Care	**102,552**	**99.0**	**1,076**	**1.0**
Mental Health	**40,156**	**69.3**	**17,813**	**30.7**
Emergency/Urgent Care	**4,585**	**19.6**	**18,751**	**80.4**
All Specialties*	**95,410**	**38.2**	**154,399**	**61.8**
Cardiology	2,773	18.0	12,660	82.0
Dermatology	1,073	29.5	2,569	70.5
Gynecology	642	71.9	251	28.1
Ophthalmology	3,902	35.0	7,240	65.0
Urology	2,167	35.1	4,015	64.9
Total	**242,703**	**55.8**	**192,039**	**44.2**

Source: OIG analysis of VA administrative data.
**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Top Five Primary Diagnoses for Outpatient Care

The OIG assessed the five most common primary outpatient diagnoses among VA direct care visits and community care visits.[16] A diagnosis for a patient with an outpatient visit was counted once, regardless of the number of visits that patient may have had with that diagnosis. Male and female patients shared three of the top five primary outpatient diagnoses (see table 4).[17]

[16] The International Classification of Diseases, 10th revision, (ICD-10) codes identify the diagnoses.
[17] For the purposes of this report, OIG considers the first ICD-10 code as the primary diagnosis.

Table 4. Top Five Primary Diagnoses for Outpatient Care by Sex

Male			Female		
ICD10 Diagnosis (Code)	**Number of Patients**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients**	**Patients (%)**
Essential (primary) hypertension (I10.)	6,834	21.3	Post-traumatic stress disorder, chronic (F43.12)	447	13.8
Sensorineural hearing loss, bilateral (H90.3)	6,401	20.0	Low back pain, unspecified (M54.50)	422	13.0
Obstructive sleep apnea (adult) (pediatric) (G47.33)	5,308	16.6	Obstructive sleep apnea (adult) (pediatric) (G47.33)	401	12.3
Type 2 diabetes mellitus without complications (E11.9)	4,354	13.6	Essential (primary) hypertension (I10.)	387	11.9
Low back pain, unspecified (M54.50)	3,176	9.9	Cervicalgia (M54.2)	285	8.8

Source: OIG analysis of VA administrative data.

Further, the OIG determined the five most common primary diagnoses for outpatient care associated with patients who had at least one visit for primary care, mental health care, or emergency/urgent care during fiscal year 2022. Patients seen through VA direct and community care share at least two of the top five primary diagnoses for primary, mental health, and emergency/urgent care (see appendix D, tables D.1–D.3).

Appendix E provides the OIG's determination of the five most common primary outpatient diagnoses from cardiology, dermatology, ophthalmology, and urology visits. Like the findings for primary, mental health, and emergency/urgent care, the OIG noted that patients seen through VA direct and community care for the selected specialties shared two to four common diagnoses (see tables E.1–E.4).

Inpatient

The system operates a total of 18 acute care beds and offers inpatient medical and surgical services.[18] Inpatient community care accounted for approximately 83 percent of overall acute inpatient bed-days of care provided in fiscal year 2022. Community care provided 92 and 91 percent of hospice and nursing home care, respectively (see table 5).

Table 5. Inpatient Utilization

Location of Care	VA Direct Care Bed-Days	Community Care Bed-Days	Total Bed-Days Provided by Community Care (%)
Acute Inpatient	4,769	23,745	83.3
Nursing Home	3,251	32,048	90.8
Domiciliary	4,883	0	0.0
Hospice	260	2,965	91.9
Residential Facility	0	603	100.0
Total	**13,163**	**59,361**	**81.9**

Source: OIG analysis of VA administrative data.

Although community care provided the majority of the acute inpatient care, the OIG noted differences when comparing the lengths of inpatient stays associated with VA direct and community care (see table 6). VA direct care inpatient stays ranged from 1 to 127 days, while community care stays ranged from 1 to 86 days. For both VA direct care and community care, 75 percent of inpatient stays were within one week—six days for VA direct care and seven days for community care. The median inpatient stay was three days for VA direct care and four days for community care.

[18] "Workload Profile Report," VHA Support Services Center, accessed February 14, 2022, https://vssc.med.va.gov/VSSCMainApp/. (This website is not publicly accessible.)

Table 6. Acute Inpatient Utilization

Measure	VA Direct Care (days)	Community Care (days)
Range (min-max)	1–127	1–86
Range of middle 50% (25–75% quartiles)	2–6	2–7
Median	3	4
Mean (standard deviation)	6.7 (11.8) days	5.9 (6.7) days

Source: OIG analysis of VA administrative data.
Note: There were 711 VA direct care acute inpatient stays and 4,000 community care acute inpatient stays.

Top Five Primary Diagnoses Responsible for Inpatient Stays

The OIG reviewed acute inpatient stays and determined the top five most common inpatient diagnoses associated with care provided by the system and community hospitals (see table 7).

Table 7. Top Five Diagnoses Among Acute Inpatient Stays

VA Direct Care*			Community Care‡		
ICD10 Diagnosis (Code)	Number of Patients	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients	Patients (%)
COVID-19 (U07.1)	72	13.7	COVID-19 (U07.1)	266	9.1
Sepsis, unspecified organism (A41.9)	21	4.0	Sepsis, unspecified organism (A41.9)	245	8.4
Unilateral primary osteoarthritis, left knee (M17.12)	15	2.9	Non-ST elevation (NSTEMI) myocardial infarction (I21.4)	104	3.6
Alcohol dependence with intoxication, unspecified (F10.229)	15	2.9	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0)	66	2.3

VA Direct Care*			Community Care‡		
ICD10 Diagnosis (Code)	Number of Patients	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients	Patients (%)
Chronic obstructive pulmonary disease with (acute) exacerbation (J44.1)	15	2.9	Pneumonia, unspecified organism (J18.9)	66	2.3

Source: OIG analysis of VA administrative data.

**In fiscal year 2022, 524 patients had an acute inpatient stay at the Montana VA Healthcare System.*

‡In fiscal year 2022, 2,917 patients had an acute inpatient stay at a community hospital.

Last, the OIG reviewed the top five inpatient diagnoses associated with care provided by the system and community hospitals for male patients (see table 8). The top five most frequently used diagnoses for female patients are not presented because of an insufficient (10 or less) number of patients.

Table 8. Top Five Diagnoses for Acute Inpatient Stays for Male Patients

VA Direct Care System*			Community Care‡		
ICD10 Diagnosis (Code)	Number of Patients	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients	Patients (%)
COVID-19 (U07.1)	69	14.4	COVID-19 (U07.1)	257	9.4
Sepsis, unspecified organism (A41.9)	21	4.4	Sepsis, unspecified organism (A41.9)	240	8.8
Chronic obstructive pulmonary disease with (acute) exacerbation (J44.1)	15	3.1	Non-ST elevation (NSTEMI) myocardial infarction (I21.4)	101	3.7
Alcohol dependence with withdrawal, unspecified (F10.239)	13	2.7	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0)	66	2.4
Unilateral primary osteoarthritis, left knee (M17.12)	13	2.7	Pneumonia, unspecified organism (J18.9)	66	2.4

Source: OIG analysis of VA administrative data.

**In fiscal year 2022, 480 male patients had an acute inpatient stay at the Montana VA Healthcare System.*

‡In fiscal year 2022, 2,736 male patients had an acute inpatient stay at a community hospital.

Reasons for Utilizing Community Care

According to VA's Office of Rural Health, 2.7 million veterans enrolled in VA live in rural or highly rural areas.[19] These communities face challenges such as higher poverty rates, more elderly residents, residents with poorer health, and fewer options for health care. VA has recognized "the need to provide accessible care to rural Veterans and allocates 32 percent of its health care budget to rural Veteran care."[20]

Approximately 74 percent of the 34,479 patients in the patient population with a Montana or bordering state (Idaho, North Dakota, South Dakota, and Wyoming) address live in rural or highly rural areas.

Over time, VA has used various metrics to assess patient wait times at its medical centers, including wait-time statistics based on appointment creation and patient preferred dates.[21] With the passage of the VA MISSION Act, eligibility criteria for obtaining care in the community included average drive times and appointment wait times:[22]

- Average drive time
    - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
    - 60-minute average drive time for specialty care
- Appointment wait time
    - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA healthcare provider
    - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA healthcare provider

Tables 9–10 describe the number of patients with geocoded residential addresses in Montana or bordering states by rurality whose drive time to the nearest VA site for primary and secondary care exceeds the 30-minute and 60-minute community care eligibility thresholds for primary and specialty care, respectively. Secondary care sites provide specialty care. Notable percentages of the patient population who live in rural and highly rural areas meet VA MISSION Act eligibility

[19] "Rural Veterans," VA Office of Rural Health, accessed April 25, 2024, https://www.ruralhealth.va.gov/aboutus/ruralvets.asp.

[20] "Rural Veterans," VA Office of Rural Health.

[21] "Completed Appointments Cube Data Definitions," VHA Support Service Center, accessed May 1, 2024, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=48&sub_ID=159. (This website is not publicly accessible.)

[22] VHA Office of Community Care, "Veteran Community Care Eligibility."

for community care based on drive-time thresholds alone: for primary care, 34 percent and 92 percent of patients living in rural and highly rural areas, respectively; for secondary care, 71 percent and 88 percent of patients living in rural and highly rural areas, respectively.[23]

Table 9. Patient Drive Time to VA Primary Care Facility by Rurality

Rurality	Total Number of Patients	Median Drive Time (minutes)	Patients Exceeding Drive Time Threshold (%)
Urban	8,803	9	<1
Rural	19,810	22	34
Highly Rural	5,866	62	92

Source: OIG analysis of VA administrative data.

Table 10. Patient Drive Time to VA Secondary Care Facility by Rurality

Rurality	Total Number of Patients	Median Drive Time (minutes)	Patients Exceeding Drive Time Threshold (%)
Urban	8,803	86	57
Rural	19,810	105	71
Highly Rural	5,866	147	88

Source: OIG analysis of VA administrative data.
Note: The median drive times presented are those to VA secondary care facilities that provide specialty care.

The OIG examined the documented reason for community care referrals, including referrals that were subsequently canceled or discontinued. A referral can include multiple documented reasons for utilizing community care. Table 11 shows that VA direct care providers made almost 90 percent of the community care referrals due to patients' associated drive time. This is not surprising given the percentages of the patient population who live in rural and highly rural areas and meet VA MISSION Act eligibility for community care based on drive-time thresholds alone (see tables 9–10). VA direct care providers made about 26 percent of routine outpatient referrals because the patients were grandfathered into the community care program. VA direct care providers made roughly 4–5 percent of community care referrals due to wait-time standards or service unavailability. The OIG noted that the use of the "No Full-Service" reason is reserved for veterans who live in a US state or territory without a full-service VA medical center, which does not apply to Montana. The OIG was not able to identify a reason (not reported) for community care utilization for about 0.6 percent of requested referrals.

[23] The VA's Geospatial Service Support Center provided the drive time data as of the last quarter of the fiscal year 2021.

Table 11. Reasons for Using Community Care for Outpatient Referrals

Reason	Number of Referrals	Referrals (%)
All Consults	82,484	100
Drive time	73,921	89.6
Grandfathered*	21,027	25.5
Service not available	4,398	5.3
Wait time	2,995	3.6
Best medical interest	635	0.8
No full-service	70	0.08
Not reported	514	0.6

Source: OIG analysis of VA administrative data.
**Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.*

The OIG also examined the documented reasons for effective community care referrals placed in fiscal year 2022.[24] As noted above, effective referrals are referrals that were not discontinued or canceled. About 82 to 84 percent of the referrals approved under "drive time," and "grandfathered," were effective referrals (see table 12).

Table 12. Reasons for Using Community Care for Effective Outpatient Referrals

Reason	Number of Referrals	Number of Effective Referrals*	Effective Referrals (%)
All Consults (N)	82,484	67,180	81.4
Drive time	73,921	60,773	82.2
Grandfathered‡	21,027	17,594	83.7
Service not available	4,398	3,314	75.4
Wait time	2,995	2,375	79.3
Best medical interest	635	503	79.2

[24] A referral, which VHA calls a consult, is a request for services on behalf of a patient. One provider requests an opinion, advice, or expertise regarding the evaluation or management of a patient-specific problem, and another provider responds to the request. The referral process provides a method of coordinating patient care among different services. VHA policy sets timeliness standards for each step of the referral process.

Reason	Number of Referrals	Number of Effective Referrals*	Effective Referrals (%)
No full-service	70	31	44.3
Not reported	514	190	37.0

Source: OIG analysis of VA administrative data.
**Effective referrals exclude canceled and discontinued referrals.*
‡Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.

Quality of Care

The Institute of Medicine has provided six objectives to address the delivery of improved quality of care, one of which being that it is provided "*timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care."[25] The OIG assessed whether the system (1) coordinated the referral processes in a timely manner, (2) met timeliness goals for providing direct and community care, and (3) used ineligible community care providers for community care services.

Timeliness of Referral Coordination

The referral process, both for VA direct and community care, begins when a provider writes a referral for a patient. VA staff then review the referral and accept it for further action if appropriate, including for community care.[26]

The next step in the referral process is scheduling the appointment. Following the appointment being scheduled, or set, the patient will attend the appointment.

Timeliness of referral coordination is essential to avoid extended wait times for patients to receive appointments.[27] The OIG measured timeliness of referral coordination for both direct and community care referrals that were not later canceled or discontinued as the following:

[25] Institute of Medicine (US) Committee on Quality of Health Care in America. "Crossing the Quality Chasm: A New Health System for the 21st Century," 2001, accessed April 25, 2024, https://www.ncbi.nlm.nih.gov/books/NBK222271/.

[26] VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021, was replaced by VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.

[27] VHA Office of Integrated Veteran Care (IVC) Community Care, "Consult Completion and Medical Records Management Metrics," chap. 4 in Office of Integrated Veteran Care (IVC) Community Care Field Guidebook, accessed August 6, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000226164/FGB-Chapter-4-050408-How-to-Evaluate-Referral-Management-Timeliness%3FarticleViewContext=article_view_related_article. (This internal website is not publicly accessible.)

- The number of days elapsed from the referral being written to the first action (timeliness of referral's first action).
- The number of days elapsed from the referral being written to the setting of the appointment (timeliness of appointment setting).
- The number of days elapsed from the requested date through the date of completion (timeliness of referral completion).

Timeliness of Referral's First Action

The OIG assessed the timeliness of a referral's first action guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to complete any necessary pre-work steps and activate the direct and community care referrals.

The OIG found that VA staff acted on approximately 90 and 91 percent of non-excluded direct and community care referrals, respectively, within two days (including weekends and holidays), indicating potential opportunities to improve the timeliness of referral action for both types of referrals (see figure 3).

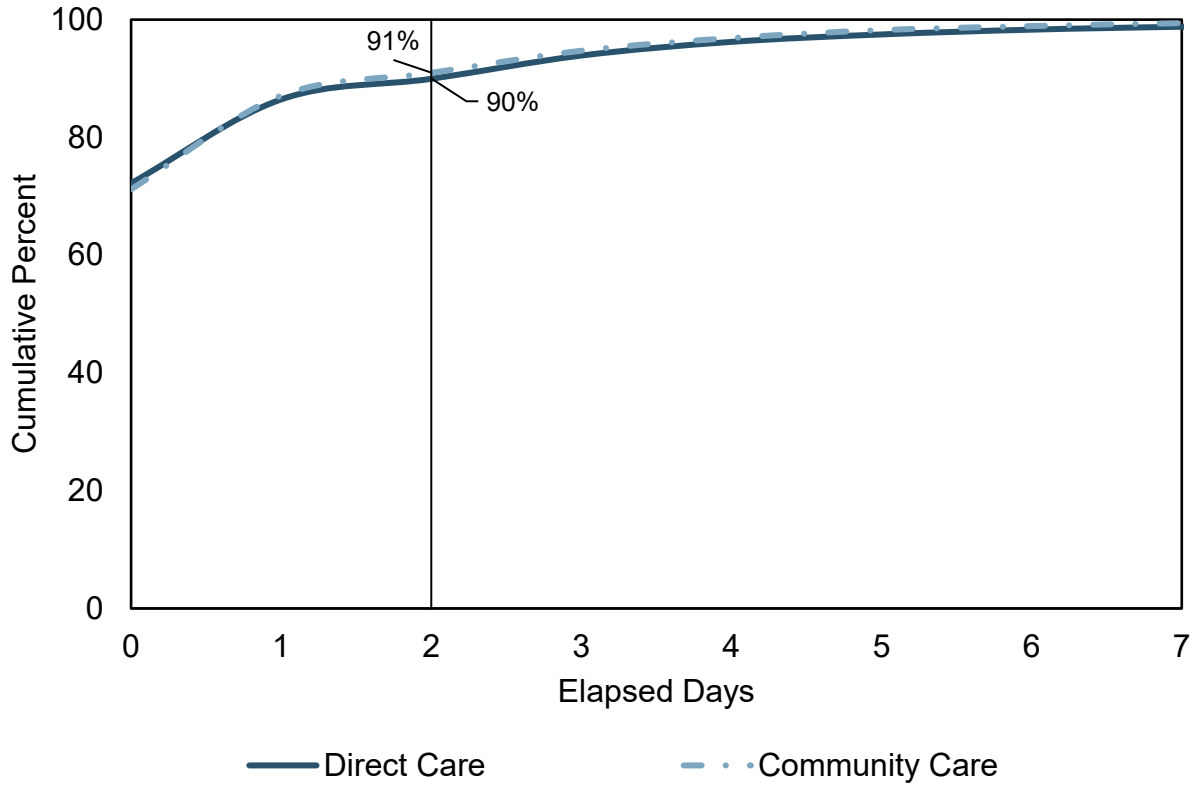

Figure 3. *Referrals with activity by elapsed days.*
Source: OIG analysis of VA administrative data.

Timeliness of Appointment Setting

The OIG assessed the timeliness of appointment setting guided by standards outlined in the *Consult Timeliness Standard Operating Procedure* which specifies:[28]

- Three business days to set an appointment to occur at a VA facility; and
- Seven, 14, or 21 calendar days to set a community care appointment, depending on the date the referral was written. Referrals written during the first quarter of fiscal year 2022 were allowed 21 days to set the appointment, those written during the second quarter were allowed 14 days, and those written after the second quarter were allowed 7 days. Fiscal year 2022 was a transition period for reducing the number of days afforded to set community care appointments.

The OIG assessed timeliness of appointment setting using both 7 and 21 calendar days.

Figure 4 shows the distribution of days to appointment setting from the day the referral was written. The OIG found that within 7 days, VA staff completed appointment setting for approximately 65 percent of effective VA direct care referrals and 18 percent of community care referrals. Within 21 days of the referral written date, VA staff completed approximately 84 percent of appointment setting for VA direct care referrals and 56 percent of appointment setting for community care referrals, indicating that appointments were often not set within the timelines outlined in the standard operating procedure.

[28] VHA IVC, "Consult Timeliness" (standard operating procedure), December 15, 2021.

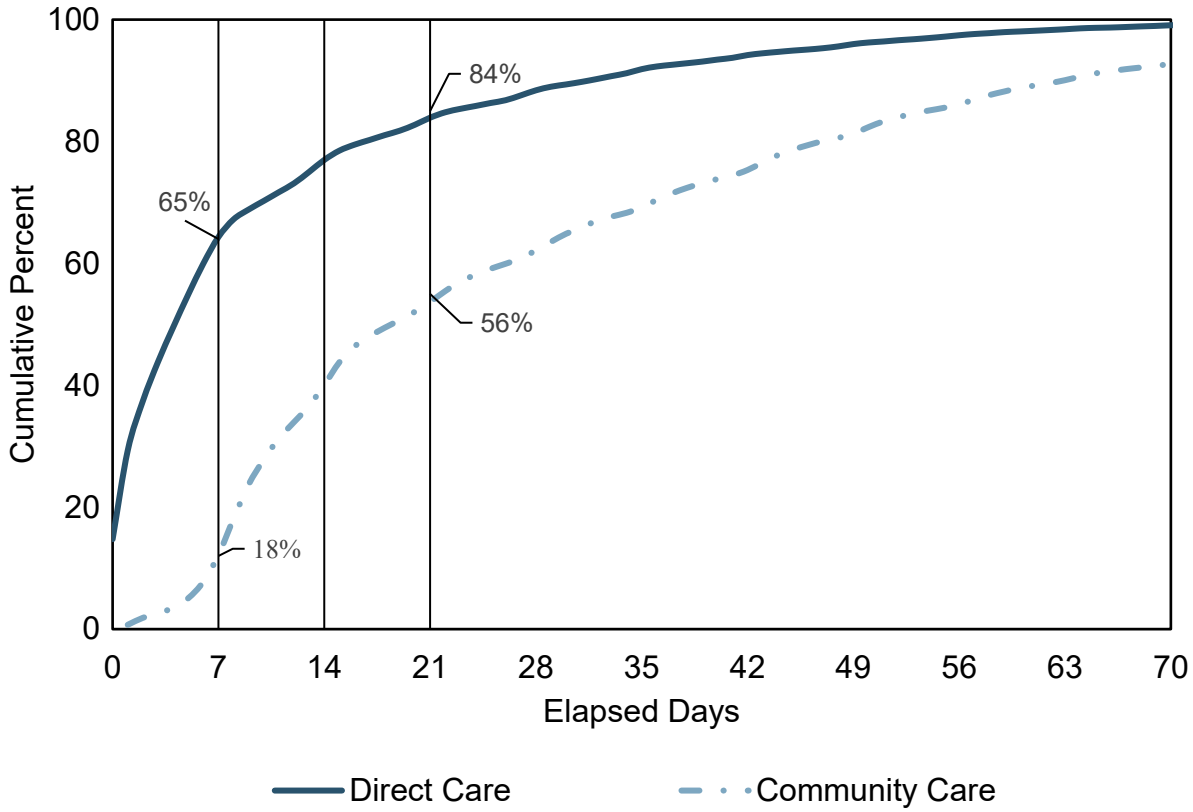

Figure 4. *Percentage of effective referrals having appointments set by elapsed days.*
Source: OIG analysis of VA administrative data.

The OIG further identified 7,513 VA direct care referrals and 59 community care referrals that had yet to have an appointment set as of December 19, 2023.

The OIG found that VA staff canceled 43 percent of VA direct care referrals and 36 percent of community care referrals before the specified time frame to set the appointments. Of those that were canceled after the required time frame to set the appointment, 20 percent of VA direct care referrals and 17 percent of community care referrals had appointments set within 7 or 21 days, respectively.

The OIG recommends an assessment of the timeliness of appointment setting for direct and community care referrals to ensure facility staff establish appointments within required time frames.

Timeliness of Referral Completion

When assessing the timeliness of referral completion, the standards outlined in the *Consult Timeliness Standard Operating Procedure* guided the OIG's analysis.[29] Those guidelines give 90 days from the requested date to complete both direct and community care referrals.

After excluding discontinued referrals, canceled referrals, and those referrals without a complete date, 45,667 VA direct care and 67,180 community care referrals remained. The OIG found that VA staff completed approximately 95 and 48 percent of VA direct and community care referrals, respectively, within 90 days of the requested date, indicating opportunities to improve the timeliness of referral completion, especially for community care referrals.

The OIG recommends the Montana VA Healthcare System Director assesses the timeliness of completion of community care appointments within 90 days of the requested date and acts on identified opportunities for improvement.

Completed Referrals Without an Appointment Set

While reviewing referral completion, the OIG noticed that some completed VA direct care referrals were missing the date the appointment was set. The OIG further analyzed three types of highly specialized referrals that generally require appointments. Table 13 shows that many Gastroenterology (GI) Endoscopy, Dermatology, and Oncology/Tumor specialty referrals are missing the date the appointment was set, despite the fact that the referral was completed. The OIG removed inter-facility consults to ensure that the scheduling activities at other facilities did not affect the analysis. GI Endoscopy referrals usually involve clinical procedures, rarely performed on a walk-in basis. This raises the question whether required consult activity data were entered.

The OIG recommends the Montana VA Healthcare System Director reviews consult management practices and ensures scheduled appointment dates are documented for VA direct care referrals.

Table 13. Completed but Unscheduled VA Direct Care Effective Referrals by Medical Specialty and Location

Medical Specialty (Stop Code)	Ordering Location*	Not Scheduled	Scheduled	Referrals Not Scheduled (%)
Dermatology (304)	Fort Harrison Medical Center	267	346	44
Dermatology (304)	Dr. J Medicine Crow VA Clinic	79	111	42
Dermatology (304)	David J. Thatcher VA Clinic	72	33	69

[29] VHA IVC, "Consult Timeliness" (standard operating procedure), December 15, 2021.

Medical Specialty (Stop Code)	Ordering Location*	Not Scheduled	Scheduled	Referrals Not Scheduled (%)
Dermatology (304)	Kalispell VA Clinic	61	29	68
Dermatology (304)	Travis W. Atkins VA Clinic	40	11	78
Dermatology (304)	Great Falls CBOC	33	21	61
Dermatology (304)	Cut Bank VA Clinic	28	6	82
Dermatology (304)	Hamilton VA Clinic	15	0	100
Dermatology (304)	Lewistown CBOC	12	9	57
Dermatology (304)	Anaconda CBOC	11	77	13
Dermatology (304)	Benjamin C. Steele VA Clinic	11	7	61
Dermatology (304)	Glasgow VA Clinic	0	26	0
GI Endoscopy (321)	Fort Harrison Medical Center	1081	746	59
GI Endoscopy (321)	Dr. J Medicine Crow VA Clinic	173	2	99
GI Endoscopy (321)	Miles City VA Medical Center	24	2	92
GI Endoscopy (321)	David J. Thatcher VA Clinic	14	29	33
GI Endoscopy (321)	Great Falls CBOC	6	13	32
GI Endoscopy (321)	Anaconda CBOC	0	22	0
GI Endoscopy (321)	Kalispell VA Clinic	0	15	0
GI Endoscopy (321)	Travis W. Atkins VA Clinic	0	15	0
Oncology/Tumor (316)	Fort Harrison Medical Center	149	47	76
Oncology/Tumor (316)	Dr. J Medicine Crow VA Clinic	54	0	100
Oncology/Tumor (316)	David J. Thatcher VA Clinic	23	0	100
Oncology/Tumor (316)	Kalispell VA Clinic	20	1	95
Oncology/Tumor (316)	Anaconda CBOC	16	1	94
Oncology/Tumor (316)	Great Falls CBOC	12	2	86

Source: OIG analysis of VA administrative data.
Note: Facilities with less than 10 referrals are omitted.
**CBOC = community-based outpatient clinic.*

Appointment Wait Time

The OIG classified referrals into the following categories: primary, specialty, and mental health care. The wait-time standards outlined by the Veterans Community Care Program for timeliness are:[30]

[30] VA MISSION Act of 2018; 38 C.F.R. § 17.4040 (2019).

- 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider.
- 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA healthcare provider.

The OIG determined the number of days patients waited for an appointment after the requested date for routine outpatient community care referrals. The OIG found that less than 1 percent of all community care referrals were for primary care and less than 3 percent were for mental health in fiscal year 2022. The OIG found that approximately 39 percent and 64 percent of community care referrals resulted in an appointment within 20 days for primary care and mental health care, respectively. The OIG found that approximately 97 percent of all community care referrals were for specialty care. For specialty care, approximately 54 percent of referrals resulted in an appointment within 28 days of the requested date (see figure 5).

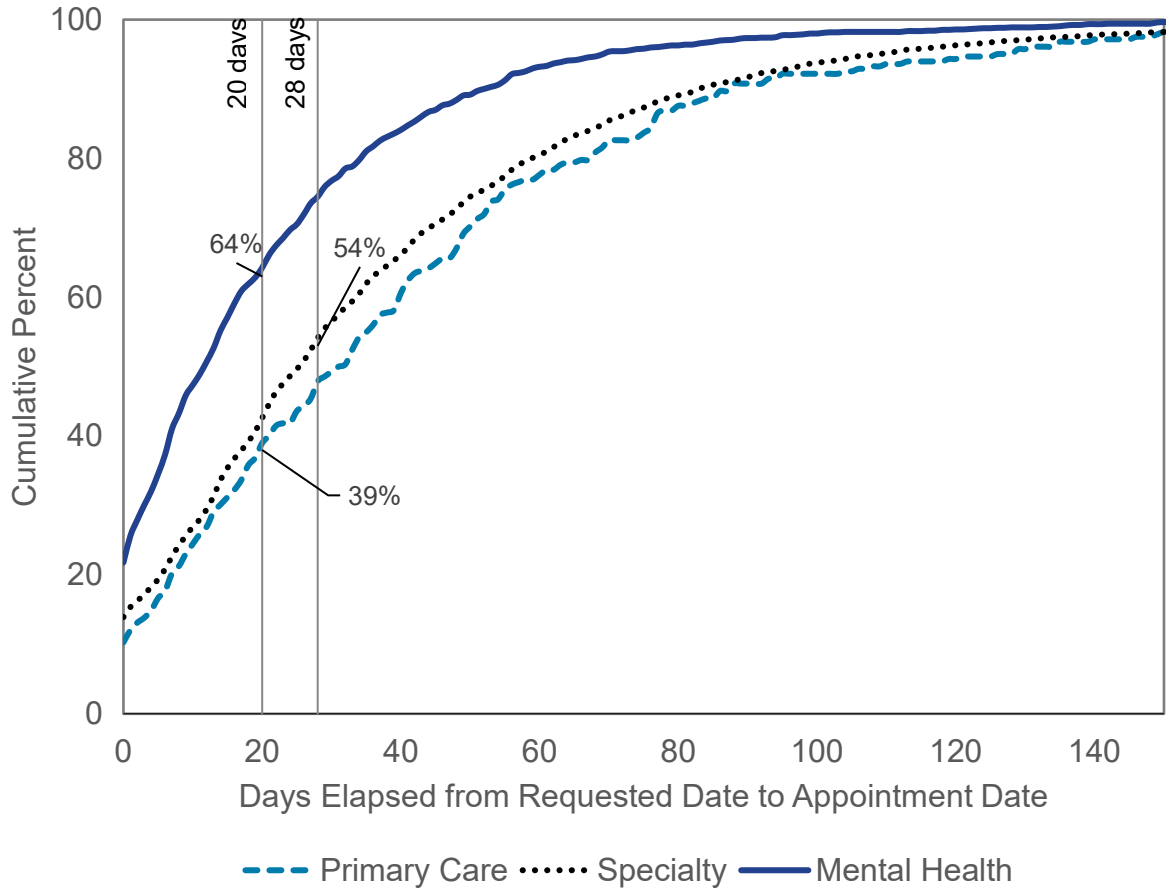

Figure 5. *Distribution of community care wait times for primary, specialty, and mental healthcare referrals. Source: OIG analysis of VA administrative data.*

The OIG assessed appointment wait times for specialty and mental healthcare referrals (see figure 6). The OIG found that 61 and 54 percent of specialty care appointments were within 28 days of the requested date for VA direct care and community care, respectively. For mental health referrals, 45 and 64 percent of the appointments were within 20 days of the requested date for VA direct care and community care, respectively.

The OIG recommends that the Montana VA Healthcare System Director reviews appointment wait times and acts on identified opportunities for improvement.

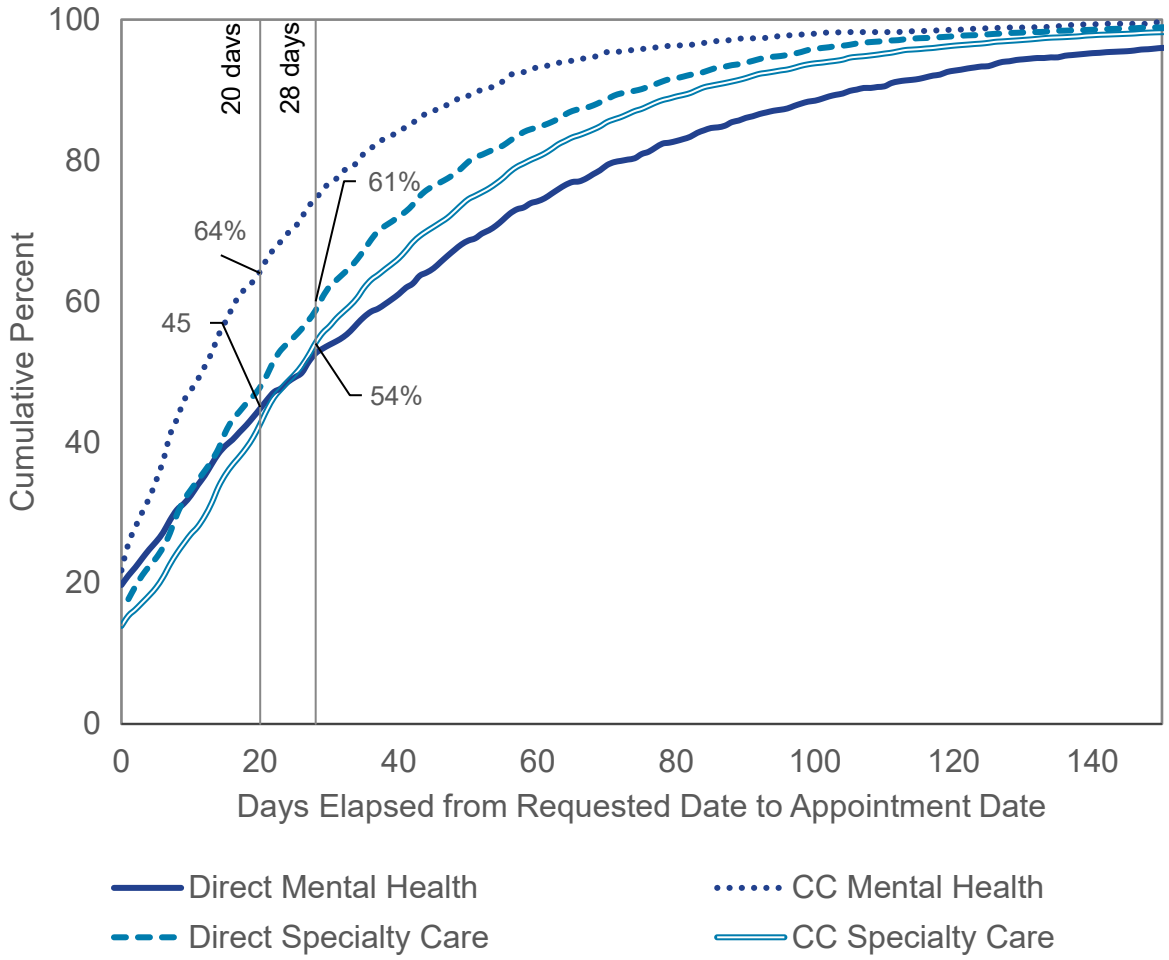

Figure 6. *Distribution of direct and community care wait times for mental health and specialty care referrals. Source: OIG analysis of VA administrative data.*

Disqualified Community Care Providers

The OIG assessed whether providers who were removed from VA employment potentially due to conduct that violated VA policy related to the delivery of safe and appropriate health care furnished community care through the system in fiscal year 2022. The OIG used the VA Human Resources Information System to identify potentially disqualified providers, based on removals utilizing combinations of "nature of action code" and "legal authority code," from the enactment of the VA MISSION Act on June 6, 2018, through the end of fiscal year 2022. The OIG then determined whether the system had paid community care claims in fiscal year 2022 for services provided by the identified, potentially disqualified, providers.

The OIG identified two potentially disqualified former VA providers associated with community care claims paid by the system:

Provider 1. The OIG found that in December 2020, VA terminated Provider 1's employment using nature of action code "330-Removal" and a legal authority code used by VA to exclude providers from the community care program. The OIG identified 15 paid claims associated with Provider 1 for community care service furnished to three system patients in fiscal year 2022.

The OIG previously found that (1) VA's exclusionary process failed to accurately identify personnel actions that indicate healthcare providers were removed for violating policies relating to delivery of safe and appropriate care, and (2) a case-by-case review of additional information beyond the nature of action and legal authority is needed to determine if the action was a result of a policy violation related to the delivery of safe and appropriate care.[31] The OIG reviewed Provider 1's Standard Form 50 (SF-50), *Notification of Personnel Action*, which documented the reason for removal as "Failure to complete credentialing requirements."[32] The OIG contacted the terminating VA facility for clarification. The terminating VA facility indicated that Provider 1's employment was not terminated due to quality of care concerns. Therefore, Provider 1 should be eligible to provide community care. However, despite the termination not being related to the delivery of safe and appropriate health care, the Provider Profile Management System incorrectly denoted Provider 1 as ineligible to furnish community care. Furthermore, the OIG found that system staff authorized community care for patients after the ineligible designation in the Provider Profile Management System, which indicates a failure in the community care authorization process.

Provider 2. The OIG found that in August 2022, the system terminated Provider 2's employment using nature of action code "312-resignation-ILIA (In Lieu Of Involuntary Action)" and a legal authority code used by VA to exclude providers from the community care program. The OIG inquired and received a response from the system that Provider 2 received notice from the system Professional Standards Board in July 2022 for

- "Copy and pasting inaccurate information into 404 out of 652 patient charts,"
- "Incorrect documentation in the Medical Record Chart,"
- "Patient Care Concerns,"
- "Ongoing documentation Concerns, and"

[31] VA OIG, *Veterans Health Administration's Failure to Properly Identify and Exclude Ineligible Providers from the VA Community Care Program*, Report No. 22-02398-131, April 9, 2024.

[32] According to the US Office of Personnel Management, "Standard Forms are used governmentwide for various employment and benefits program purposes," accessed April 25, 2024, https://www.opm.gov/forms/standard-forms/.

- "Professionalism Concerns."[33]

Provider 2 resigned before the scheduled date to appear before the system Professional Standards Board. Two system physicians completed a review of the allegations in November 2022, and "both stated the investigation had no patient care concerns after review … and no report to SLB [state licensing board] would have been done without a [*sic*] patient care issues."

Despite the resignation in lieu of adverse action and legal authority code used by VA to exclude providers from the community care program, the Provider Profile Management System still identified Provider 2 as eligible to furnish community care.

The OIG identified three paid claims for skilled home health care for one patient associated with this provider. However, it appears Provider 2's involvement in the patient's care was as the referring VA provider, not the community care provider.

The OIG recommends that the Montana VA Healthcare System Director ensures community care providers utilized by the system are designated as eligible in the Provider Profile Management System and acts on identified opportunities to improve the accuracy of eligibility designations.

Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially in a rural environment in which many patients qualify for community care based solely on where they live. In the system, that amounted to about 74 percent of the 34,479 patients in the patient population with a Montana or bordering state address. The OIG recognizes the challenges, especially with respect to specialty care, involved in providing the care that veterans living in rural areas require. To assist leaders in evaluating the care delivered at Montana VA Healthcare System, the OIG conducted a review of community care utilization, delivery of timely care, and provider qualifications for fiscal year 2022. The OIG made five recommendations for improvement.

Recommendations 1–5

1. The Montana VA Healthcare System Director assesses the timeliness of appointment setting for VA direct and community care referrals and ensures facility staff establish appointments within required time frames.

[33] VA Handbook 5005, *Staffing*, April 6, 2020. According to VA, professional standards boards "determine eligibility for appointment and conduct probationary reviews."

2. The Montana VA Healthcare System Director assesses the timeliness of completion of community care appointments within 90 days of the requested date and acts on identified opportunities for improvement.
3. The Montana VA Healthcare System Director reviews consult management practices and ensures scheduled appointment dates are documented for VA direct care referrals.
4. The Montana VA Healthcare System Director reviews appointment wait times and acts on identified opportunities for improvement.
5. The Montana VA Healthcare System Director ensures community care providers utilized by the system are designated as eligible in the Provider Profile Management System and acts on identified opportunities to improve the accuracy of eligibility designations.

Appendix A: Montana VA Healthcare System Profile

The table below provides general background information for this medium complexity (Level 2) VA healthcare system reporting to VISN 19.[34]

Table A.1. Profile for Montana VA Healthcare System (436) (October 1, 2019, through September 30, 2022)

Profile Element	Fiscal Year 2020*	Fiscal Year 2021‡	Fiscal Year 2022§
Total medical care budget	$439,525,849	$488,970,897	$506,415,898
Number of:			
• Unique patients	38,579	38,835	39,854
• Outpatient visits	421,725	445,854	410,979
Type and number of operating beds:			
• Community living center	20	17	17
• Domiciliary	24	24	24
• Hospital	18	18	18
Average daily census:			
• Community living center	9	6	9
• Domiciliary	13	8	13
• Hospital	10	14	13

Source: VA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.
**October 1, 2019, through September 30, 2020.*
‡October 1, 2020, through September 30, 2021.
§October 1, 2021, through September 30, 2022.

[34] VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," accessed July 24, 2024, https://dvagov.sharepoint.com/sites/VHAOPES/SitePages/Facility-Complexity-Model-and-Patient-Level-Risk-Adjustment-Models.aspx. (This website is not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

Appendix B: Priority Group Definitions

Table B.1. Priority Group Definitions

Priority Group	Definition
1	(1) Veterans with a combined rating of 50 percent or greater based on one or more service-connected (SC) disabilities. (2) Veterans determined by VA to be unemployable due to SC conditions. (3) Veterans who have been awarded the Medal of Honor.
2	Veterans with a combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.
3	(1) Veterans who are former prisoners of war. (2) Veterans awarded the Purple Heart medal. (3) Veterans awarded a combined rating of 10 percent or 20 percent based on one or more service-connected disabilities. (4) Veterans who were discharged or released from active military, naval, air, or space service for a disability incurred or aggravated in the line of duty. (5) Veterans who receive disability compensation under 38 U.S.C. § 1151, which provides benefits for individuals disabled by treatment or vocational rehabilitation. (6) Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay. (7) Veterans receiving compensation at the 10 percent rating level based on multiple non-compensable service-connected disabilities that clearly interfere with normal employability.
4	(1) Veterans who receive aid and attendance or housebound pension benefits from VA. (2) Veterans who are determined to be Catastrophically Disabled (CD) by the Chief of Staff (or equivalent clinical official) at the VA medical facility where they were examined, unless the Veteran qualifies for placement in a higher Priority Group.
5	(1) Nonservice-connected Veterans and non-compensable 0 percent service-connected Veterans with annual income below the VA Means Test (MT) threshold and Geographic Means Test (GMT) threshold. (2) Veterans who receive VA pension benefits. (3) Veterans who are eligible for Medicaid programs.

Priority Group	Definition
6	(1) Toxic-exposed Veterans under 38 U.S.C. § 1710(e)(1): (a) Vietnam-era herbicide-exposed Veterans. (b) Radiation-exposed Veterans. (c) Veterans in Southwest Asia during the Persian Gulf War. (d) Combat Veterans who served in a theater of combat operations after the Persian Gulf War and those Veterans who served in combat against a hostile force during a period of hostilities after November 11, 1998. **NOTE:** *After their enhanced eligibility period and enrollment in Priority Group 6 ends, combat Veterans will remain enrolled and placed into Priority Group 8, unless they are otherwise eligible for a higher priority group.* (e) Project 112/SHAD Veterans. (f) Camp Lejeune Veterans. (g) Toxic-exposure risk activity Veterans. (h) "Covered Veterans" under 38 U.S.C. § 1119(c). (i) Veterans who deployed in support of a named contingency operation (Operation Enduring Freedom, Operation Freedom's Sentinel, Operation Iraqi Freedom, Operation New Dawn, Operation Inherent Resolve, and Resolute Support Mission). (2) World War II (WWII) Veterans. NOTE: Guidance on determining WWII eligibility, can be found at: "(VAMC Enroll_Elig) VES Cleland Dole Act Add a Person (AAP) - JA," accessed May 1, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001046/content/554400000223534/VAMC-Enroll-Elig-VES-Cleland-Dole-Act-Add-a-Person-AAP-JA. *(This is an internal VA website that is not available to the public.)* (3) Veterans with a compensable zero percent service-connected disability rating(s). **NOTE:** All Veterans in Priority Group 6 may be charged copayments for care received to treat illnesses and medical conditions not related to their military service. Additional information on special eligibility factors can be found at: "(VAMC Enroll_Elig) VES Special Eligibility Factors Review and Updates – JA," accessed May 1, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001046/content/554400000136015/VAMC-Enroll-Elig-VES-Special-Eligibility-Factors-Review-and-Updates-JA?query=special%20eligibilities. (*This is an internal VA website that is not available to the public.)*
7	Veterans who agree to pay the VA the applicable copayment (under 38 U.S.C. § 1710(f) and (g)) if their income (including income of their spouse and dependents) for the previous year constitutes low income under the geographical income limits established by HUD [Housing and Urban Development] for the fiscal year that ended on September 30th, of the previous calendar year. To avoid hardship to a Veteran, VA may use the projected income for the current year of the Veteran, spouse, and dependent children if their projected income is below the low-income limit referenced in 38 C.F.R. § 17.36(b)(7).
8	Veterans with gross household income above the MT threshold and GMT income threshold who agree to pay the applicable copayments under 38 U.S.C. §§ 1719(f) and 1710(g).

Source: VHA Directive 1601A.01(3), Registration and Enrollment, July 7, 2020 (amended April 4, 2024).

Appendix C: All Outpatient Visits–Direct and Community Care

In the main body of this report, the reported outpatient visit data excludes visits for which the patient could not readily choose between VA direct care and community care. Appendix C tables provide outpatient utilization data that includes visits where the patient could not readily choose between VA direct care and community care. This is a broader measure of the clinical visits provided by the Montana VA Healthcare System. The results are similar to those in the body of the report.

Table C.1. Patients with an Outpatient Visit-Day by Medical Care Type

Medical Care Type	Number (%) of Patients with Only VA Direct Care Visit-Days	Number (%) of Patients with Only Community Care Visit-Days	Number (%) of Patients with Both VA Direct and Community Care Visit-Days	Total Patients
Primary Care	**29,071 (98.8)**	**211 (0.7)**	**137 (0.5)**	**29,419**
Mental Health	**5,946 (77.5)**	**784 (10.2)**	**939 (12.2)**	**7,669**
Emergency/Urgent Care	**1,870 (17.3)**	**8,396 (77.8)**	**521 (4.8)**	**10,787**
All Specialties*	**5,544 (19.5)**	**9,658 (34)**	**13,211 (46.5)**	**28,413**
Cardiology	997 (18.9)	3,544 (67.3)	723 (13.7)	5,264
Dermatology	799 (38.4)	1,225 (58.9)	55 (2.6)	2,079
Gynecology	287 (71.0)	91 (22.5)	26 (6.4)	404
Ophthalmology	2,489 (45.7)	2,740 (50.3)	216 (4.0)	5,445
Urology	1,126 (46.8)	1,143 (47.5)	139 (5.8)	2,408
Other specialties	6,108 (22.7)	9,481 (35.2)	11,343 (42.1)	26,932

Source: OIG analysis of VA administrative data.

Note: Each row of table C.1 is calculated independently, so comparisons across rows must be done carefully. For example, there are 6,108 patients whose visits to other specialties (i.e., other than cardiology, dermatology, gynecology, ophthalmology, and urology) were only through VA direct care. If one of those patients also had a community care visit to a cardiologist, then that patient would not be included in the 5,544 patients whose visits to specialists were only through VA direct care, because the All Specialties row includes both cardiology and any specialty in Other Specialties.

**This is the number of patients whose only visits to specialists were through VA direct care, the number of patients whose only visits to specialists were to community care specialists, and the number of patients who had a visit to both a VA direct care and a community care specialist in fiscal year 2022.*

Table C.2. Outpatient Utilization by Medical Care Type

Medical Care Type	VA Direct Care Visit-Days	Percent of Visit-Days by Medical Care Type	Community Care Visit-Days	Percent of Visit-Days by Medical Care Type
Primary Care	**104,541**	**99.0**	**1,077**	**1.0**
Mental Health	**40,295**	**69.3**	**17,836**	**30.7**
Emergency/Urgent Care	**4,586**	**19.6**	**18,756**	**80.4**
All Specialties*	**96,050**	**36.4**	**167,985**	**63.6**
Cardiology	2,774	18.0	12,663	82.0
Dermatology	1,073	29.5	2,569	70.5
Gynecology	642	71.9	251	28.1
Ophthalmology	3,925	35.1	7,242	64.9
Urology	2,168	35.1	4,015	64.9
Total	**245,472**	**54.4**	**205,654**	**45.6**

Source: OIG analysis of VA administrative data.

**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Table C.3. Outpatient Utilization by Medical Care Type–Overall Visit-Days

Medical Care Type	VA Direct Care Visit-Days	Overall Visit-Days (%)	Community Care Visit-Days	Overall Visit-Days (%)
Primary Care	**104,541**	**23.2**	**1,077**	**0.2**
Mental Health	**40,295**	**8.9**	**17,836**	**4.0**
Emergency/Urgent Care	**4,586**	**1.0**	**18,756**	**4.2**
All Specialties*	**96,050**	**21.3**	**167,985**	**37.2**
Cardiology	2,774	0.6	12,663	2.8
Dermatology	1,073	0.2	2,569	0.6
Gynecology	642	0.1	251	0.1
Ophthalmology	3,925	0.9	7,242	1.6
Urology	2,168	0.5	4,015	0.9
Total	**245,472**	**54.4**	**205,654**	**45.6**

Source: OIG analysis of VA administrative data.

**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Table C.4. Top Five Primary Diagnoses for Primary Care Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (29,419)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (29,202)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (348)**	**Patients (%)**
Essential (primary) hypertension (I10.)	6,627	22.5	Essential (primary) hypertension (I10.)	6,579	22.5	Essential (primary) hypertension (I10.)	48	13.8
Type 2 diabetes mellitus without complications (E11.9)	3,206	10.9	Type 2 diabetes mellitus without complications (E11.9)	3,179	10.9	Type 2 diabetes mellitus without complications (E11.9)	27	7.8
Hyperlipidemia, unspecified (E78.5)	1,962	6.7	Hyperlipidemia, unspecified (E78.5)	1,950	6.7	COVID-19 (U07.1)	19	5.5
Low back pain, unspecified (M54.50)	1,792	6.1	Low back pain, unspecified (M54.50)	1,782	6.1	Other chronic pain (G89.29)	14	4.0
Chronic obstructive pulmonary disease, unspecified (J44.9)	1,376	4.7	Chronic obstructive pulmonary disease, unspecified (J44.9)	1,370	4.7	Hyperlipidemia, unspecified (E78.5)	12	3.4

Source: OIG analysis of VA administrative data

Table C.5. Top Five Primary Diagnoses for Mental Health Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (7,669)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (6,885)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,723)**	**Patients (%)**
Post-traumatic stress disorder, chronic (F43.12)	2,557	33.3	Post-traumatic stress disorder, chronic (F43.12)	1,998	29.0	Post-traumatic stress disorder, chronic (F43.12)	559	32.4
Post-traumatic stress disorder, unspecified (F43.10)	1,403	18.3	Post-traumatic stress disorder, unspecified (F43.10)	1,105	16.0	Post-traumatic stress disorder, unspecified (F43.10)	298	17.3
Major depressive disorder, recurrent, moderate (F33.1)	862	11.2	Anxiety disorder, unspecified (F41.9)	715	10.4	Major depressive disorder, recurrent, moderate (F33.1)	222	12.9
Anxiety disorder, unspecified (F41.9)	769	10.0	Major depressive disorder, recurrent, moderate (F33.1)	640	9.3	Generalized anxiety disorder (F41.1)	143	8.3
Adjustment disorder with mixed anxiety and depressed mood (F43.23)	635	8.3	Major depressive disorder, single episode, unspecified (F32.9)	546	7.9	Adjustment disorder with mixed anxiety and depressed mood (F43.23)	90	5.2

Source: OIG analysis of VA administrative data

Table C.6. Top Five Primary Diagnoses for Emergency/Urgent Care Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (10,787)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,391)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (8,917)**	**Patients (%)**
COVID-19 (U07.1)	1,023	9.5	Acute upper respiratory infection, unspecified (J06.9)	177	7.4	COVID-19 (U07.1)	895	10.0
Chest pain, unspecified (R07.9)	857	7.9	Low back pain, unspecified (M54.50)	135	5.6	Chest pain, unspecified (R07.9)	784	8.8
Shortness of breath (R06.02)	608	5.6	COVID-19 (U07.1)	128	5.4	Shortness of breath (R06.02)	575	6.4
Other chest pain (R07.89)	454	4.2	Chest pain, unspecified (R07.9)	73	3.1	Other chest pain (R07.89)	417	4.7
Acute upper respiratory infection, unspecified (J06.9)	402	3.7	Urinary tract infection, site not specified (N39.0)	64	2.7	Weakness (R53.1)	345	3.9

Source: OIG analysis of VA administrative data

Table C.7. Top Five Primary Diagnoses for Cardiology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (5,264)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,720)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (4,267)**	**Patients (%)**
Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,370	26.0	Chest pain, unspecified (R07.9)	184	10.7	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,245	29.2
Unspecified atrial fibrillation (I48.91)	637	12.1	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	125	7.3	Unspecified atrial fibrillation (I48.91)	516	12.1
Chest pain, unspecified (R07.9)	630	12.0	Unspecified atrial fibrillation (I48.91)	121	7.0	Essential (primary) hypertension (I10.)	457	10.7
Essential (primary) hypertension (I10.)	559	10.6	Bradycardia, unspecified (R00.1)	118	6.9	Chest pain, unspecified (R07.9)	446	10.5
Paroxysmal atrial fibrillation (I48.0)	346	6.6	Essential (primary) hypertension (I10.)	102	5.9	Paroxysmal atrial fibrillation (I48.0)	312	7.3

Source: OIG analysis of VA administrative data

Table C.8. Top Five Primary Diagnoses for Dermatology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (2,079)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (854)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,280)**	**Patients (%)**
Actinic keratosis (L57.0)	594	28.6	Actinic keratosis (L57.0)	383	44.8	Other seborrheic keratosis (L82.1)	248	19.4
Other seborrheic keratosis (L82.1)	297	14.3	Neoplasm of uncertain behavior of skin (D48.5)	85	10.0	Actinic keratosis (L57.0)	211	16.5
Neoplasm of uncertain behavior of skin (D48.5)	243	11.7	Inflamed seborrheic keratosis (L82.0)	72	8.4	Neoplasm of uncertain behavior of skin (D48.5)	158	12.3
Inflamed seborrheic keratosis (L82.0)	137	6.6	Disorder of the skin and subcutaneous tissue, unspecified (L98.9)	64	7.5	Melanocytic nevi of trunk (D22.5)	96	7.5
Basal cell carcinoma of skin of other parts of face (C44.319)	111	5.3	Other seborrheic keratosis (L82.1)	49	5.7	Basal cell carcinoma of skin of other parts of face (C44.319)	92	7.2

Source: OIG analysis of VA administrative data

Table C.9. Top Five Primary Diagnoses for Ophthalmology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (5,445)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,705)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,956)**	**Patients (%)**
Type 2 diabetes mellitus without complications (E11.9)	971	17.8	Type 2 diabetes mellitus without complications (E11.9)	724	26.8	Age-related nuclear cataract, bilateral (H25.13)	384	13.0
Age-related nuclear cataract, bilateral (H25.13)	582	10.7	Age-related nuclear cataract, bilateral (H25.13)	198	7.3	Age-related nuclear cataract, right eye (H25.11)	318	10.8
Age-related nuclear cataract, right eye (H25.11)	338	6.2	Primary open-angle glaucoma, bilateral, mild stage (H40.1131)	183	6.8	Age-related nuclear cataract, left eye (H25.12)	298	10.1
Age-related nuclear cataract, left eye (H25.12)	325	6.0	Dry eye syndrome of bilateral lacrimal glands (H04.123)	167	6.2	Type 2 diabetes mellitus without complications (E11.9)	247	8.4
Dry eye syndrome of bilateral lacrimal glands (H04.123)	264	4.8	Open angle with borderline findings, low risk, bilateral (H40.013)	151	5.6	Combined forms of age-related cataract, left eye (H25.812)	198	6.7

Source: OIG analysis of VA administrative data

Table C.10. Top Five Primary Diagnoses for Urology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (2,408)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,265)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,282)**	**Patients (%)**
Malignant neoplasm of prostate (C61.)	563	23.4	Malignant neoplasm of prostate (C61.)	333	26.3	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	311	24.3
Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	495	20.6	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	184	14.5	Malignant neoplasm of prostate (C61.)	230	17.9
Elevated prostate specific antigen [PSA] (R97.20)	360	15.0	Elevated prostate specific antigen [PSA] (R97.20)	166	13.1	Elevated prostate specific antigen [PSA] (R97.20)	194	15.1
Calculus of kidney (N20.0)	190	7.9	Malignant neoplasm of bladder, unspecified (C67.9)	66	5.2	Calculus of kidney (N20.0)	152	11.9
Retention of urine, unspecified (R33.9)	162	6.7	Carcinoma in situ of prostate (D07.5)	61	4.8	Retention of urine, unspecified (R33.9)	119	9.3

Source: OIG analysis of VA administrative data

Appendix D: Top Five Outpatient Diagnoses for Primary Care, Mental Health, and Emergency/Urgent Care Visits

Appendix D includes outpatient diagnoses for outpatient primary care, mental health, and emergency/urgent care visits not included in the body of the report. These also exclude visit types for which the patient could not readily choose between direct care and community care.

Table D.1. Top Five Primary Diagnoses for Primary Care Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (29,404)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (29,192)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (348)**	**Patients (%)**
Essential (primary) hypertension (I10.)	6,594	22.4	Essential (primary) hypertension (I10.)	6,546	22.4	Essential (primary) hypertension (I10.)	48	13.8
Type 2 diabetes mellitus without complications (E11.9)	3,187	10.8	Type 2 diabetes mellitus without complications (E11.9)	3,160	10.8	Type 2 diabetes mellitus without complications (E11.9)	27	7.8
Hyperlipidemia, unspecified (E78.5)	1,960	6.7	Hyperlipidemia, unspecified (E78.5)	1,948	6.7	COVID-19 (U07.1)	19	5.5
Low back pain, unspecified (M54.50)	1,790	6.1	Low back pain, unspecified (M54.50)	1,780	6.1	Other chronic pain (G89.29)	14	4.0
Chronic obstructive pulmonary disease, unspecified (J44.9)	1,356	4.6	Chronic obstructive pulmonary disease, unspecified (J44.9)	1,350	4.6	Hyperlipidemia, unspecified (E78.5)	12	3.4

Source: OIG analysis of VA administrative data.

Table D.2. Top Five Primary Diagnoses for Mental Health Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (7,652)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (6,868)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,723)**	**Patients (%)**
Post-traumatic stress disorder, chronic (F43.12)	2,555	33.4	Post-traumatic stress disorder, chronic (F43.12)	1,996	29.1	Post-traumatic stress disorder, chronic (F43.12)	559	32.4
Post-traumatic stress disorder, unspecified (F43.10)	1,402	18.3	Post-traumatic stress disorder, unspecified (F43.10)	1,104	16.1	Post-traumatic stress disorder, unspecified (F43.10)	298	17.3
Major depressive disorder, recurrent, moderate (F33.1)	859	11.2	Anxiety disorder, unspecified (F41.9)	715	10.4	Major depressive disorder, recurrent, moderate (F33.1)	222	12.9
Anxiety disorder, unspecified (F41.9)	769	10.0	Major depressive disorder, recurrent, moderate (F33.1)	637	9.3	Generalized anxiety disorder (F41.1)	143	8.3
Adjustment disorder with mixed anxiety and depressed mood (F43.23)	632	8.3	Major depressive disorder, single episode, unspecified (F32.9)	544	7.9	Adjustment disorder with mixed anxiety and depressed mood (F43.23)	90	5.2

Source: OIG analysis of VA administrative data.

Table D.3. Top Five Primary Diagnoses for Emergency/Urgent Care Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (10,787)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,391)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (8,917)**	**Patients (%)**
COVID-19 (U07.1)	1,023	9.5	Acute upper respiratory infection, unspecified (J06.9)	177	7.4	COVID-19 (U07.1)	895	10.0
Chest pain, unspecified (R07.9)	857	7.9	Low back pain, unspecified (M54.50)	135	5.6	Chest pain, unspecified (R07.9)	784	8.8
Shortness of breath (R06.02)	608	5.6	COVID-19 (U07.1)	128	5.4	Shortness of breath (R06.02)	575	6.4
Other chest pain (R07.89)	454	4.2	Chest pain, unspecified (R07.9)	73	3.1	Other chest pain (R07.89)	417	4.7
Acute upper respiratory infection, unspecified (J06.9)	402	3.7	Urinary tract infection, site not specified (N39.0)	64	2.7	Weakness (R53.1)	345	3.9

Source: OIG analysis of VA administrative data.

Appendix E: Top Five Outpatient Diagnoses for Selected Specialty Care Visits

Appendix E includes outpatient diagnoses for outpatient specialty visits not included in the body of the report. These also exclude visit types for which the patient could not readily choose between direct care and community care.

Table E.1. Top Five Primary Diagnoses for Cardiology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (5,263)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,719)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (4,267)**	**Patients (%)**
Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,370	26.0	Chest pain, unspecified (R07.9)	184	10.7	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,245	29.2
Unspecified atrial fibrillation (I48.91)	637	12.1	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	125	7.3	Unspecified atrial fibrillation (I48.91)	516	12.1
Chest pain, unspecified (R07.9)	630	12.0	Unspecified atrial fibrillation (I48.91)	121	7.0	Essential (primary) hypertension (I10.)	457	10.7
Essential (primary) hypertension (I10.)	559	10.6	Bradycardia, unspecified (R00.1)	118	6.9	Chest pain, unspecified (R07.9)	446	10.5

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (5,263)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,719)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (4,267)**	**Patients (%)**
Paroxysmal atrial fibrillation (I48.0)	346	6.6	Essential (primary) hypertension (I10.)	102	5.9	Paroxysmal atrial fibrillation (I48.0)	312	7.3

Source: OIG analysis of VA administrative data

Table E.2. Top Five Primary Diagnoses for Dermatology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (2,079)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (854)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,280)**	**Patients (%)**
Actinic keratosis (L57.0)	594	28.6	Actinic keratosis (L57.0)	383	44.8	Other seborrheic keratosis (L82.1)	248	19.4
Other seborrheic keratosis (L82.1)	297	14.3	Neoplasm of uncertain behavior of skin (D48.5)	85	10.0	Actinic keratosis (L57.0)	211	16.5
Neoplasm of uncertain behavior of skin (D48.5)	243	11.7	Inflamed seborrheic keratosis (L82.0)	72	8.4	Neoplasm of uncertain behavior of skin (D48.5)	158	12.3
Inflamed seborrheic keratosis (L82.0)	137	6.6	Disorder of the skin and subcutaneous tissue, unspecified (L98.9)	64	7.5	Melanocytic nevi of trunk (D22.5)	96	7.5
Basal cell carcinoma of skin of other parts of face (C44.319)	111	5.3	Other seborrheic keratosis (L82.1)	49	5.7	Basal cell carcinoma of skin of other parts of face (C44.319)	92	7.2

Source: OIG analysis of VA administrative data

Table E.3. Top Five Primary Diagnoses for Ophthalmology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (5,425)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,685)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (2,956)**	**Patients (%)**
Type 2 diabetes mellitus without complications (E11.9)	956	17.6	Type 2 diabetes mellitus without complications (E11.9)	711	26.5	Age-related nuclear cataract, bilateral (H25.13)	384	13.0
Age-related nuclear cataract, bilateral (H25.13)	582	10.7	Age-related nuclear cataract, bilateral (H25.13)	198	7.4	Age-related nuclear cataract, right eye (H25.11)	318	10.8
Age-related nuclear cataract, right eye (H25.11)	338	6.2	Primary open-angle glaucoma, bilateral, mild stage (H40.1131)	183	6.8	Age-related nuclear cataract, left eye (H25.12)	298	10.1
Age-related nuclear cataract, left eye (H25.12)	325	6.0	Dry eye syndrome of bilateral lacrimal glands (H04.123)	166	6.2	Type 2 diabetes mellitus without complications (E11.9)	245	8.3
Dry eye syndrome of bilateral lacrimal glands (H04.123)	263	4.8	Open angle with borderline findings, low risk, bilateral (H40.013)	151	5.6	Combined forms of age-related cataract, left eye (H25.812)	198	6.7

Source: OIG analysis of VA administrative data

Table E.4. Top Five Primary Diagnoses for Urology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (2,408)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,264)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (1,282)**	**Patients (%)**
Malignant neoplasm of prostate (C61.)	562	23.3	Malignant neoplasm of prostate (C61.)	332	26.3	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	311	24.3
Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	495	20.6	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	184	14.6	Malignant neoplasm of prostate (C61.)	230	17.9
Elevated prostate specific antigen [PSA] (R97.20)	360	15.0	Elevated prostate specific antigen [PSA] (R97.20)	166	13.1	Elevated prostate specific antigen [PSA] (R97.20)	194	15.1
Calculus of kidney (N20.0)	190	7.9	Malignant neoplasm of bladder, unspecified (C67.9)	66	5.2	Calculus of kidney (N20.0)	152	11.9
Retention of urine, unspecified (R33.9)	162	6.7	Carcinoma in situ of prostate (D07.5)	61	4.8	Retention of urine, unspecified (R33.9)	119	9.3

Source: OIG analysis of VA administrative data

Appendix F: Excluded Referral Types to Obtain Routine Outpatient Referrals

Table F.1. Excluded Referrals

Referral Type	VA Direct Care		Community Care	
	Number of Referrals	Referrals (%)	Number of Referrals	Referrals (%)
Inpatient	5,521	4.5	419	0.41
Dental	1,335	1.1	4,720	4.6
Geriatric and Extended Care	0	0	4,520	4.4
E-Consult	2,856	2.3	0	0
Prosthetics	40,581	33.3	4,898	4.8
Administrative	5,237	4.3	2,154	2.1
Future Care*	432	0.4	599	0.6
Emergency/Urgent Care	42	0.03	1,130	1.1
Laboratory	0	0	939	0.9
Routine Outpatient Referrals	66,011	54.1	82,484	81.0

Source: OIG analysis of VA administrative data

**Appointment is expected to occur more than 90 days from the date the referral was entered.*

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 13, 2024

From: Director, Department of Veterans Affairs (VA) Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022

To: Director, Office of Healthcare Inspections (54HI00)
Executive Director, Office of Integrity and Compliance (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive the timely, high-quality, care they have earned through utilizing the principles, pillars, and values of high reliability.

2. I concur with the report findings and recommendations.

3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by*:)

Eliott VanderStek
Acting Network Director

[OIG comment: The OIG received the above memorandum from VHA on December 19, 2024.]

Appendix H: Montana VA Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: December 13, 2024

From: Director, Montana Department of Veterans Affairs (VA) Healthcare System (436/00)

Subj: Healthcare Inspection—Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022

To: Director, VA Rocky Mountain Network (10N19)

1. We appreciate the opportunity to review and comment on the Office of Inspector General draft report, Healthcare Inspection—Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022.

2. VA Direct Care average wait time represents a completed appointment. However, community care average wait time methodology is better thought of as consult timeliness or scheduling timeliness and represents the date of the scheduled appointment. There are many variables that play into the calculations of the associated time frames included in this report and we find it important to note that VA Direct Care wait times and community care scheduling timeliness may not be an equal comparison.

3. VA Montana Healthcare System concurs with the findings and will take appropriate actions as stated in the attached action plan.

4. If there are any questions regarding responses or additional information required, please contact Chief of Quality Management for the Montana VA Health Care System.

(*Original signed by*:)

Duane B. Gill, FACHE

[OIG comment: The OIG received the above memorandum from VHA on December 19, 2024.]

Facility Director Response

Recommendation 1

The Montana VA Healthcare System Director assesses the timeliness of appointment setting for direct and community care referrals and ensures facility staff establish appointments within required time frames.

_X _Concur

____Nonconcur

Target Date for completion: July 1, 2025

Director Comments

The Montana Department of Veterans Affairs (VA) Healthcare System will complete an assessment of the timeliness of appointment setting for Direct and Community Care referrals, identify gaps, and act on identified opportunities. The Consult Oversight Committee will monitor compliance and when warranted, take actions to address and improve compliance with timeliness of appointment setting.

Recommendation 2

The Montana VA Healthcare System Director assesses the timeliness of completion of community care appointments within 90 days of requested date and acts on identified opportunities for improvement.

_X _Concur

____Nonconcur

Target Date for completion: July 1, 2025

Director Comments

The Montana VA Healthcare System will assess barriers to timely completion of appointments, and act on identified opportunities. The Consult Oversight Committee will review the results of the actions taken on the identified opportunities and review when monitors indicate the need to reassess potential improvement options.

Recommendation 3

The Montana VA Healthcare System Director reviews consult management practices and ensures receiving staff document scheduled appointment dates for VA direct care referrals.

_X _Concur

____Nonconcur

Target Date for completion: July 1, 2025

Director Comments

The Montana VA Healthcare System will review consult management practices and identify opportunities to improve staff documentation of scheduled appointment dates.

The Consult Oversight Committee will determine what actions to leverage with the identified opportunities and establish action plans as warranted.

Recommendation 4

The Montana VA Healthcare System Director reviews appointment wait times and acts on identified opportunities for improvement.

_X _Concur

____Nonconcur

Target Date for completion: July 1, 2025

Director Comments

The Montana VA Healthcare System will complete a review of appointment wait times and act on identified opportunities. The Consult Oversight Committee will determine what actions to leverage with the identified opportunities and establish action plans as warranted. The Montana VA Healthcare System will also review any active action plans or initiatives at the local, regional, or national level that may address this recommendation.

Recommendation 5

The Montana VA Healthcare System Director ensures community care providers utilized by the system are designated as eligible in the Provider Profile Management System and acts on identified opportunities to improve the accuracy of eligibility designations.

_X _Concur

____Nonconcur

Target Date for completion: April 1, 2025

Director Comments

The Montana VA Healthcare System will review the Provider Profile Management System and verify eligibility on a quarterly and as needed basis.

VHA Office of Integrated Veteran Care and Workforce Management and Consulting Office reviewed the two providers identified in the audit and noted no patient safety concerns that would preclude those providers from being eligible in Provider Profile Management System.

OIG Contact and Staff Acknowledgments

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